

General Information:

- Check one: I am applying for new Comprehensive Major Medical Preferred-Provider coverage (new applicant)
 I am adding dependent(s) to my existing coverage



An Individual Preferred-Provider Program
 Utilizing the Keystone Health Plan West
 Network of Providers

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association

If applying for husband and wife or family coverage, applicant must be the older spouse.
 If children only are applying, youngest child must be the applicant.

(PLEASE PRINT) Applicant's Last Name		First Name	Middle Initial	County
Home Address		City	State	Zip Code
Home Phone Number ()		Work Phone Number ()		
Home Email		Work Email		

Enrollment Information:

This Comprehensive Major Medical Preferred-Provider Subscription Agreement for Individual Members Utilizing the Keystone Health Plan West Network of Providers, Without a Gatekeeper ("Agreement") renews on a month-to-month basis. The premium is payable in advance to Highmark Blue Cross Blue Shield on a monthly basis. Once enrolled, you can choose to pay your monthly premium via electronic funds transfer through the Pay It Easy program.

Monthly premium: \$ _____

List spouse and/or eligible child(ren) you are enrolling. (Eligible children are unmarried children under age 19.)

	Self	Spouse	Child	Child	Child
Name					
Do you smoke or use smokeless tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number					
Birth Date (MM/DD/YY)	/ /	/ /	/ /	/ /	/ /
Present Age					
Sex					
Height					
Weight					
Current Physician					
Physician's Phone Number	()	()	()	()	()
HBCBS Use Only					

1. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have in force? This includes any current Highmark Blue Cross Blue Shield policy.
 YES If "yes," proceed to 1 (a) and (b). NO If "no," proceed to question 2.

1 (a). If you answered "yes" to question 1, please provide the insurance company name and applicable group and identification number(s):

Company Name: _____

Group No: _____ Agreement or Policy No: _____

1 (b). If you answered "yes" to question 1, please complete the enclosed Notice to Applicant Regarding Replacement of Accident and Sickness Coverage form and mail it with your application.

2. Have you or any applicants ever applied and been rejected for any:

Name or Person(s) Rejected and Reason

Medical policies Yes No

Life insurance policies Yes No

3. Are you or any of your dependents who are applying for this coverage enrolled in or eligible for Medicare due to age and/or disability? Yes No

ANY PERSON ELIGIBLE FOR MEDICARE OR MEDICARE DISABILITY BENEFITS IS NOT ELIGIBLE FOR THIS COVERAGE.

4. Payment Enclosed \$	Group Number 039000-00	Applicant's Social Security Number
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Medical Information:

Section A.

Please answer each question completely. If it is found that you have supplied fraudulent information, or made fraudulent statements or omissions with the intent to deceive, your Agreement may be voided.

1. Do you – or any family member applying – use any medical equipment (such as a walker, wheelchair, cane or hospital bed)? Yes No

2. Are you – or any family member applying – currently receiving home health care? Yes No

3. If you answered “YES” to question 1 or 2, please provide the name(s) of the affected person(s) and specifics about the condition:

Name of Person	Condition/Reason
_____	_____
_____	_____

4. Give date of last menstrual period for each female family member applying:

Name of Person	Date of Last Period
_____	_____
_____	_____

5. Have you — or any family member applying — been recently (i.e., within the past nine (9) months) medically diagnosed or treated for pregnancy? Yes No

Name(s) of pregnant person(s): _____ Date medically diagnosed or treated: _____

6. Have you – or any family member applying – gained or lost more than 20 pounds over the past 3 months?

Yes No If “YES,” provide person’s name and amount gained or lost.

Name of Person	Weight Gained/Lost
_____	_____
_____	_____

Section B.

Please indicate by checking the appropriate block(s) below if you — or any family member applying — have been treated by, diagnosed by, or received medical advice from a physician or other health care provider for any condition, illness, injury or surgery listed below WITHIN THE LAST FIVE (5) YEARS.

Conditions	Applicant		List Dependent(s) by Name			
	Applicant	Spouse				
7. AIDS or Positive Test for HIV, HTLV-III/LAV Antibodies						
8. Alcoholism						
9. Alzheimer's Disease						
10. Amputation of Limb (Specify) _____						
11. Arterio-Venous Malformation (AVM)						
12. Arthritis						
*13. Other Joint Disease (Specify) _____						
14. Asthma						
*15. Back Disabilities						
*16. Back Pain - Chronic						
17. Brain Tumor						
18. Cancer						
19. Cataract(s) right _____ left _____						
20. Chest Pain or Angina						
21. Chiropractic Visits (Specify Number of Visits) _____						
22. Cholesterol (Specify Current Reading) _____						
23. Cirrhosis						
24. Other Liver Disease (Specify) _____						
25. Congenital Anomalies and Conditions (Specify) _____						
26. Dementia, “Senility” or Increasing Forgetfulness with Age						
27. Diabetes – Controlled with Diet (Specify Current Fasting Blood Sugar) _____						
28. Diabetes – Controlled with Medication						

*If you check this condition, you must list under Section C or on a separate sheet of paper the name(s) of the attending physician, osteopath or chiropractor and date(s) of treatment for each family member.

