HIGHMARK® BLUE SHIELD®

An Independent Licensee of the Blue Cross and Blue Shield Association

HOW TO COMPLETE YOUR HIGHMARK BLUE SHIELD ENROLLMENT APPLICATION

Following are instructions for completing the Highmark Blue Shield Enrollment Application. All information must be completed as indicated.

EMPLOYEE INFORMATION

The first thirteen (13) items ask for information regarding the employee. The information you must complete includes:

1) Employer Name

2) Employee First Name, skip a space, Last Name. (no middle initial)

3) Employee Street Address

4) City

5) State

6) Zip Code

7) Employee Social Security Number

8) Effective Date of Coverage

9) Employee Status: Please check (✓) the appropriate box indicating whether you are an Active, Retired, Hourly or Salary employee

10) Employee Daytime Phone Number (including area code)

11) Employee Evening Phone Number (including area code)

12) Employee Date of Hire

13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).

Items **14** through **18** ask for important information about yourself and each eligible member of your family (**14** yourself, **15** your spouse/domestic partner, **16-18** your dependents). Please complete all requested information. We require this information to properly enroll you and your eligible dependents. If relationship is "other", please indicate the dependent's relationship to you according to the codes provided on the application.

- **First Name/Last Name**—Complete the first and last name for each eligible person listed. Skip a space between first and last name. Do not use a middle initial.
- **Social Security Number**—Please include the Social Security Number of each person.
- **Do you have other insurance?**—If you or a family member have other medical insurance, including Medicare, respond "Yes". If not, you must respond "no".
- **Birth Date** (month/day/year)
- **Sex** (female or male)
- **Check if: Student over 19 and/or Disabled**—If your dependent is over the age of 19 and a full time student or a disabled dependent of any age, please check (✓) the appropriate column by that dependent's name.

19) If you checked "Yes" for ***Other Insurance***, this information needs to be completed if you, your spouse/domestic partner or one of your eligible dependents has other health insurance coverage or is eligible for Medicare. Please complete all information requested.

20) Should be completed by your account administrator.

21) You must sign and date the form where indicated.

22) Do not complete any of the information below the Employee Signature and Date.

Once the form is completed, retain the last copy for your records.