HIGHMARK. West Virginia

LARGE GROUP ENROLLMENT/CHANGE FORM

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

❑ **ENROLLING** (Complete sections I, II, IV & V) ❑ **WAIVING** (Complete sections I and III)

If you are applying for Medicare Supplemental coverage, do not complete this Application. Request a Medicare Supplemental Application from your Group Administrator.

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

Effective Date	Employer Name	Group Number	Payroll Location

REASON FOR COMPLETION:
❑ New Enrollee ❑ Changes ❑ Rehire
❑ COBRA/mini-COBRA ❑ Cancel Contract
Start Date _____
End Date _____

DEPENDENT CHANGES:
Add dependent(s) due to:
❑ Birth ❑ Marriage ❑ Adoption
Date of Above Event _____
Cancel dependent(s) due to:
❑ Divorce ❑ Death ❑ Other _____
Date of Above Event _____

OTHER CHANGES:
❑ New Name
❑ New Address
❑ Change to Medicare Eligible
❑ Change Coverage (HIPAA Life Event)
❑ Other _____
Date of Above Event _____

CANCEL REASON/ COBRA REASON FOR CONTRACT HOLDER:
❑ Deceased ❑ Left Employment ❑ Involuntary Lay-Off ❑ Other Coverage ❑ Other_____ Date of Event _____

First Name	MI	Last Name	Social Security No. — —	Date of Birth (Month/Day/Year) / /	Age

Street Address	Gender ❑ Male ❑ Female	Marital Status (Please check one): ❑ Single / Widowed ❑ Married ❑ Divorced

City	State	Zip	County	Home/Cell Phone	Email Address

Employment Status	Date of Full-Time Hire or Rehire			Hours Worked	Job Title
❑ Active ❑ Rehire ❑ COBRA/mini-COBRA ❑ Retired	Mo	Day	Yr	Per Week	

Product Selection: ❑ Medical Product Name: _____ ❑ Dental (Dental only applicable for 10+ sized groups)

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient? ❑ Yes ❑ No

II. DEPENDENT ENROLLMENT INFORMATION AND COVERAGE SELECTION

(If additional space is required, attach a separate sheet)

First Name	MI	Last Name	Relationship to You? ❑ Spouse[1] ❑ Domestic Partner[2]

Social Security Number (If no SS#, write N/A) — —	Gender ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /	Age

Product Selection: ❑ Medical Product Name: _____ ❑ Dental (Dental only applicable for 10+ sized groups)

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient? ❑ Yes ❑ No

[1] If spouse's last name differs from the Applicant, please include a copy of marriage certificate.
[2] If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and financial verification documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Other* ❑ Adopted*

Social Security Number (If no SS#, write N/A) — —	Gender ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /	Age	Dependent Status if over Age 26 ❑ Disabled**

Product Selection: ❑ Medical Product Name: _____ ❑ Dental (Dental only applicable for 10+ sized groups)

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient? ❑ Yes ❑ No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Other* ❑ Adopted*

Social Security Number (If no SS#, write N/A) — —	Gender ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /	Age	Dependent Status if over Age 26 ❑ Disabled**

Product Selection: ❑ Medical Product Name: _____ ❑ Dental (Dental only applicable for 10+ sized groups)

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient? ❑ Yes ❑ No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Other* ❑ Adopted*

Social Security Number (If no SS#, write N/A) — —	Gender ❑ Male ❑ Female	Date of Birth (Month/Day/Year) / /	Age	Dependent Status if over Age 26 ❑ Disabled**

Product Selection: ❑ Medical Product Name: _____ ❑ Dental (Dental only applicable for 10+ sized groups)

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient? ❑ Yes ❑ No

* Legal Documentation (Court Decree, Custodial Papers, etc.) must be attached to this application if the relationship is Adopted or Other.

** HMWV Disabled Dependent Adult Verification Eligibility Form must be attached to this application for review.

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

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**:
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

REASON FOR DECLINING MEDICAL COVERAGE:

- ❑ Insured under spouse's contract with the following insurance carrier:

_____

- ❑ Other: _____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

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 special enrollment (described below) occurs before coverage will be offered.

