HIGHMARK West Virginia

GROUP PRODUCT ENROLLMENT AND CHANGE FORM

Complete this application in blue or black INK. DO NOT USE A PENCIL OR A HIGHLIGHTER.

HIPAA/GINA COMPLIANT

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

Social Security Number (use boxes below)	Group Number	Group Name	Effective Date	Dept. Code

Level of Benefits Applied for: ❑ Medical Only ❑ Dental Only ❑ Medical Dental **Dental only applicable for 10+ sized groups

REASON FOR COMPLETION: ❑ New Enrollee ❑ Changes (see below) ❑ Cancel (see below) ❑ Re-enrollment
❑ COBRA Start Date_____ ❑ COBRA End Date _____ (see below)

DEPENDENT CHANGES

Add dependents due to:
❑ Birth ❑ Marriage ❑ Adoption
Date of Above Event_____

Drop dependents due to:
❑ Divorce ❑ Death ❑ Other_____
Date of Above Event_____

OTHER CHANGES:
❑ New Name
❑ New Address
❑ Change to Medicare Eligible
❑ Change Coverage
❑ Other _____
Date of Above Event_____

CANCEL/COBRA REASON:
❑ Deceased
❑ Left Employment
❑ Involuntary Lay-Off
❑ Other Coverage
❑ Other _____
Date of Above Event_____

Applicant's Last Name (Please Use the Boxes) First Name MI

Street Address City State Zip County

Mailing Address (if different than Street Address) City State Zip County

Birth date	Phone Number(s)	Gender	Marital Status	Date Married
Month Day Year	Home (_____)_____ Day (_____)_____	❑ M ❑ F	❑ Single ❑ Widowed ❑ Married ❑ Divorced	Month Day Year

Employment Status	Date of Full-Time Hire	Hours Worked Per Week	Job Title
❑ Active ❑ Retired ❑ COBRA	Mo Da Yr		

COVERED DEPENDENT INFORMATION

Covered Dependents Relationship	Birth date Mo/Da/Yr	Gender M/F	Last Name	First Name	Social Security #	Dependent Status If Over Age 26
SPOUSE						
❑ Child ❑ Other ❑ Step-Child ❑ Adopted						❑ Disabled
❑ Child ❑ Other ❑ Step-Child ❑ Adopted						❑ Disabled
❑ Child ❑ Other ❑ Step-Child ❑ Adopted						❑ Disabled

Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship is Adoption or Other.

WAIVER OF COVERAGE

COMPLETE THIS SECTION ONLY IF YOU WISH TO DECLINE COVERAGE OFFERED FOR YOU AND/OR FAMILY MEMBER(S).

I HEREBY DECLINE MEDICAL COVERAGE
❑ For myself
❑ For myself and all family members
❑ For family members only
❑ For the following person(s)_____

REASON FOR DECLINING COVERAGE:
❑ Have not met employer's eligibility
❑ Insured under spouse's contract with the following insurance carrier _____
❑ Other

I HEREBY DECLINE DENTAL COVERAGE
❑ For myself
❑ For myself and all family members
❑ For family members only
❑ For the following person(s)_____

REASON FOR DECLINING COVERAGE:
❑ Have not met employer's eligibility
❑ Insured under spouse's contract with the following insurance carrier_____

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 occurs before coverage will be offered. Any pre-existing conditions specified in the contract will apply.

Signature _____ Date _____

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance 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.

STOP HERE IF DECLINING COVERAGE FOR YOURSELF

ABOUT YOUR OTHER GROUP OR NON-GROUP HEALTH INSURANCE COVERAGE AND MEDICARE

Please list any previous coverage for you or any of your dependents for the past 18 months. Indicate effective and cancel dates. If the coverage listed will not be cancelled, but will coordinate coverage as a primary or secondary payor, please indicate by checking the appropriate box.

Name(s) of Covered Person(s)	Name of Other Insurance Co.	Policy Number	Effective Date	Cancel Date	Coverage Type(s)
					❑ Medical ❑ Prescription Drug ❑ Previous ❑ Primary/Secondary
					❑ Medical ❑ Prescription Drug ❑ Previous ❑ Primary/Secondary

REASON FOR CANCELING
Most Recent Coverage:

The above section can be used by Highmark WV in lieu of Certificate of Creditable Coverage and will be used, in part, as the basis in determining the pre-existing condition waiting period. If applicable, Highmark WV may require other documentation such as Certificate of Creditable Coverage, EOB's, etc. in determining pre-existing condition waiting periods. YOU have a right to demonstrate creditable coverage and to request a Certificate of Creditable Coverage from a prior carrier. We will provide assistance if you cannot obtain a Certificate of Creditable Coverage from your prior carrier.

Medicare Information - Check the appropriate boxes and fill in all information for you and any dependents who are covered by Medicare.

❑ You	Medicare #	Eff. Date - Part A: / /	Part B: / /	❑	Check this box for each individual who is receiving treatment for end-stage renal disease.
❑ Spouse	Medicare #	Eff. Date - Part A: / /	Part B: / /	❑	
❑ Dependent	Medicare #	Eff. Date - Part A: / /	Part B: / /	❑	

MEDICAL HISTORY INFORMATION

YOUR HEIGHT (ft./in.) _____ YOUR WEIGHT (lbs.) _____ SPOUSE'S HEIGHT (ft./in.) _____ SPOUSE'S WEIGHT (lbs.) _____

Have you or any of your dependents EVER had any of the conditions listed below? If so, please indicate by marking "X" in each appropriate box. List in the Explanation Section the patient's name, diagnosis, treatment(s) and treatment date(s), surgeries and surgery date(s), and the prognosis for each condition marked. DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

1. CANCERS

❑ Site of cancer_____ List all other requested information in the Explanation Section.

