



Qualified High Deductible Plan LARGE GROUP ENROLLMENT/CHANGE FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN **BLUE** OR **BLACK INK**.
DO NOT USE PENCIL OR HIGHLIGHTER.

ENROLLING (Complete sections I, II, IV & V) **WAIVING** (Complete sections I and III)

If you are applying for Medicare Supplemental coverage, do not complete this Application. Request a Medicare Supplemental Application from your Group Administrator.

I. APPLICANT INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name	Group Number	Payroll Location
----------------	---------------	--------------	------------------

REASON FOR COMPLETION: <input type="checkbox"/> New Enrollee <input type="checkbox"/> Changes <input type="checkbox"/> Rehire <input type="checkbox"/> COBRA/mini-COBRA <input type="checkbox"/> Cancel Contract Start Date _____ End Date _____	DEPENDENT CHANGES: Add dependent(s) due to: <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Adoption Date of Above Event _____ Cancel dependent(s) due to: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other _____ Date of Above Event _____	OTHER CHANGES: <input type="checkbox"/> New Name <input type="checkbox"/> New Address <input type="checkbox"/> Change to Medicare Eligible <input type="checkbox"/> Change Coverage (HIPAA Life Event) <input type="checkbox"/> Other _____ Date of Above Event _____
---	--	--

CANCEL REASON/ COBRA REASON FOR CONTRACT HOLDER:
 Deceased Left Employment Involuntary Lay-Off Other Coverage Other _____ Date of Event _____

First Name	MI	Last Name	Social Security No.	Date of Birth (Month/Day/Year)	Age
Street Address			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status (Please check one): <input type="checkbox"/> Single / Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
City	State	Zip	County	Home/Cell Phone	Email Address
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Rehire <input type="checkbox"/> COBRA/mini-COBRA <input type="checkbox"/> Retired		Date of Full-Time Hire or Rehire Mo Day Yr		Hours Worked Per Week	Job Title

Product Selection: Medical Product Name: _____

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	------------------------------------	---

II. DEPENDENT ENROLLMENT INFORMATION AND COVERAGE SELECTION (If additional space is required, attach a separate sheet)

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Spouse ¹ <input type="checkbox"/> Domestic Partner ²
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) Age

Product Selection: Medical Product Name: _____

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	------------------------------------	--

¹ If spouse's last name differs from the Applicant, please include a copy of marriage certificate.
² If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and financial verification documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other* <input type="checkbox"/> Adopted*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) Age Dependent Status if over Age 26 <input type="checkbox"/> Disabled**

Product Selection: Medical Product Name: _____

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	------------------------------------	--

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other* <input type="checkbox"/> Adopted*		
Social Security Number (If no SS#, write N/A) — —	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /	Age	Dependent Status if over Age 26 <input type="checkbox"/> Disabled**	

Product Selection: Medical Product Name: _____

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	------------------------------------	--

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Other* <input type="checkbox"/> Adopted*		
Social Security Number (If no SS#, write N/A) — —	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /	Age	Dependent Status if over Age 26 <input type="checkbox"/> Disabled**	

Product Selection: Medical Product Name: _____

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
---	------------------------------------	--

*Legal Documentation (Court Decree, Custodial Papers, etc.) must be attached to this application if the relationship is Adopted or Other.

** HMWV Disabled Dependent Adult Verification Eligibility Form must be attached to this application for review.

**III. WAIVER OF COVERAGE (Complete this section ONLY if you wish to decline coverage offered for you AND/OR family member(s))
EMPLOYEE MUST SIGN BELOW**

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

- For myself
- For family members **ONLY**:
- For myself and **ALL** family members
- For the following family members:

REASON FOR DECLINING MEDICAL COVERAGE:

- Insured under spouse's contract with the following insurance carrier:

- Other: _____

I HEREBY DECLINE DENTAL COVERAGE:

- For myself
- For family members **ONLY**
- For myself and **ALL** family members
- For the following family members:

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

Employee Signature

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Date

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, or not later than 60 days if the other coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

IV. OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage (If additional space is required, attach a separate sheet)

Name of Insurance Carrier	Policy Number	Group Number	Effective Date / /
Name of Policy Holder	Policy Holder Date of Birth / /	Relationship to Policy Holder	Policyholder Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired List Date of Retirement: / /
Cancel Date / /	Cancel Reason		

List all covered dependents: _____

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

V. IMPORTANT: EMPLOYEE MUST SIGN BELOW

I have read the entire Application and by signing this Application, I declare that all information, statements, and answers are true and complete for all listed individuals applying for coverage. I also understand and agree that coverage, if issued, will be issued in full reliance on this Application and that any untrue or incomplete information, statements, and answers in this Application may result in the denial of a claim or rescission of coverage and may subject me to legal action by Highmark WV. I also understand under WV Code §33-41-3, "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison." I also acknowledge that a copy of this Application shall be as valid as the original.

I acknowledge that no right whatsoever is created by this Application and that I and others applying for coverage will not be covered by Highmark WV unless and until this Application for coverage is approved and I have been provided an Effective Date and Group Number, and only as long as the Group continues to qualify under the terms of the Group contract with Highmark WV, including timely payment of premiums.

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 WV may use and disclose Protected Health Information for payment, treatment of health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark WV's Notice of Privacy Practices is available on Highmark WV's web site, or from the Highmark WV Privacy Office.

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark WV 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.

Print Company Name

Employee Signature

Date

Print Employee's Name

OFFICE USE ONLY (DO NOT WRITE IN THE SPACES BELOW)

SALES RECEIVED DATE	ENROLLMENT & BILLING RECEIVED DATE	UNDERWRITING RECEIVED DATE		
<p style="text-align: center;">SEND TO:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding-right: 20px;"> <p>For New Business</p> <p>Highmark West Virginia Attn: Sales P.O. Box 1948 Parkersburg, WV 26102 Fax: (304) 424-0323</p> </td> <td style="width: 50%; vertical-align: top;"> <p>For Changes</p> <p>Highmark West Virginia Attn: Enrollment & Billing P.O. Box 1948 Parkersburg, WV 26102 Fax: (866) 251-0741</p> </td> </tr> </table>		<p>For New Business</p> <p>Highmark West Virginia Attn: Sales P.O. Box 1948 Parkersburg, WV 26102 Fax: (304) 424-0323</p>	<p>For Changes</p> <p>Highmark West Virginia Attn: Enrollment & Billing P.O. Box 1948 Parkersburg, WV 26102 Fax: (866) 251-0741</p>	<p>Coverage Effective Date _____</p> <p>Date Approved _____</p> <p>Date Denied _____</p> <p>Approved By _____</p>
<p>For New Business</p> <p>Highmark West Virginia Attn: Sales P.O. Box 1948 Parkersburg, WV 26102 Fax: (304) 424-0323</p>	<p>For Changes</p> <p>Highmark West Virginia Attn: Enrollment & Billing P.O. Box 1948 Parkersburg, WV 26102 Fax: (866) 251-0741</p>			