# HIGHMA[redacted]CROSS BLUE SHIELD ENROLLMENT APPLICATION

HIGHMARK

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

**EMPLOYEE INFORMATION — Employee must complete items 1 through 17 and sign.**

1) Employer Name

Reason for Application: ❑ New Hire ❑ Rehire ❑ Enrollment ❑ Act 4 ❑ Other: ❑ COBRA

2) Employee First Name / Middle Initial / Last Name

3) Street Address | 4) City | 5) State | 6) Zip

7) Social Security Number | 8) Effective Date of Coverage Month Day Year | 9) Employee Status ❑ Active ❑ Retired (Date) ❑ Hourly ❑ Salary

10) Employee Phone #—Home ( ) | 11) Employee Phone #—Work ( ) | 12) Employee Hire Date Month Day Year

| 13) Check Type of Coverage | MEDICAL | DENTAL | VISION | DRUG | PRODUCT NAME |
|---|---|---|---|---|---|
| Employee Only | ❑ | ❑ | ❑ | ❑ | ❑ |
| Insured & Spouse/Domestic Partner | ❑ | ❑ | ❑ | ❑ | ❑ |
| Family | ❑ | ❑ | ❑ | ❑ | ❑ |
| Parent & Child | ❑ | ❑ | ❑ | ❑ | ❑ |
| Parent & Children | ❑ | ❑ | ❑ | ❑ | ❑ |

**14) To be completed by Account Administrator only**

| Group Number | Report Code Qualifier | Report Code Value |
|---|---|---|
| | | |

**Complete items 15 through 18 where applicable. List eligible participants. (If you have additional dependents, attach separate sheet.)**

| | First Name / Middle Initial / Last Name | Social Security Number | Do you have other insurance? | Birth Date Mo | Dy | Yr | Sex F/M | Check If: Student Benefits Apply | Dis-abled | Act 4 |
|---|---|---|---|---|---|---|---|---|---|---|
| 15) Self | | | ❑ Yes ❑ No If YES, then complete #24 | | | | | | | |
| a) Full Name of Physician of Record (POR) Group Practice | | b) POR Number from Provider Directory | | c) Are you an Established Patient? ❑ Yes ❑ No | | | | | | |
| 16) ❑ Spouse ❑ Dom. Part.* | | | ❑ Yes ❑ No If YES, then complete #24 | | | | | | | |
| a) Full Name of Physician of Record (POR) Group Practice | | b) POR Number from Provider Directory | | c) Is Spouse/DP an Established Patient? ❑ Yes ❑ No | | | | | | |
| 17) ❑ Child ❑ Other* | | | ❑ Yes ❑ No If YES, then complete #24 | | | | | | | |
| a) Full Name of Physician of Record (POR) Group Practice | | b) POR Number from Provider Directory | | c) Is Dependent an Established Patient? ❑ Yes ❑ No | | | | | | |
| 18) ❑ Child ❑ Other* | | | ❑ Yes ❑ No If YES, then complete #24 | | | | | | | |
| a) Full Name of Physician of Record (POR) Group Practice | | b) POR Number from Provider Directory | | c) Is Dependent an Established Patient? ❑ Yes ❑ No | | | | | | |

***If "domestic partner" or "other" applies, complete using one of the following codes: (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter, (29) Domestic Partner**

**19)** If you checked YES to other insurance, fill in appropriate line:

Name of Insurance Carrier: _____

Group No: _____ Effective Date: _____

Name of Policy Holder: _____

Policy Number: _____

Relationship to Highmark Policy Holder: _____

Policy Holder Date of Birth: _____

Policy Holder Employment Status: ❑ Active ❑ Retired (Date) _____

**MEDICARE INFORMATION:** List any family member that is eligible for Medicare Benefits:

| Name of Member Last | First | Health Insurance Claim Number | Part A Effective Date (Mo-Day-Yr) | Part B Effective Date (Mo-Day-Yr) | Part D Effective Date (Mo-Day-Yr) |
|---|---|---|---|---|---|
| | | | / / | / / | / / |
| | | | / / | / / | / / |
| | | | / / | / / | / / |

Why are you eligible for Medicare? ❑ Age ❑ Disability ❑ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that complements Medicare? ❑ Yes ❑ No

25038

To the best of my knowledge and belief, the information provided on this application is true and correct. 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. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark Health Services may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark Health Services' Notice of Privacy Practices is available on Highmark Health Services' Web site, or from the Highmark Health Services Privacy Office.

20) _____
Authorized Employer Signature — Date

21) _____
Employee Signature — Date

MARGINAL WORDS

# United Concordia Insurance Company

# DENTAL ENROLLMENT FORM

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please complete the applicable "Type of Activity" change(s) in Section A along with the identification number and employee name in Section B and Section C for dependent changes.

## SECTION A: GENERAL INFORMATION

Effective Date (mm/dd/yyyy)

**1. TYPE OF PROGRAM**

- [x] FFS
  (Indemnity, Active PPO, Passive PPO - Please Specify)
  - [ ] Concordia Access
  - [ ] Concordia Choice
  - [ ] Concordia Flex
  - [ ] Concordia Preferred
  - [ ] Concordia Select
  - [ ] Other

**2. TYPE OF ACTIVITY**

- [x] New Enrollment
- [ ] Cancel Coverage
  - [ ] Cancel All Coverage (Employee & All Dependents)
  - [ ] Cancel Dependent(s) Only (List dependents to be cancelled)
- [ ] Change (Please Specify)
  - [ ] Add Dependent (e.g., spouse, domestic partner, child, etc.)
  - [ ] Change Address
  - [ ] Reinstate Coverage
  - [ ] Change Name
  - [ ] Change Group Number
  - [ ] COBRA
  - [ ] Other

