Independence

For employer Group Administrator to complete.

Group Name: _____

Member Effective Date: _____

Group # (medical): _____

Group # (dental): _____

Group # (vision): _____

Group Administrator signature: _____

Application/Change form for Small Employer Coverage

Keystone Health Plan East (KHPE) HMO Plans and QCC Insurance Company PPO Plans*

Thank you for choosing Independence Blue Cross. In order to process your application as quickly as possible, please refer to the instructions on page 1 and provide the information requested.

SECTION A — Plan selections

Type of coverage	Change	Reason for application	Other change
☐ Employee only ☐ Employee and child ☐ Employee and children ☐ Employee and spouse or domestic partner ☐ Family	☐ Address ☐ Last name ☐ Primary care office ☐ Rehire ☐ Primary dental office	☐ Add spouse/domestic partner ☐ Add a dependent ☐ Delete a dependent ☐ Other Life event date: (mm/dd/yy) _____/_____/_____	☐ COBRA Effective date Effective date of coverage _____/_____/_____ mm dd yy

Choice of Plan

Keystone Health Plan East Plans:[1]

- ☐ HMO Platinum Preferred $10/$20/$150
- ☐ HMO Platinum Preferred $20/$40/$200
- ☐ HMO Platinum Preferred $30/$60/$400
- ☐ HMO Gold Preferred $35/$70/$650
- ☐ HMO Gold Proactive
- ☐ HMO Gold Classic $1,500 $25/$50/90%
- ☐ HMO Gold Classic $2,500 $40/$80/100%
- ☐ HMO Silver Classic $4,250 $25/$50/70%
- ☐ HMO Silver Secure $5,000 $40/$80/$600
- ☐ HMO Silver Classic $4,500 $40/$80/100%
- ☐ HMO Silver Classic $3,250 $30/$60/50%
- ☐ HMO Silver Proactive
- ☐ HMO Bronze Essential $6,850 $50/$100/$700
- ☐ DPOS Platinum Preferred $10/$20/$150
- ☐ DPOS Platinum Preferred $20/$40/$200
- ☐ DPOS Gold Preferred $35/$70/$650
- ☐ DPOS Gold Classic $1,500 $25/$50/90%
- ☐ DPOS Silver Classic $4,250 $25/$50/70%
- ☐ DPOS Silver Classic $3,250 $30/$60/50%
- ☐ DPOS Bronze Essential $6,850 $50/$100/$700

Personal Choice PPO Plans:[1]

- ☐ Platinum Preferred $10/$20/$150
- ☐ Platinum Preferred $20/$40/$150
- ☐ Gold Preferred $35/$70/$600
- ☐ Gold Classic $1,500 $15/$30/80%
- ☐ Gold Classic $2,500 $40/$80/100%
- ☐ Silver Secure $4,500 $35/$70/$600
- ☐ Silver Classic $4,750 $50/$100/90%
- ☐ Silver Classic $3,250 $30/$60/70%
- ☐ Platinum HSA-50 $1,600/100%
- ☐ Gold HSA-25 $2,400/90%
- ☐ Gold HSA-0 $1,900/100%
- ☐ Gold HSA-25 $2,600/80%
- ☐ Silver HSA-0 $3,200/100%
- ☐ Silver HSA-0 $2,100/70%
- ☐ Silver HSA-0 $2,700/90%
- ☐ Bronze HSA-0 $5,200/50%
- ☐ Bronze HSA-0 $6,750/100%
- ☐ Gold HRA-25 $3,200/100%

Personal Choice EPO Plans:[1]

- ☐ Silver HSA-0 $3,000/80%

Medicare Supplemental plan:

- ☐ MedigapSecurity

Vision:

- ☐ _____

Dental plans:

HMO & DPOS

- ☐ Adult DHMO[2]

PPO/HSA/HRA/HMO & DPOS

- ☐ Preferred Family PPO
- ☐ Premier Family PPO
- ☐ Deluxe Family PPO
- ☐ Adult Preventive PPO
- ☐ Adult Preferred PPO
- ☐ Adult Premier PPO

*The Keystone Health Plan East HMO/DPOS Plans are underwritten by Keystone Health Plan East. PPO Plans are underwritten by QCC Insurance Company.

[1] Includes prescription drug, pediatric and adult vision, and pediatric dental benefits.

[2] Available for HMO and DPOS plans only.

SECTION B — Primary applicant information

Primary applicant name: Last, first, middle initial		Social Security Number (required)	
Employer name	Birth date (mm/dd/yy) ____/____/_____	Age	Gender: ☐M ☐F
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†		
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†		

† A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. You can also call 1-800-ASK-BLUE (1-800-275-2583) (TTY: 711) to request a PCP or PDO directory (for HMO/DPOS plans only).