Medical Information (Continued)

Conditions	Applicant		List Dependent(s) by Name			
	Applicant	Spouse				
29. Diseases of the Esophagus, Stomach or Intestine (for example, Crohn's Disease or Ulcerative Colitis) (Specify) _____						
30. Drug Dependency						
31. Ear Conditions (including frequent ear infections) (Specify) _____						
32. Emphysema						
33. Other Lung Disease (including work-related, for example, "Black Lung") (Specify) _____						
34. Gynecological (Specify) _____ If recent delivery, please provide date of medical release (post-partum check-up) from Obstetrician/Gynecologist: _____						
35. Heart Attack						
36. Other Heart Disease (Specify) _____						
37. Hepatitis						
38. High Blood Pressure (if checked, indicate usual blood pressure) _____						
39. Infertility (Specify) _____						
40. Immunization for Children Name and address of pediatrician: _____ _____ _____						
41. Kidney/Renal Failure						
42. Other Kidney Disorder (Specify) _____						
43. Leukemia						
44. Other Hematologic (Blood) Disorder (Specify) _____						
45. Musculoskeletal (pertaining to muscle or bone) Injury or Illness (Specify) _____						
46. Neurologic Deficit or Disorder, including head or spinal injury or paralysis (Specify) _____						
47. Psychiatric Disorder/Behavioral Health						
48. Severe Injury or Burns (Specify) _____						
49. Severe Visual Impairment/Blindness						
50. Spinal Injuries						
51. Stroke						
52. Surgery of any kind (Specify) _____						
53. Temporomandibular Joint Syndrome (TMJ)						
54. Transient Ischemic Attacks (TIA's)						
55. Urological						
56. Any other conditions, injuries or ailments not specifically mentioned above for which you or your eligible dependents have been treated by, diagnosed by, or received medical advice from a physician or other health care provider within the last five (5) years? Please explain:	_____ _____ _____ _____					

Please note: Any physician charges or other fees incurred during the process of completing this application are the responsibility of the applicant.

Medical Information (Continued)

Section C.

If any of the conditions in Section B are checked, please explain below. Use additional paper if necessary. Please provide details of the condition.

Patient's Name/Diagnosis Type of Treatment/Surgery	Hospital Treatment?	Attending Physician	Dates of Illness
57.	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date ____/____/____	Name: _____ Address: _____ Phone: () _____ Hospital Name: _____	From: _____ To: _____
58.	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date ____/____/____	Name: _____ Address: _____ Phone: () _____ Hospital Name: _____	From: _____ To: _____
59.	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date ____/____/____	Name: _____ Address: _____ Phone: () _____ Hospital Name: _____	From: _____ To: _____

60. When was the last time each person applying for coverage visited a doctor (other than at an emergency room)? Include date of visit, name and address of physician or other provider (gynecologist/obstetrician, osteopath, chiropractor, etc.) and reason for visit. Use additional paper if necessary.

Applicant: _____ Date of Exam _____

Provider's Name and Address _____

Reason _____

Spouse: _____ Date of Exam _____

Provider's Name and Address _____

Reason _____

Dependent Child: _____ Date of Exam _____

Provider's Name and Address _____

Reason _____

Dependent Child: _____ Date of Exam _____

Provider's Name and Address _____

Reason _____

Medical Information (Continued)

61. When was the last time each person applying for coverage visited an emergency room at a hospital or other medical facility? Include date of visit, name and address of emergency room, attending physician's name and reason for visit. Use additional paper if necessary.

Applicant: _____ Date of Visit _____

Hospital Name and Address _____

Physician _____

Reason _____

Spouse: _____ Date of Visit _____

Hospital Name and Address _____

Physician _____

Reason _____

Dependent Child: _____ Date of Visit _____

Hospital Name and Address _____

Physician _____

Reason _____

Dependent Child: _____ Date of Visit _____

Hospital Name and Address _____

Physician _____

Reason _____

Dependent Child: _____ Date of Visit _____

Hospital Name and Address _____

Physician _____

Reason _____

Medical Information (Continued)

Section D.

If you — or any family members applying —

62. — Drink alcoholic beverages, please indicate frequency of use:

Name of Person

Number of Drinks per Week

(Serving size per drink equals 1½ oz. liquor, 12 oz. beer, 5 oz. wine)

63. — Have ever smoked, please indicate amount of cigarettes, cigars, pipes or smokeless tobacco (snuff, chewing tobacco, etc.) used and length of use:

Name of Person

Amount per Day/Type

Dates of Use

Name of Person	Amount per Day/Type	Dates of Use	
		From:	To:
		From:	To:
		From:	To:
		From:	To:
		From:	To:

64. — Have taken prescribed drugs within the last year, please list drug(s) taken and reason:

Name of Person

Medication/Dosage

Dates of Use

Condition/Reason

Name of Person	Medication/Dosage	Dates of Use		Condition/Reason
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	

Conditions of Enrollment

I, the undersigned, hereby apply for coverage for myself and all my listed eligible dependents.