Employee Signature — **ONLY SIGN IF YOU ARE WAIVING COVERAGE** — Date

Special Enrollment Rights:

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

IV. OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage (If additional space is required, attach a separate sheet)

Name of Insurance Carrier	Policy Number	Group Number	Effective Date / /

Name of Policy Holder	Policy Holder Date of Birth / /	Relationship to Policy Holder	Policyholder Employment Status ❑ Active ❑ Retired
Cancel Date / /	Cancel Reason		List Date of Retirement: / /

List all covered dependents: _____

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You?
			❑ Child ❑ Step-child ❑ Other* ❑ Adopted*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age	Dependent Status if over Age 26
— —	❑ Male ❑ Female	/ /		❑ Disabled**

Product Selection: ❑ Medical Product Name: _____ ❑ Dental (Dental only applicable for 10+ sized groups)

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient?
		❑ Yes ❑ No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You?
			❑ Child ❑ Step-child ❑ Other* ❑ Adopted*

Social Security Number (If no SS#, write N/A)	Gender	Date of Birth (Month/Day/Year)	Age	Dependent Status if over Age 26
— —	❑ Male ❑ Female	/ /		❑ Disabled**

Product Selection: ❑ Medical Product Name: _____ ❑ Dental (Dental only applicable for 10+ sized groups)

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Dependent an Established Patient?
		❑ Yes ❑ No

*Legal Documentation (Court Decree, Custodial Papers, etc.) must be attached to this application if the relationship is Adopted or Other.

** HMWV Disabled Dependent Adult Verification Eligibility Form must be attached to this application for review.

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

EMPLOYEE MUST SIGN BELOW

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**:
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

REASON FOR DECLINING MEDICAL COVERAGE:

- ❑ Insured under spouse's contract with the following insurance carrier:

_____

- ❑ Other: _____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

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 special enrollment (described below) occurs before coverage will be offered.

Employee Signature

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Date

Special Enrollment Rights:

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

IV. OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage (If additional space is required, attach a separate sheet)

Name of Insurance Carrier	Policy Number	Group Number	Effective Date
			/ /

Name of Policy Holder	Policy Holder Date of Birth	Relationship to Policy Holder	Policyholder Employment Status
	/ /		❑ Active ❑ Retired

Cancel Date	Cancel Reason	List Date of Retirement:
/ /		/ /

List all covered dependents: _____

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

V. IMPORTANT: EMPLOYEE MUST SIGN BELOW

I have read the entire Application and by signing this Application, I declare that all information, statements, and answers are true and complete for all listed individuals applying for coverage. I also understand and agree that coverage, if issued, will be issued in full reliance on this Application and that any untrue or incomplete information, statements, and answers in this Application may result in the denial of a claim or recision of coverage and may subject me to legal action by Highmark WV. I also understand under WV Code §33-41-3, "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison." I also acknowledge that a copy of this Application shall be as valid as the original.

I acknowledge that no right whatsoever is created by this Application and that I and others applying for coverage will not be covered by Highmark WV unless and until this Application for coverage is approved and I have been provided an Effective Date and Group Number, and only as long as the Group continues to qualify under the terms of the Group contract with Highmark WV, including timely payment of premiums.

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 WV may use and disclose Protected Health Information for payment, treatment of health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark WV's Notice of Privacy Practices is available on Highmark WV's web site, or from the Highmark WV Privacy Office.

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark WV and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

Print Company Name

Employee Signature

Date

Print Employee's Name

OFFICE USE ONLY (DO NOT WRITE IN THE SPACES BELOW)

SALES RECEIVED DATE	ENROLLMENT & BILLING RECEIVED DATE	UNDERWRITING RECEIVED DATE

SEND TO:

For New Business
Highmark West Virginia
Attn: Sales
P.O. Box 1948
Parkersburg, WV 26102
Fax: (304) 424-0323

For Changes
Highmark West Virginia
Attn: Enrollment & Billing
P.O. Box 1948
Parkersburg, WV 26102
Fax: (866) 251-0741

Coverage Effective Date _____

Date Approved _____

Date Denied _____

Approved By _____

PLEASE RETURN COMPLETED FORM TO:

LORI MILLER SMITH
IOGAWV
300 SUMMERS STREET
SUITE 820
CHARLESTON, WV 25301