Application for Group Coverage

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. Your Group Administrator must complete section 2 before your application can be processed. If this is an application for a new member or a member changing plans, the Group Administrator must indicate the type of coverage elected.

PPO	HMO	POS	RX	Vision	Dental	CMM	Traditional	MedigapSecurity
_____	_____	_____	_____	_____	_____	_____	_____	_____

3. Provide information about your spouse and dependents only if they are also applying for coverage (Section 4). 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 2) to indicate your relationship to each person covered under the plan.
4. Your Group Administrator must complete Sections 2 and 7 and sign the application before it can be processed.
5. Before signing your application, please carefully read the Declarations and Conditions of Enrollment on page 4. 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!

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Universal Enrollment Form

SECTION 1 — Subscriber or member enrollment or change — Employee MUST complete in full

Type of coverage	Change	Reason for application	Other change
☐ Employee and child ☐ Employee and children ☐ Employee only ☐ Employee and spouse ☐ Family	☐ Open enrollment ☐ Address ☐ Last name ☐ Primary care office ☐ Rehire ☐ Dental office	☐ Add spouse ☐ Add a dependent ☐ Delete a dependent ☐ Other Life event date _____	☐ COBRA Effective date _____ Effective Date of Coverage _____

SECTION 2: To be completed by Group Administrator

Plan (please specify copay or benefit option):					Terminate contract
PPO	HMO	POS	☐ CMM ☐ Traditional ☐ MedigapSecurity	Employment Status: ☐ Active ☐ Retiree	☐ Terminated employment ☐ Full-time to part-time ☐ Deceased. Indicate date. _____ ☐ Other. Please Explain _____
RX	Vision	Dental			

SECTION 3: Subscriber information — please complete this entire section, whether you are a new applicant or are making a change to an existing contract

Social Security Number or ID number		Last name		Middle initial	First name	
Gender M/F	Date of birth	Street address				Apt or suite
City		State	Zip code	Date of hire		
Telephone number including area code Home _____ Work _____		Primary Care Office ID number _____ Primary Dental office ID number _____			Primary Care Office name ☐ Check if current patient Primary Dental Office name ☐ Check if current patient	

SECTION 4 — Family information (if applying)*

Spouse name: Last, First, Middle Initial		Social Security Number		
Employer name	Birth date (mm/dd/yy) _____/_____/_____	Age	Gender: ☐ M ☐ 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) † ☐ Yes ☐ 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).

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

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

SECTION 4 — Family information (continued)*

Dependent†† name: Last, First, Middle Initial				Social Security Number
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: ☐ M ☐ 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)† ☐ Yes ☐ 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: ☐ M ☐ 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)† ☐ Yes ☐ 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: ☐ M ☐ 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)† ☐ Yes ☐ No	Primary Dental Office ID#			

SECTION 5: Dependent Information — If you listed dependents, you MUST answer these questions.

Do any dependents listed live at another address? ☐ Yes ☐ No Is any dependent's last name different from yours? ☐ Yes ☐ No	If you answered yes to either question, please explain. ____________________ ____________________

† 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.

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

‡Relationship Codes:
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SECTION 6: Other insurance

Please list health insurance information if you or any dependents listed in Section 4 have other coverage.

Insurance Company Name _____ Policy Number _____

Policy Holder _____ Type of benefits _____ Effective date _____

Are you or any of your dependents receiving Medicare Benefits? ☐ Yes ☐ No

	Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason
Self					Check all that apply ☐ Age ☐ Disability ☐ ESRD
Spouse					
Child					
Child					

SECTION 7: Group and employer information

Your Group Administrator MUST complete this section. Your application CANNOT be processed unless this section is complete.

Group name _____ Group number _____ Payroll/ Work Location _____

Employer or Group Administrator signature _____ Date _____ Account number _____

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 affiliates, QCC Insurance Company, Highmark Blue Shield, and ancillary service providers who are responsible for administrating 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 administrating 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.

Employee Signature _____ Date _____

Subscriber's County of Residence _____

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