

Application for Group Coverage

Thank you for applying for coverage from Independence Blue Cross (IBC). Follow the instructions below to complete your application.

1. Carefully review and complete each section by printing clearly in black ink.
2. Your Group Administrator must complete section 2 before your application can be processed. If this is an application for a new member or a member changing plans, the Group Administrator must indicate the type of coverage elected.

PPO HMO POS RX Vision Dental CMM Traditional MedigapSecurity

3. Provide information about your spouse and dependents only if they are also applying for coverage (Section 4). If you need additional space, attach a separate sheet with your signature and date. Important: You must include a Relationship Code (listed at the bottom of page 2) to indicate your relationship to each person covered under the plan.
4. Your Group Administrator must complete Section 7 and sign the application before it can be processed.
5. Before signing your application, please carefully read the Declarations and Conditions of Enrollment on page 4. Once you have completed and signed your application, be sure to make a copy for your records. Mail your application to or have your Group Administrator mail your paperwork to:

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

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-800-ASK-BLUE (1-800-275-2583), Monday through Friday, between 8 a.m. and 6 p.m. Brokers and small group employers should call 1-866-272-9684, Monday through Friday, 8:30 a.m. to 5 p.m., with any questions. Thank you for taking the time to complete your application. We look forward to having you as a member of the IBC family!

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Universal Enrollment Form

SECTION 1 — Subscriber or member enrollment or change — Employee MUST complete in full

Type of coverage <input type="checkbox"/> Employee and child <input type="checkbox"/> Employee and children <input type="checkbox"/> Employee only <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Family	Change <input type="checkbox"/> Address <input type="checkbox"/> Last name <input type="checkbox"/> Primary care office <input type="checkbox"/> Rehire <input type="checkbox"/> Dental office	Reason for application <input type="checkbox"/> Add spouse <input type="checkbox"/> Add a dependent <input type="checkbox"/> Delete a dependent <input type="checkbox"/> Other Life event date _____	Other change <input type="checkbox"/> COBRA Effective date _____ Effective Date of Coverage _____
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SECTION 2: To be completed by Group Administrator

Plan (please specify copay or benefit option): PPO _____ HMO _____ POS _____ RX _____ Vision _____ Dental _____	<input type="checkbox"/> CMM <input type="checkbox"/> Traditional <input type="checkbox"/> MedigapSecurity	Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retiree	Terminate contract <input type="checkbox"/> Terminated employment <input type="checkbox"/> Full-time to part-time <input type="checkbox"/> Deceased. Indicate date. <input type="checkbox"/> Other. Please Explain _____
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SECTION 3: Subscriber information — please complete this entire section, whether you are a new applicant or are making a change to an existing contract

Social Security Number or ID number		Last name		Middle initial	First name
Gender M/F	Date of birth	Street address			Apt or suite
City		State	Zip code	Date of hire	
Telephone number including area code Home _____ Work _____		Primary Care Office ID number _____		Primary Care Office name <input type="checkbox"/> Check if current patient	
		Primary Dental office ID number _____		Primary Dental Office name <input type="checkbox"/> Check if current patient	

SECTION 4 — Family information (if applying)*

Spouse name: Last, First, Middle Initial		Social Security Number			
Employer name	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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)† <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Dental Office ID#			

† A primary care physician (PCP) and primary dental office are required for all HMO/DPOS medical and dental plans. Use our website www.ibx.com/findadoctor to find a primary care physician (PCP) or a primary dental office. You can also call 215-241-CARE (2273) to request a PCP directory (HMO/DPOS plans only).

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

‡ Relationship Codes:

18 = Subscriber/Self (For dependents, value identifies relationship to the subscriber)

01 = Spouse

09 = Adopted Child

10 = Foster Child

17 = Stepson or Stepdaughter

19 = Child

31 = Court Appointed Guardian

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SECTION 4 — Family information (continued)*

Dependent ^{††} name: Last, First, Middle Initial		Social Security Number		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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) [†] <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Dental Office ID#			

Dependent ^{††} name: Last, First, Middle Initial		Social Security Number		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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) [†] <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Dental Office ID#			

Dependent ^{††} name: Last, First, Middle Initial		Social Security Number		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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) [†] <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Dental Office ID#			

SECTION 5: Dependent Information — If you listed dependents, you MUST answer these questions.

Do any dependents listed live at another address? <input type="checkbox"/> Yes <input type="checkbox"/> No	If you answered yes to either question, please explain. _____ _____
Is any dependent's last name different from yours? <input type="checkbox"/> Yes <input type="checkbox"/> No	

† A primary care physician (PCP) and primary dental office are required for all HMO/DPOS medical and dental plans. Use our website www.ilx.com/findadoctor to find a primary care physician (PCP) or a primary dental office. You can also call 215-241-CARE (2273) to request a PCP directory (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.

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

‡Relationship Codes:

18 = Subscriber/Self (For dependents, value identifies relationship to the subscriber)

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SECTION 6: Other insurance

Please list health insurance information if you or any dependents listed in Section 4 have other coverage.

Insurance Company Name _____

Policy Number _____

Policy Holder _____

Type of benefits _____

Effective date _____

Are you or any of your dependents receiving Medicare Benefits? Yes No

	Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason
Self	_____	_____	_____	_____	Check all that apply <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD
Spouse	_____	_____	_____	_____	
Child	_____	_____	_____	_____	
Child	_____	_____	_____	_____	

SECTION 7: Group and employer information

Your Group Administrator MUST complete this section. Your application CANNOT be processed unless this section is complete.

Group name _____

Group number _____

Payroll/
Work Location _____

Employer or Group Administrator signature _____

Date _____

Account number _____

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 affiliates, QCC Insurance Company, Highmark Blue Shield, and ancillary service providers who are responsible for administering 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, all medical or dental care must be initiated at the primary care office or primary care 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 administering 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.

Employee Signature _____ Date _____

Email Address _____ Subscriber's County of Residence _____

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