Application for Group Coverage

Instructions:

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. Provide information about your spouse and dependents only if they are also applying for coverage (Section C). 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 4) to indicate your relationship to each person covered under the plan.
3. Your Group Administrator must complete the box on page 3 before your application can be processed.
4. Before signing your application, please carefully read the Declarations and Conditions of Enrollment (Section I) on page 7. 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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For Group Administrator to complete.

Group name: _____

Member effective date: _____

Group #: _____

Group Administrator signature: _____

Application/Change Form for Group Coverage

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

Thank you for choosing IBC. 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 and child ☐ Employee and children ☐ Employee only ☐ Employee and spouse ☐ Family	☐ Address ☐ Last name ☐ Primary care office ☐ Rehire ☐ Dental office	☐ Add spouse ☐ Add a dependent ☐ Delete a dependent ☐ Other Life event date _____	☐ COBRA Effective date _____ Effective Date of Coverage _____

Choice of Plan			
Keystone HMO plans: ☐ HMO Platinum Premier ☐ HMO Platinum ☐ HMO Gold Premier ☐ HMO Gold ☐ HMO Silver Premier ☐ HMO Silver ☐ HMO Bronze ☐ HMO Gold Proactive ☐ HMO Silver Proactive ☐ DPOS Platinum Premier ☐ DPOS Platinum ☐ DPOS Gold Premier ☐ DPOS Gold ☐ DPOS Silver Premier ☐ DPOS Silver ☐ DPOS Bronze	Personal Choice PPO Plans: ☐ PPO Platinum Premier ☐ PPO Platinum ☐ PPO Gold Premier ☐ PPO Gold ☐ PPO Silver ☐ PPO Platinum HSA 50 ☐ PPO Gold HSA 25 ☐ PPO Gold HSA ☐ PPO Gold HSA 50 ☐ PPO Silver HSA 25 ☐ PPO Silver HSA ☐ PPO Bronze HSA Premier ☐ PPO Bronze HSA ☐ PPO Platinum HRA 50 ☐ PPO Gold HRA 25 ☐ PPO Gold HRA ☐ PPO Gold HRA 50 ☐ PPO Silver HRA 25 ☐ PPO Silver HRA ☐ PPO Bronze HRA Premier ☐ PPO Bronze HRA	Medicare Supplemental plan: ☐ MedigapSecurity Vision: ☐ _____ Dental plans: HMO & POS ☐ Adult DHMO PPO/HRA/HSA ☐ Adult Plus PPO ☐ Adult Preventive PPO	Conversion Plans: Keystone HMO ☐ HMO Platinum ☐ HMO Gold ☐ HMO Silver ☐ HMO Bronze ☐ HMO Gold Proactive ☐ HMO Silver Proactive Personal Choice PPO ☐ PPO Platinum ☐ PPO Gold ☐ PPO Silver ☐ PPO Bronze ☐ PPO Bronze Reserve ☐ PPO Silver Reserve ☐ Catastrophic

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

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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#		

†Required for all HMO/DPOS plans. Use our website, www.ibx.com/findadoctor, to find your primary care physician's (PCP) group ID. To find a new PCP, visit www.ibx.com/findadoctor or call 215-241-CARE (2273) to request a PCP directory (HMO/DPOS plans only).

SECTION C — Family Information (if applying)*

Spouse name: Last, First, Middle Initial		Social Security Number		
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#			

Dependent†† name: Last, First, Middle Initial		Social Security Number		
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#			

†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).
††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:
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

* 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		
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#			

Dependent†† name: Last, First, Middle Initial		Social Security Number		
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#			

†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).
††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.

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17 = Stepson or Stepdaughter
19 = Child
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 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

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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: Do not cancel any existing coverage until you have received notification that your application has been processed.

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 or a dependent 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): _____/_____/_____

_____ _____

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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, 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 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)

Mail your application to:

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

NOTE: Please make sure your Group Administrator has completed the box on page 3 and signed this form before you or the Group Administrator mail the form to Independence Blue Cross.

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Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

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