HIGHMARK Delaware

STATE OF DELAWARE APPLICATION FOR COVERAGE

FOR STATE OF DELAWARE USE ONLY

Name	Phone	Date	Group Number	Contact	Dept./Agency

A. REASON FOR APPLICATION (CHECK ALL THAT APPLY). PLEASE PRINT LEGIBLY.

☐ New coverage
☐ Change coverage
☐ Information change
☐ Refuse coverage *(see Section E)*

ADD DEPENDENTS DUE TO:
☐ Marriage/Civil Union ☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship Date of event checked:

CANCEL DEPENDENTS DUE TO:
☐ Divorce/Dissolution ☐ Death
☐ Over age ☐ Other
☐ No longer dependent Date of event checked:

REINSTATE COVERAGE DUE TO:
☐ Rehire ☐ Administrative error
☐ Return from leave ☐ Other
☐ Return from layoff Date of event checked:

B. PERSONAL INFORMATION

☐ Male ☐ Retiree ☐ Non-employee ☐ Female ☐ Surviving spouse	Date of Hire/Retirement (month, day, year)	Social Security Number	Agency or School District

Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)

Street Address	City	State	Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family
PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE: ☐ First State Basic ☐ Comprehensive PPO
☐ Special Medicfill ☐ Special Medicfill without prescription
☐ **I AM 65 OR OLDER.** ☐ **MY SPOUSE IS 65 OR OVER; I AM A FULLTIME EMPLOYEE.**

MEDICARE INFORMATION:
Applicant's Medicare #: ______________________
Part A Effective Date: ______________________
Part B Effective Date: ______________________

D. ELIGIBLE DEPENDENTS TO BE COVERED

If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.

☐ Add ☐ Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date (month, day, year)	Spouse's Social Security Number	
☐ Add ☐ Cancel	Dependent's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date (month, day, year)	Dependent's Social Security Number	☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female
☐ Add ☐ Cancel	Dependent's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date (month, day, year)	Dependent's Social Security Number	☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female
☐ Add ☐ Cancel	Dependent's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date (month, day, year)	Dependent's Social Security Number	☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female

ENR-196 (R3-17)

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐ I am ☐ My spouse ☐ My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Highmark DE contract? ☐ Y ☐ N

F. TERMS OF AGREEMENT

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Blue Cross Blue Shield Delaware (Highmark DE). 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark DE, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents to Highmark DE or its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark DE to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law. 6) If covering a spouse, you must go online at and complete a Coordination of Benefits form.

I elect not to participate in the State Health Insurance Program. Signature:	I have read and do agree to the above terms. Signature:	Date

HIGHMARK. Delaware

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).