



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 and Reason for Application
- 2) Employee First Name, Middle Initial, Last Name.
- 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. If retired, please indicate retirement date.
- 10) Employee Home Phone Number (including area code) – Please provide so that we may contact you if we have questions about your application and to better serve you.
- 11) Employee Work Phone Number (including area code)
- 12) Employee Hire Date (i.e., date employee is first eligible to enroll for benefits) – Specify month/day/year. Required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- 13) Check Type of Coverage for which you are enrolling, using the appropriate category (employee, two person or family).
- 14) To be completed by Account/Administrator only

Items 15 through 19 ask for important information about yourself and each eligible member of your family (15 yourself, 16 your spouse/ domestic partner, 17-19 your dependents). Please complete all requested information. If relationship is "other," please indicate the dependent's relationship to the employee according to the codes provided on the application.

- **First Name/Middle Initial/Last Name**—Complete the First Name, Middle Initial and Last Name for each eligible person listed.
- **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.
- 20) 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. Refer to your Medicare card to complete the Medicare Information section.
- 21) Should be completed by your Account Administrator.
- 22) You must sign and date the form where indicated.

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