**SECTION E: FOR EMPLOYER USE ONLY**

**EMPLOYER INFORMATION**

Employer Name: wyoming valley west school distric

Group Number: 836530

Sub Group: 440

UCCI Payroll Location:

## SECTION B: EMPLOYEE INFORMATION - Please print clearly to expedite your request.

| 1. Identification Number (For example, Social Security Number) | 2. Original Employment Date (mm/dd/yyyy) | | |
|---|---|---|---|
| 3. Employee Name (Last, First, Middle Initial) | 4. Date of Birth | 5. Sex | 6. Provider Number (DHMO Only) |
| 7. Home Address | City | State | Zip Code |

## SECTION C: DEPENDENT INFORMATION

Please list the added/cancelled dependents in this section. For more than five dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time students age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

| 1. Identification Number (For example, Social Security Number) | 2. Type | 3. Last Name | 4. First Name | 5. MI | 6. Sex | 7. Date of Birth |
|---|---|---|---|---|---|---|
| | Spouse | | | | | |
| | Dependent (A) | | | | | |
| | Dependent (B) | | | | | |
| | Dependent (C) | | | | | |
| | Dependent (D) | | | | | |
| | Other Class of Persons | | | | | |

## SECTION D: OTHER DENTAL COVERAGE

Do you or your dependent(s) have other Group Dental Coverage? Yes [ ] No [ ]
If your answer is yes, please complete the following information.

| Policy Holder | Insurance Company | Policy/Identification Number | Effective Date (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Employee Signature

Date

Employer Signature

(570) 938-0950
Phone Number

Date

SCRIPTS

*Charting the Future of Pharmacy*

xw8A

**Northeastern PA School Health**

Level 1 (Sponsor): 2007

Level 2 (Location): 4100D

Effective Date: _____

Term Date: _____

Add: ☐ Cardholder ☐ Spouse ☐ Dependent(s)

Term: ☐ Cardholder ☐ Spouse ☐ Dependent(s)

Reinstate: ☐ Cardholder ☐ Spouse ☐ Dependent(s)

Update: ☐ Cardholder ☐ Spouse ☐ Dependent(s)

Level 2 (Location) Change from: _____ to: _____ as of: _____

Other: **Group # WXS000000523606 Wyoming Valley West School District**

## Cardholder Information

Social Security #: _____

Dependent Code: 01

Name: _____
Last Name First Name MI

Date of Birth: _____ Coverage Code: 3 Relationship Code: 1 Gender: ☐ Male ☐ Female

Address: _____
Street Address or PO Box

_____
City State Zip

[X] Order Card

## Dependent Information

*Use 4-out-of-5 logic*

| Name (Last, Frist, MI) | Relationship Code * | Gender | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

*Relationship Code: 1 = Cardholder, 2 = Spouse, 3 = Child, 4 = Student, 5 = Disabled Depedent, 6 = Adult Dedpendent, 7 = Significant Other

Submitted by: _____ Phone: _____ Fax: _____

Send to: Express Scripts, Attn: Eligibility-STL1416, 14000 Riverport, Maryland Heights, MO 63043 Fax: (314) 919-4213 Email: manualeligibility@express-scripts.com

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N4

# Davis Vision Enrollment Application

DAVIS VISION
EYECARE REFRAMED℠

## Employee Information (Please Print)

Employer Name/Group Number

Reason For Application:
☐ Addition ☐ Reinstate ☐ Termination
☐ Change ☐ COBRA ☐ Waive Coverage

Check Type of Coverage:
Employee Only ☐
Employee and Spouse or Domestic Partner ☐
Family ☐
Employee & Child ☐
Employee & Children ☐

Employee (Member) First Name / Middle Initial / Last Name

Mailing Address | City | State | Zip code

Employee (Member) Identification Number

Effective Date: Month | Day | Year

Employee Status
☐ Active ☐ Hourly ☐ Salary
☐ Retired (Date) _____

Employee Phone Number

Employee Hire Date: Month | Day | Year

To be completed by Account Administrator or Human Resources representative only:

Group Number _____

Payroll Code _____

Subgroup Code | Plan Code

## Please indicate the change(s) that you need to make to your record:

☐ Change of Name
☐ Change of Address
☐ Change of Phone
☐ Change Birthdate
☐ Change Effective Date
☐ Change Report Code
Existing _____
New _____
☐ Change in Group Number
Existing _____
New _____
☐ Change Enrollment Status to:
☐ Employee Only
☐ Employee/Children
☐ Employee and Spouse / Domestic Partner
☐ Employee and Child
☐ Family

| Complete If Applicable | First Name / Middle Initial / Last Name | Social Security Number | Change | Effective Date of Change MM | DD | YY | Sex F/M | Check If Student Over 19 | Disabled | Birth Date* MM | DD | YY |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Self | | | ☐ Add ☐ Term | | | | | | | | | |
| ☐ Spouse ☐ Dom. Part. | | | ☐ Add ☐ Term | | | | | | | | | |
| ☐ Child ☐ Other | | | ☐ Add ☐ Term | | | | | | | | | |
| ☐ Child ☐ Other | | | ☐ Add ☐ Term | | | | | | | | | |
| ☐ Child ☐ Other | | | ☐ Add ☐ Term | | | | | | | | | |
| ☐ Child ☐ Other | | | ☐ Add ☐ Term | | | | | | | | | |
| ☐ Child ☐ Other | | | ☐ Add ☐ Term | | | | | | | | | |
| ☐ Child ☐ Other | | | ☐ Add ☐ Term | | | | | | | | | |

"I certify that this enrollment information is true and correct."

Member/Employee Signature _____ Date _____

*Required for all Employee/dependents

MS00109 10-6-10