

Application for Group Coverage

Instructions:

Thank you for applying for coverage from Independence Blue Cross (IBC). Follow the instructions below to complete your application.

1. Carefully review and complete each section by printing clearly in black ink.
2. Provide information about your spouse and dependents only if they are also applying for coverage (Section C). If you need additional space, attach a separate sheet with your signature and date.

Important: You must include a Relationship Code (listed at the bottom of page 4) to indicate your relationship to each person covered under the plan.

3. Your Group Administrator must complete the box on page 3 before your application can be processed.
4. Before signing your application, please carefully read the Declarations and Conditions of Enrollment (Section I) on page 7. Once you have completed and signed your application, be sure to make a copy for your records. Mail your application to or have your Group Administrator mail your paperwork to:

Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101-8240

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-800-ASK-BLUE (1-800-275-2583), Monday through Friday, between 8 a.m. and 6 p.m. Brokers and small group employers should call 1-866-272-9684, Monday through Friday, 8:30 a.m. to 5 p.m., with any questions. Thank you for taking the time to complete your application. We look forward to having you as a member of the IBC family!



For Group Administrator to complete.

Group name: _____

Member effective date: _____

Group #: _____

Group Administrator signature: _____

Application/Change Form for Group Coverage

Keystone Health Plan East (KHPE) HMO Plans and QCC Insurance Company PPO Plans*

Thank you for choosing IBC. In order to process your application as quickly as possible, please refer to the instructions on page 1 and provide the information requested.

SECTION A — Plan Selections

Type of coverage	Change	Reason for application	Other change
<input type="checkbox"/> Employee and child <input type="checkbox"/> Employee and children <input type="checkbox"/> Employee only <input type="checkbox"/> Employee and spouse <input type="checkbox"/> Family	<input type="checkbox"/> Address <input type="checkbox"/> Last name <input type="checkbox"/> Primary care office <input type="checkbox"/> Rehire <input type="checkbox"/> Dental office	<input type="checkbox"/> Add spouse <input type="checkbox"/> Add a dependent <input type="checkbox"/> Delete a dependent <input type="checkbox"/> Other Life event date _____	<input type="checkbox"/> COBRA Effective date _____ Effective Date of Coverage _____

Choice of Plan			
Keystone HMO plans: <input type="checkbox"/> HMO Platinum Premier <input type="checkbox"/> HMO Platinum <input type="checkbox"/> HMO Gold Premier <input type="checkbox"/> HMO Gold <input type="checkbox"/> HMO Silver Premier <input type="checkbox"/> HMO Silver <input type="checkbox"/> HMO Bronze <input type="checkbox"/> HMO Gold Proactive <input type="checkbox"/> HMO Silver Proactive <input type="checkbox"/> DPOS Platinum Premier <input type="checkbox"/> DPOS Platinum <input type="checkbox"/> DPOS Gold Premier <input type="checkbox"/> DPOS Gold <input type="checkbox"/> DPOS Silver Premier <input type="checkbox"/> DPOS Silver <input type="checkbox"/> DPOS Bronze	Personal Choice PPO Plans: <input type="checkbox"/> PPO Platinum Premier <input type="checkbox"/> PPO Platinum <input type="checkbox"/> PPO Gold Premier <input type="checkbox"/> PPO Gold <input type="checkbox"/> PPO Silver <input type="checkbox"/> PPO Platinum HSA 50 <input type="checkbox"/> PPO Gold HSA 25 <input type="checkbox"/> PPO Gold HSA <input type="checkbox"/> PPO Gold HSA 50 <input type="checkbox"/> PPO Silver HSA 25 <input type="checkbox"/> PPO Silver HSA <input type="checkbox"/> PPO Bronze HSA Premier <input type="checkbox"/> PPO Bronze HSA <input type="checkbox"/> PPO Platinum HRA 50 <input type="checkbox"/> PPO Gold HRA 25 <input type="checkbox"/> PPO Gold HRA <input type="checkbox"/> PPO Gold HRA 50 <input type="checkbox"/> PPO Silver HRA 25 <input type="checkbox"/> PPO Silver HRA <input type="checkbox"/> PPO Bronze HRA Premier <input type="checkbox"/> PPO Bronze HRA	Medicare Supplemental plan: <input type="checkbox"/> MedigapSecurity Vision: <input type="checkbox"/> _____ Dental plans: HMO & POS <input type="checkbox"/> Adult DHMO PPO/HRA/HSA <input type="checkbox"/> Adult Plus PPO <input type="checkbox"/> Adult Preventive PPO	Conversion Plans: Keystone HMO <input type="checkbox"/> HMO Platinum <input type="checkbox"/> HMO Gold <input type="checkbox"/> HMO Silver <input type="checkbox"/> HMO Bronze <input type="checkbox"/> HMO Gold Proactive <input type="checkbox"/> HMO Silver Proactive Personal Choice PPO <input type="checkbox"/> PPO Platinum <input type="checkbox"/> PPO Gold <input type="checkbox"/> PPO Silver <input type="checkbox"/> PPO Bronze <input type="checkbox"/> PPO Bronze Reserve <input type="checkbox"/> PPO Silver Reserve <input type="checkbox"/> Catastrophic

*The Keystone Health Plan East HMO/DPOS Plans are underwritten by Keystone Health Plan East. PPO Plans are underwritten by QCC Insurance Company.