I represent, to the best of my knowledge and belief, that:

1. I have read and have supplied all the requested information on this form with regard to myself and any family members applying for coverage. (If not, I have attached a letter which explains why.)
2. All applicants for this policy are in good health except for those conditions listed in the Medical Information portion of the application.
3. No material information has been withheld or omitted about the past or present state of my health or any family member(s) applying.

I understand and agree that:

1. Any person eligible for Medicare or Medicare disability benefits is not eligible for this coverage.
2. This coverage does not begin until this application is accepted by Highmark Blue Cross Blue Shield and an Effective Date of coverage is assigned; and
3. Initial payment must be submitted with the application; and
4. Receipt of my money (check or money order) does not constitute enrollment under any program; and
5. This coverage is provided only to residents of the geographical area of western Pennsylvania served by Highmark Blue Cross Blue Shield. We reserve the right to investigate and confirm your residence from time to time.
6. If applicant is under age 18, the signature of a parent or guardian is required on this application.

I also understand and agree that Highmark Blue Cross Blue Shield may:

1. Require me and any family member(s) applying to provide upon request medical history or to have a medical examination, blood test or other applicable medical test prior to acceptance of the application (Highmark Blue Cross Blue Shield may choose to specify the provider);
2. Deny this application, in which case any premium submitted will be refunded and accepted by me; or
3. Void this Agreement or deny a claim for loss incurred or disability (as defined in the Agreement) during the first three (3) years from the effective date of this Agreement if the applicant made a material misrepresentation of a material fact in the application that affected the risk or hazard assumed by the Plan.
4. Void this Agreement or deny a claim for loss or disability (as defined in the Agreement) after three (3) years from the Effective Date only for fraudulent material misstatements made by the applicant in the application for such Agreement.

I also understand and agree that the Agreement will not provide benefits for me or any enrolled dependents during the twelve-month period following the Effective Date on which I and any dependents become enrolled under the Agreement for any condition for which medical advice or treatment was recommended by or received from a physician within a five-year period prior to the Effective Date of the Agreement.

I understand and agree that the terms and conditions of our coverage will be controlled by the written Agreement with Highmark Blue Cross Blue Shield and that it may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I recognize that our coverage will only apply to admissions that occur and services that are provided on or after the effective date of our coverage.

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 may use and disclose Protected Health Information for payment, treatment and health care operations.

A copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

To the best of my knowledge and belief, the information provided on this application is true and correct.

Notice: 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 request this coverage to become effective _____.

Your requested Effective Date must be within two (2) months of your date of signature below.

Note: The Effective Date of coverage is usually the first day of the month following medical underwriting approval. However, we cannot guarantee that your requested Effective Date can be met. The Effective Date is in all cases the date on which your coverage begins following medical underwriting approval and assignment of an Effective Date.

Please note: To avoid delays in processing your application, this form must be received by Highmark Blue Cross Blue Shield within fifteen (15) days of the date of your signature.

If you and your spouse are applying for this coverage, your spouse also must read and understand these "Conditions of Enrollment," and sign and date this application below.

Applicant's Signature	Date
Spouse's Signature	Date

DO NOT WRITE IN THIS AREA

R FLAG: _____

DEC DATE: _____

DEPT. CD: _____

DEN CD: _____

OVR EFF DATE: _____

INITIAL RECEIPT DATE: _____

CLERK NO: _____

C.O. REASON: _____

C.O. DECISION DATE: _____

WHO DENIED: _____

REAPPLY DATE: _____

REMARKS: _____

Credit Card Payment Option:

Applications processed with a credit or debit card deposit are generally processed a week to two weeks faster than applications with an attached check. The credit or debit card payment is for your initial premium payment only. You will receive a bill on your next billing statement if approved for coverage.

Credit Card Type: VISA MasterCard
Cardholder's Name (exactly as it appears on the card)

Account Number :

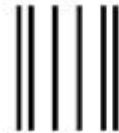
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Card Expiration Date:

□ □ / □ □

Postage Paid Return Envelope:

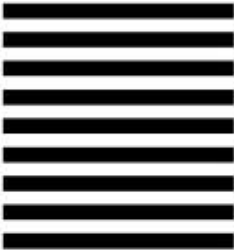
For your convenience, we will pay for the postage to return your application. Cut at the dotted line below. Tape or glue to the top right corner of a blank envelope. A standard, letter sized envelope (#10) is the preferred envelope size. Use more than one envelope if mailing more than one application.



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



POSTAGE WILL BE PAID BY ADDRESSEE



APPLICATION PROCESSING CENTER
PMB 373
256 EAGLEVIEW BLVD STE 200
EXTON PA 19341-9977

