An Individual Preferred-Provider
High-Deductible 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

General Information:

Checkon e: ☐ **I am applying for new ComprehensiveM ajor Medical Preferred-Provider High-Deductible coverage (new applicant).**

☐ **I am adding dependent(s) to my existing coverage.**

Ifa pplying for husbanda nd wife or familyc overage, applicant must be the older spouse.
Ifc hildren onlya re 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:

Annual deductible you prefer: ☐ **$1,200 (3)** ☐ **$2,600 (4)** ☐ **$3,500 (8)** **$**_______________ **Monthly premium**

Note: Deductible level can be **increased** only on the contract anniversary date if the request is received prior tot his date. Deductible level can be **decreased** as of the contract anniversary date only after the member holds a contract fort wo consecutive years and the request is received at leastone month prior to contract anniversary date.

This Comprehensive Major Medical Preferred-Provider High-Deductible 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 HighmarkBlue Cross Blue Shield ona monthly basis. Once enrolled, you can chooset o pay your monthly premium via electronic funds transfer through the Pay It Easyprogram.

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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Social SecurityN umber					
Birth Date (MM/DD/YY)	/ /	/ /	/ /	/ /	/ /
PresentAge					
Sex					
Height					
Weight					
Current Physician					
Physician's Phone Number	( )	( )	( )	( )	( )
HBCBS Use Only					

1. Is this coverage for which you are applying intended tor eplace any other accident or health insurance you or any family members applying currently have in force? This includes any current HighmarkB lueC ross BlueS hield policy.
   ☐ YES If "yes," proceed to 1 (a) and(b). ☐ NO If "no," proceedt o question 2.

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

   CompanyN ame: ____

   GroupN o: ______________________ Agreement orI .D. No: ______________________

   1 (b). If you answered "yes" to question 1, please complete the enclosed *Notice to Applicant Regarding Replacemento f Accident and SicknessC overage* form and maili t with your application.

2. Have you or any applicants ever applied and beenr ejected for any: Name or Person(s)R ejected andR eason

   Medical policies ☐ Yes ☐ No ______________________

   LifeI nsurance policies ☐ Yes ☐ No ______________________

3. Are you or any of your dependents who are applying for this coverage enrolled in or eligible for Medicare duet o age and/ord isability? ☐ Yes ☐ No

ANY PERSONE LIGIBLE FOR MEDICARE OR MEDICARE DISABILITY BENEFITS IS NOT ELIGIBLEF OR THIS COVERAGE.

4.

Payment Enclosed	Group Number	Applicant's Social Security Number
$	**035000-00**	

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.

			List Dependent(s) by Name			
Conditions	**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	Spouse	List Dependent(s) by Name			
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.		☐ Inpatient ☐ Outpatient Date ____/____/____	Name: ____ Address: ____ Phone: ( ) ____ Hospital Name: ____	From: ____ To: ____
58.		☐ Inpatient ☐ Outpatient Date ____/____/____	Name: ____ Address: ____ Phone: ( ) ____ Hospital Name: ____	From: ____ To: ____
59.		☐ Inpatient ☐ 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 sizep er drink equals1 ½ oz. liquor,1 2 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	
		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
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	

Highmarki s a registered service marko f Highmarkl nc.

Blue Cross, Blue Shield andt he Crossa nd Shield symbolsa re registered service marks of
the Blue Cross andB lue Shield Association, an association of independent Blue Cross and BlueS hield Plans.
PPOBluei s a service mark of the Blue Crossa nd Blue Shield Association.

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.

This program is available to individuals who wish to purchase a qualified high deductible health plan for use with a Health Savings Account as defined by the Internal Revenue Service.

____
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 :

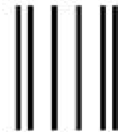
☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

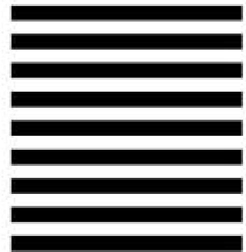
Card Expiration Date:

☐☐ / ☐☐

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.





POSTAGE WILL BE PAID BY ADDRESSEE

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