APPLICATION FOR NEW INDIVIDUAL/FAMILY PLAN HEALTH INSURANCE

PLEASE COMPLETE STEPS 1-6.

If you are an insurance agent/producer, please complete Steps 1-7.

STEP 1) Find your county in the list below and go to the page number provided to choose your plan.

COUNTY	PAGE #	COUNTY	PAGE #	COUNTY	PAGE #
Allegheny	3	Clearfield	7	Lawrence	4
Armstrong	4	Crawford	4	McKean	4
Beaver	3	Elk	5	Mercer	3
Bedford	5	Erie	3	Potter	6
Blair	6	Fayette	3	Somerset	5
Butler	3	Forest	6	Venango	5
Cambria	5	Greene	3	Warren	3
Cameron	6	Huntingdon	5	Washington	3
Centre	7	Indiana	4	Westmoreland	3
Clarion	6	Jefferson	6 - 7		

STEP 2) Tell us about yourself.

STEP 3) Tell us about your household.

STEP 4) Tell us if you have other health insurance.

STEP 5) Sign, authorize, and date your Application.

STEP 6) Send your completed Application and payment to Highmark.

STEP 7) If you are an insurance agent/producer, please complete and return the Producer Certificate with the rest of the completed Application.

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Keystone Health Plan West.

WHO CAN ENROLL IN THE PLANS LISTED ON THIS APPLICATION?

You can enroll in one of these plans, regardless of your age, if:

- You reside in one of the counties listed on pages 3-7 of the Application
- You meet eligibility guidelines listed in Step 5 of this Application
- You are not entitled to benefits under Medicare Part A, enrolled in Medicare Part B, Medical Assistance or CHIP
- You want to purchase directly from Highmark and NOT through the Health Insurance Marketplace. Plans available on this Application do not apply federal premium tax credits or cost sharing reductions.

*If you are unsure if you qualify for federal premium tax credits or cost sharing reductions, go to the Health Insurance Marketplace.

DO YOU NEED CONVERSION OR HIPAA COVERAGE?

Are you converting from group to individual coverage because you lost your Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Keystone Health Plan West group coverage? You are eligible for an individual Conversion plan that covers you beginning on the date your Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Keystone Health Plan West group coverage ends. Depending on the coverage Effective Date you select, your first premium payment will include a prorated amount for the days remaining in the month your group coverage ended. The amount is based on the number of family members who were enrolled in your Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Keystone Health Plan West group plan on the date coverage was terminated. The amount of your first premium payment will also include the following full month of coverage. Your Application and first premium are due by the date noted in Step 1b of this Application on page 8.

Are you enrolling in Health Insurance Portability & Accountability Act (HIPAA) coverage because your employer group, governmental or church plan coverage ended? Please indicate the date you lost coverage in Step 1b of this Application. You must return your Application within 63 days from the date that your prior Employer group, governmental or church coverage ended. If your children are eligible for HIPAA, you can enroll them in the program without choosing HIPAA coverage for yourself.

To apply, please begin by completing STEP 1b on page 8.

NEED HELP?

Call: 1-877-959-2550

Click: www.DiscoverHighmark.com

Visit: Your local Highmark Direct store (www.HighmarkDirect.com)

Agent/Producer: Call or visit your local insurance agent/producer

You can also complete this Application online at: www.DiscoverHighmark.com

We are committed to providing outstanding service for our applicants and members. If you need special assistance due to limited English proficiency or because you have a disability, call us at 1-877-959-2550, call TTY at "711," or visit one of our Highmark Direct stores to receive assistance free of charge.

STEP 1a CHOOSE YOUR PLAN

FOR RESIDENTS OF THE FOLLOWING COUNTIES: ALLEGHENY, BEAVER, BUTLER, ERIE, FAYETTE, GREENE, MERCER, WARREN, WASHINGTON, WESTMORELAND

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

I am/we are applying for **new** coverage under:

To purchase one of these plans, complete Step 2a on page 9 for Highmark Blue Cross Blue Shield Insurance.

- ☐ **Major Events Blue PPO 6600 a Community Blue Plan**
  $6,600 Annual Individual Deductible/$13,200 Annual Family Deductible
  Applicants must be under age 30 or have received an exemption certificate from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.
- ☐ **Balance Blue PPO 500 a Community Blue Flex Plan**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible
- ☐ **Balance Blue PPO 1000 a Community Blue Flex Plan**
  $1,000 Annual Individual Deductible/$2,000 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 5500 a Community Blue Flex Plan**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 2650 a Community Blue Flex Plan**
  $2,650 Annual Individual Deductible/$5,300 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 1200 a Community Blue Flex Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible
- ☐ **Health Savings Blue PPO 2750 a Community Blue Flex Plan**
  $2,750 Annual Individual Deductible/$5,400 Annual Family Deductible
- ☐ **Total Health Blue PPO 1200 a Community Blue Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible

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To purchase one of these plans, complete Step 2b on page 10 for Highmark Health Insurance Company.

