ENROLLMENT/WAIVER FORM

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

❑ ENROLLING
❑ WAIVING

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

Effective Date	Employer Name	Group Number	Payroll Location

Last Name | First Name | MI | Social Security No.

Address | Email Address

City | State | Zip | Home Phone | Work Phone

Marital Status (Please check one):
❑ Single/Widowed
❑ Married
❑ Divorced

Employment Status: ❑ Active ❑ COBRA ❑ Disabled

Date of Full-Time Hire: Mo | Day | Yr

Hours Worked Per Week

❑ COBRA
Start Date ____________
End Date ____________

COBRA REASON:
❑ Deceased ❑ Involuntary Lay-Off Date of Event ____________
❑ Left Employment ❑ Other ____________

II ENROLLMENT INFORMATION AND COVERAGE SELECTION

Covered Dependents and Relationship	First Name & Middle Initial (show Last Name if different from Subscriber)	Social Security #	Birthdate	Sex	Height	Weight	Dependent Status If Over Age 26	Med	Vis	Den
Self			/ /	❑ M ❑ F						
❑ Spouse ❑ Dom. Part.*			/ /	❑ M ❑ F						
❑ Child ❑ Other*			/ /	❑ M ❑ F			❑ Disabled			
❑ Child ❑ Other*			/ /	❑ M ❑ F			❑ Disabled			
❑ Child ❑ Other*			/ /	❑ M ❑ F			❑ Disabled			

*If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter and (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship: ❑ Other: ____________

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

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:
❑ For myself
❑ For family members **ONLY**
❑ For myself and **ALL** family members
❑ For the following person(s):
____

REASON FOR DECLINING MEDICAL COVERAGE:
❑ Insured under spouse's contract with the following insurance carrier:
____
❑ Other: ____________

VISION

I HEREBY DECLINE VISION COVERAGE:
❑ For myself
❑ For family members **ONLY**
❑ For myself and **ALL** family members
❑ For the following person(s):
____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:
❑ For myself
❑ For family members **ONLY**
❑ For myself and **ALL** family members
❑ For the following person(s):
____

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 qualifying event occurs before coverage will be offered.

Employee Signature | Date | Employer Signature | Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance 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 plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, as long as you are covered by the group's health insurance plan provided by your employer, 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.

BOTH EMPLOYEE AND EMPLOYER SIGNATURES ARE REQUIRED FOR WAIVERS

Highmark Health Insurance Company is an independent licensee of the Blue Cross and Blue Shield Association