SECTION C — Family information (if applying)*

Spouse / domestic partner name: Last, first, middle initial		Social Security Number (required)		
Employer name	Birth date (mm/dd/yy) _____/_____/_____	Age	Gender: ☐M ☐F	Relationship code:‡
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†			
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†			

Dependent†† name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) _____/_____/_____	Age	Gender: ☐M ☐F	Relationship code:‡
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†			
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†			

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. You can also call 1-800-ASK-BLUE (1-800-275-2583) (TTY: 711) to request a PCP or PDO directory (for HMO/DPOS plans only).

††Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

SECTION C — Family information (continued)*

Dependent†† name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) _____/_____/_____	Age	Gender: ☐M ☐F	Relationship code:‡
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†			
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†			

Dependent†† name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) _____/_____/_____	Age	Gender: ☐M ☐F	Relationship code:‡
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†			
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†			

† A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. You can also call 1-800-ASK-BLUE (1-800-275-2583) (TTY: 711) to request a PCP or PDO directory (for HMO/DPOS plans only).

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* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

SECTION D — Personal information

Residence address			Mailing address (if different from residence address)		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			County		

SECTION E — Contact information

Home phone number ( )	Business phone number ( )	Best time to call: ☐Morning ☐Afternoon
Mobile phone number ( )	Email address	Best location to call: ☐Home ☐Business ☐Mobile

**By voluntarily giving Independence Blue Cross my mobile phone number and/or e-mail address, I authorize Independence and its subsidiaries (collectively "Independence") to send me information/data about Independence, including, but not limited to, information about my account and other insurance products and services. Independence may contact me via e-mail, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from Independence. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/ibx. Any information provided by me to Independence is subject to Independence's Privacy Policy.

SECTION F — Household information

Do all applicants reside in the same household? ☐ Yes ☐ No

If no, provide reason: _____

Applicant's name _____	Applicant's address _____
Applicant's name _____	Applicant's address _____

SECTION G — Other insurance

A. Are you or any applicants currently insured with Independence Blue Cross or an affiliate of Independence Blue Cross, or another Blue Cross and Blue Shield plan?	☐ Yes ☐ No
B. Do you have any health insurance in effect?	☐ Yes ☐ No
C. Are you replacing the health insurance plan listed in A or B above?	☐ Yes ☐ No
If "Yes," termination date (mm/dd/yy): _____/_____/_____	

Important: Confirm group coverage prior to cancelling any existing coverage.

If you answered "Yes" to question A or B, provide the following information for each applicant.

Name	Health care carrier	Policy number	Term/ Renewal date

SECTION H - Additional information

1. Have you, your spouse / domestic partner, or any dependents used a tobacco product on average four or more times per week within the past 6 months, other than for religious or ceremonial use? ☐ Yes ☐ No

If "Yes,": ☐ Yes, but I am participating in a smoking cessation program. ☐ Yes, and I am not participating in a smoking cessation program.

The above questions are applicable to members and their dependents age 21 and older.

Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____

SECTION I — Declarations and Conditions of Enrollment *Please read carefully before signing below.*

Your application cannot be processed without your signature.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For PPO members:

By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically-related facility, insurance company, or other organization or institute that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and its affiliate, QCC Insurance Company, Highmark Blue Shield, and ancillary service providers who are responsible for administrating certain covered services. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my employer, association, or welfare board and Independence Blue Cross and Highmark Blue Shield.

For HMO and DPOS members:

I understand that the provision of services to me and my dependents as members of Keystone Health Plan ("Keystone") is governed by the applicable master group contract, which provides that:

1. Except for emergencies and select DPOS services, all medical or dental care must be initiated at the primary care office or primary dental office we have selected; and,
2. I and my dependents authorize any person or organization provider services to furnish Keystone, its affiliates, and ancillary service providers who are responsible for administrating certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, Keystone quality and utilization review.

I further understand that I can change health plans only at the time my employer and Keystone specify.

Keystone DPOS program self-referred benefits may be underwritten by QCC Insurance company. Referred benefits underwritten or administered by Keystone Health Plan East.

SIGN HERE

X _____ ___/___/_____

Applicant/Parent or legal guardian signature — Date (mm/dd/yy)

Group Administrator: Mail application to:

Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101-8240

NOTE: Please make sure your Group Administrator has completed the gray-shaded section on page 2 of this application.

To get the Summary of Benefits and Coverage, you can visit ibxpress.com or call 1-800-ASK-BLUE (1-800-275-2583) (TTY:711) to request a copy in paper form free of charge.