HIGHMARK® HEALTH INSURANCE COMPANY

MEMBER CHANGE FORM

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

For Changes:
Highmark Health Insurance Company
P.O. Box 890172
Camp Hill, PA 17089-0172

APPLICANT INFORMATION

Effective Date	Employer Name	Group Number	Payroll Location

REASON FOR COMPLETION:
❑ Changes ❑ Act 4 Dependent ❑ Cancel
❑ COBRA/mini-COBRA
Start Date _____
End Date _____

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 _____

Last Name	First Name	MI	Home/Cell Phone

Street Address	City	State	Zip	County

Birth Date (Month / Day / Year)	Gender	Marital Status	Employment Status	Date of Full-Time Hire (Mo / Da / Yr)	Hours Worked Per Week
	❑ M ❑ F	❑ Single ❑ Married ❑ Widowed ❑ Divorced	❑ Active ❑ COBRA ❑ Disabled		

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

APPLICANT

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

Dependent Status if over Age 26 ❑ Act 4
If Act 4 Dependent, provide: Employee (parent) Name _____ and Social Security No. ___ — ___ —

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
If "Yes," when was the last time you used tobacco regularly? ___ / ___ / ___ (Month/Day/Year)

DEPENDENT #1

First Name	MI	Last Name	Relationship to You?
			❑ Spouse ❑ Dom. Part.

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

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
If "Yes," when was the last time you used tobacco regularly? ___ / ___ / ___ (Month/Day/Year)

DEPENDENT #2

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

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

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No
If "Yes," when was the last time you used tobacco regularly? ___ / ___ / ___ (Month/Day/Year)

*If "other" applies, complete using one of the following codes: (02) Adopted Child, (03) Court Appointed Guardian, (05) Grandchild, or (07) Nephew or Niece. Legal Documentation (Court Decree, Custodial Papers, etc.) must be attached to this Application if relationship is other, and may be required in other instances.

DEPENDENT #3

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

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

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly?_____/_____/_____ (Month/Day/Year)

DEPENDENT #4

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

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

Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ❑ Yes ❑ No

If "Yes," when was the last time you used tobacco regularly?_____/_____/_____ (Month/Day/Year)

*If "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece. Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship is other, and may be required in other instances.

Please check one if applicable (If additional space is required, attach a separate sheet). If you ❑, your Spouse/domestic partner ❑, or dependent(s) ❑, are enrolled in another Program or Medicare, please give the following information:

Name of Insurance Carrier:_____ Effective Date:_____

Name of Policy Holder:_____ Cancel Date:_____

Relationship to Highmark Health Insurance Co. Policy Holder:_____ Cancel Reason:_____

Policy Holder Date of Birth:_____ Policy Number:_____

Group No.:_____ Policy Holder Employment Status: ❑ Active ❑ Retired (Date):_____

MEDICARE INFORMATION List any family member that is eligible for Medicare Benefits:

Name of Members Last	First	Health Insurance Claim Number	Part A Effective Date (Mo-Day-Yr)	Part B Effective Date (Mo-Day-Yr)	Part D Effective Date (Mo-Day-Yr)
			/ /	/ /	/ /
			/ /	/ /	/ /

Why are you eligible for Medicare?: ❑ Age ❑ Disability ❑ End Stage Renal Disease

Do you have a Medicare Supplement or other coverage that compliments Medicare? ❑ Yes ❑ No

IMPORTANT: AUTHORIZED SIGNATURES (REQUIRED)

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark Health Insurance Company 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. To the best of my knowledge and belief, the information provided on this application is true and correct.

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.

Employee Signature:_____ **Date:**_____