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SECTION B – Primary Applicant Information

Primary applicant name: Last, First, Middle Initial		Social Security Number (required)	
Employer name	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Primary care office/ PCP name (HMO/DPOS only) [†]		Primary Care Physician Office ID# (HMO ID#, HMO/DPOS only) [†]	
Current patient of PCP? (HMO/DPOS only) [†] <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Dental Office ID#	

[†]Required for all HMO/DPOS plans. Use our website, www.ibx.com/findadoctor, to find your primary care physician's (PCP) group ID. To find a new PCP, visit www.ibx.com/findadoctor or call 215-241-CARE (2273) to request a PCP directory (HMO/DPOS plans only).

SECTION C – Family Information (if applying)*

Spouse name: Last, First, Middle Initial		Social Security Number	
Employer name	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Primary care office/ PCP name (HMO/DPOS only) [†]		Primary Care Physician Office ID# (HMO ID#, HMO/DPOS only) [†]	
Current patient of PCP? (HMO/DPOS only) [†] <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Dental Office ID#	
Dependent ^{††} name: Last, First, Middle Initial		Social Security Number	
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Primary care office/ PCP name (HMO/DPOS only) [†]		Primary Care Physician Office ID# (HMO ID#, HMO/DPOS only) [†]	
Current patient of PCP? (HMO/DPOS only) [†] <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary Dental Office ID#	

[†]A primary care physician (PCP) and primary dental office are required for all HMO/DPOS medical and dental plans. Use our website www.ibx.com/findadoctor to find a primary care physician (PCP) or a primary dental office. You can also call 215-241-CARE (2273) to request a PCP directory (HMO/DPOS plans only).

^{††}Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

[‡]Relationship Codes:

18 = Subscriber/Self (For dependents, value identifies relationship to the subscriber)	10 = Foster Child
01 = Spouse	17 = Stepson or Stepdaughter
09 = Adopted Child	19 = Child
	31 = Court Appointed Guardian

* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.



SECTION C — Family Information (continued)*

Dependent ^{††} name: Last, First, Middle Initial		Social Security Number		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship Code: [‡]
Primary care office/ PCP name (HMO/DPOS only) [†]	Primary Care Physician Office ID# (HMO ID#, HMO/DPOS only) [†]			
Current patient of PCP? (HMO/DPOS only) [†] <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Dental Office ID#			

Dependent ^{††} name: Last, First, Middle Initial		Social Security Number		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship Code: [‡]
Primary care office/ PCP name (HMO/DPOS only) [†]	Primary Care Physician Office ID# (HMO ID#, HMO/DPOS only) [†]			
Current patient of PCP? (HMO/DPOS only) [†] <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Dental Office ID#			

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10 = Foster Child	

* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

SECTION D — Personal Information

Residence address			Mailing address (if different from residence address)		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			County		

SECTION E — Contact Information

Home phone number ()	Business phone number ()	Best time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon
Mobile phone number ()	Email address	Best location to call: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Mobile

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SECTION F — Household Information

Do all applicants reside in the same household? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, provide reason: _____ _____	
Applicant's name _____	Applicant's address _____ _____
Applicant's name _____	Applicant's address _____ _____

SECTION G — Other Insurance

A. Are you or any applicants currently insured with Independence Blue Cross or an affiliate of Independence Blue Cross, or another Blue Cross and Blue Shield plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Do you have any health insurance in effect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Are you replacing the health insurance plan listed in A or B above?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If "Yes," termination date (mm/dd/yy): ____/____/____		

Important: Do not cancel any existing coverage until you have received notification that your application has been processed.

If you answered "Yes" to question A or B, provide the following information for each applicant.

Name	Health care carrier	Policy number	Term/ Renewal date

SECTION H - Additional Information

1. Have you or a dependent used a tobacco product on average four or more times per week within the past 6 months, other than for religious or ceremonial use? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes,": <input type="checkbox"/> Yes, but I am participating in a smoking cessation program. <input type="checkbox"/> Yes, and I am not participating in a smoking cessation program.		
The above questions are applicable to members and their dependents age 21 and older.		
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): ____/____/____

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SECTION I – Declarations and Conditions of Enrollment *Please read carefully before signing below.*

Your application cannot be processed without your signature.

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.

For PPO members:

By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically-related facility, insurance company, or other organization or institute that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and its affiliate, QCC Insurance Company, Highmark Blue Shield, and ancillary service providers who are responsible for administering certain covered services. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my employer, association, or welfare board and Independence Blue Cross and Highmark Blue Shield.

For HMO and DPOS members:

I understand that the provision of services to me and my dependents as members of Keystone Health Plan (“Keystone”) is governed by the applicable master group contract, which provides that:

1. Except for emergencies, all medical or dental care must be initiated at the primary care office or primary care dental office we have selected; and,
2. I and my dependents authorize any person or organization provider services to furnish Keystone, its affiliates, and ancillary service providers who are responsible for administering certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, Keystone quality and utilization review.

I further understand that I can change health plans only at the time my employer and Keystone specify.

Keystone DPOS program self-referred benefits may be underwritten by QCC Insurance company. Referred benefits underwritten or administered by Keystone Health Plan East.

SIGN HERE X _____ / /
 Applicant/Parent or Legal Guardian signature Date (mm/dd/yy)

Mail your application to:

**Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101-8240**

NOTE: Please make sure your Group Administrator has completed the box on page 3 and signed this form before you or the Group Administrator mail the form to Independence Blue Cross.



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Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