2. HEART/LUNG

- ❑ Anemia
- ❑ Aneurysm
- ❑ Arteriosclerosis
- ❑ Congenital Heart Disease
- ❑ Congestive Heart Failure
- ❑ Heart Attack
- ❑ Hemophilia
- ❑ Hypertension
- ❑ Ischemic Heart Disease
- ❑ Rheumatic Heart Disease
- ❑ Stroke
- ❑ Valvular Disease
- ❑ Apnea
- ❑ Asthma
- ❑ Cystic Fibrosis
- ❑ Emphysema
- ❑ Tuberculosis

3. HEART/LUNG TREATMENTS

- ❑ Angioplasty
- ❑ Bypass
- ❑ Cardiac Catherization
- ❑ Pacemaker Implant
- ❑ Heart Valve Replacement

4. IMMUNE

- ❑ AIDS
- ❑ ARC-AIDS Related Complex
- ❑ Any Immune Suppressed Illness
- ❑ HIV (list status in Explanation Section)
- ❑ Kaposi's Sarcoma
- ❑ Systemic Lupus

5. RENAL

- ❑ Blood in Urine
- ❑ Dialysis
- ❑ Polycystic Kidney Disease
- ❑ Renal Failure
  Acute_____ Chronic_____

6. DIGESTIVE/INTESTINAL

- ❑ Cirrhosis of Liver
- ❑ Colostomy
- ❑ Crohn's Disease
- ❑ Diabetes: Juvenile____Adult____
  Diet Controlled_____
  Oral Medications_____
  Insulin_____Units/Day_____
- ❑ Hepatitis Type: A___ B___ C___
- ❑ Pancreatitis
- ❑ Ulcerative Colitis

7. NEUROLOGICAL/PSYCHOLOGICAL

- ❑ Alzheimer's
- ❑ Amyolateral Sclerosis—
  Lou Gehrig's Disease
- ❑ Attempted Suicide
- ❑ Cerebral Palsy
- ❑ Depression
- ❑ Drug/Alcohol Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Parkinson's
- ❑ Spina Bifida: Cystica____ Occulta____

8. MUSCULAR/SKELETAL

- ❑ Amputation
- ❑ Arthritis: Rheumatoid_____Osteo_____
- ❑ Degenerative Disc or Joint Disease
- ❑ Herniated Disc
- ❑ Joint Replacement
- ❑ Marfans Syndrome
- ❑ Muscular Dystrophy

9. Reproductive

- ❑ Infertility: In Vitro ____ GIFT ____
- ❑ Pregnancy, Due Date___/___/___
- ❑ Sexually Transmitted Disease(s)
- ❑ Other Reproductive

ANY QUESTIONS BELOW ANSWERED WITH A "YES" MUST BE EXPLAINED IN THE EXPLANATION SECTION

	Y	N	
10.	❑	❑	Do you or any of your dependents use Cigarettes or Tobacco? If Yes, please note in the explanation section the type of product and usage per day.
11.	❑	❑	Have you or any of your dependents ever had or been advised to have an organ or bone marrow transplant?
12.	❑	❑	Do you or any of your dependents have any other medical conditions not listed above that have been diagnosed or treated by a health care provider in the past FIVE years?
13.	❑	❑	Have you or any of your dependents been hospitalized or had surgery within the past FIVE years?
14.	❑	❑	Have you or any of your dependents been advised to have surgery which has not been performed yet?
15.	❑	❑	Are you or any of your dependents currently taking prescription medications? If yes, please list patient's name, name of medication, dosage, and the reason taking the medication in the Explanation Section.
16.	❑	❑	Have you or any of your dependents been treated by a health care provider six months prior to your enrollment date? If yes, please explain.
17.	❑	❑	Have you or any of your dependents ever been covered by Worker's Compensation, Disability, or Subrogation for any of the conditions listed in the Medical History Section above?

EXPLANATION SECTION

Provide an explanation for each box marked in questions 1–9 and for each box marked "Yes" in questions 10–16 from the previous page and above. If additional space is needed, use the Other Information section below. Attach additional sheets if needed.

Question #	Patient Name	Hospitalization Date(s)	Treatment Dates From/To	Diagnosis, Treatment, Prognosis, and Medications/Dosages

OTHER INFORMATION (Continue on Separate Paper if Necessary)

IMPORTANT: APPLICATION FOR COVERAGE

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 with 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.

If applicable, I understand that unless I or my dependents have twelve (12) months of Creditable Coverage, as defined by the Health Insurance Portability and Accountability Act of 1996, this coverage will not pay for any loss incurred during the first twelve (12) months after the earlier of the effective date of this coverage or the 1st day of a waiting period, for any condition, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) month period prior to the earlier of the effective date of this coverage or the 1st day of a waiting period. Please see your health care certificate for a more detailed explanation. This pre-existing condition exclusion period will be reduced by any days of Creditable Coverage that occurred before a "Significant Break in Coverage" defined as a period of sixty-three (63) consecutive days during all of which the individual does not have any Creditable Coverage.

This enrollment form conforms to the Genetic Information Nondiscrimination Act of 2008 (GINA) requirements.

Applicant's Signature _____ Date _____

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

Sales Received Date	Underwriting Received Date	Membership Received Date (1)
U/A RQ Date	Membership Received Date (2)	On INSINQ
U/A Rcv RQ Date		Inquiry Closed
Completed or Closed	Verified	ID Mailed

Date Approved _____

Approved By _____

Date Denied _____

Coverage Effective Date _____

This is a Waiver _____

Date Rec'd by Membership _____

Date on System _____

INSINQ Inquiry Number _____

Send to:

HIGHMARK WV

P.O. Box 1948

Parkersburg, WV 26102