- ☐ **Shared Cost Blue PPO 5500**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 3200**
  $3,200 Annual Individual Deductible/$6,400 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ☐ **Health Savings Blue PPO 3400**
  $3,400 Annual Individual Deductible/$6,800 Annual Family Deductible
- ☐ **Health Savings Blue PPO 2500**
  $2,500 Annual Individual Deductible/$5,000 Annual Family Deductible
- ☐ **Health Savings Blue PPO 1300**
  $1,300 Annual Individual Deductible/$2,600 Annual Family Deductible
- ☐ **Comprehensive Care Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ☐ **Comprehensive Care Blue PPO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

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To purchase this plan, complete Step 2c on page 11 for Keystone Health Plan West.

- ☐ **Care Guide Blue HMO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

Applicant's Last Name	First Name	Applicant's Social Security Number

STEP 1a CHOOSE YOUR PLAN

FOR RESIDENTS OF THE FOLLOWING COUNTIES: ARMSTRONG, CRAWFORD, INDIANA, LAWRENCE, MCKEAN

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

I am/we are applying for **new** coverage under:

- ❑ **Major Events Blue PPO 6600 a Community Blue Plan**
  $6,600 Annual Individual Deductible/$13,200 Annual Family Deductible
  Applicants must be under age 30 or have received an exemption certificate from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.
- ❑ **Balance Blue PPO 500 a Community Blue Flex Plan**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible
- ❑ **Balance Blue PPO 1000 a Community Blue Flex Plan**
  $1,000 Annual Individual Deductible/$2,000 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 5500 a Community Blue Flex Plan**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 2650 a Community Blue Flex Plan**
  $2,650 Annual Individual Deductible/$5,300 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 1200 a Community Blue Flex Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible
- ❑ **Health Savings Blue PPO 2750 a Community Blue Plan**
  $2,750 Annual Individual Deductible/$5,400 Annual Family Deductible
- ❑ **Total Health Blue PPO 1200 a Community Blue Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible
- ❑ **Flex Blue PPO 1200 PA Mountains Healthcare Region a Community Blue Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible

To purchase one of these plans, complete Step 2a on page 9 for Highmark Blue Cross Blue Shield Insurance.

- ❑ **Shared Cost Blue PPO 5500**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 3200**
  $3,200 Annual Individual Deductible/$6,400 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ❑ **Health Savings Blue PPO 3400**
  $3,400 Annual Individual Deductible/$6,800 Annual Family Deductible
- ❑ **Health Savings Blue PPO 2500**
  $2,500 Annual Individual Deductible/$5,000 Annual Family Deductible
- ❑ **Health Savings Blue PPO 1300**
  $1,300 Annual Individual Deductible/$2,600 Annual Family Deductible
- ❑ **Comprehensive Care Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ❑ **Comprehensive Care Blue PPO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

To purchase one of these plans, complete Step 2b on page 10 for Highmark Health Insurance Company.

- ❑ **Care Guide Blue HMO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

To purchase this plan, complete Step 2c on page 11 for Keystone Health Plan West.

Applicant's Last Name	First Name	Applicant's Social Security Number

STEP 1a CHOOSE YOUR PLAN

FOR RESIDENTS OF THE FOLLOWING COUNTIES: BEDFORD, CAMBRIA, ELK, HUNTINGDON, SOMERSET VENANGO

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

I am/we are applying for **new** coverage under:

To purchase one of these plans, complete Step 2a on page 9 for Highmark Blue Cross Blue Shield Insurance.

- ❑ **Major Events Blue PPO 6600 a Community Blue Plan**
  $6,600 Annual Individual Deductible/$13,200 Annual Family Deductible
  Applicants must be under age 30 or have received an exemption certificate from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.
- ❑ **Balance Blue PPO 500 a Community Blue Flex Plan**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible
- ❑ **Balance Blue PPO 1000 a Community Blue Flex Plan**
  $1,000 Annual Individual Deductible/$2,000 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 5500 a Community Blue Flex Plan**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 2100 a Community Blue Flex Plan**
  $2,100 Annual Individual Deductible/$4,200 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 1000 a Community Blue Flex Plan**
  $1,000 Annual Individual Deductible/$2,000 Annual Family Deductible
- ❑ **Total Health Blue PPO 1200 a Community Blue Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible

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To purchase one of these plans, complete Step 2b on page 10 for Highmark Health Insurance Company.

- ❑ **Shared Cost Blue PPO 5500**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 3200**
  $3,200 Annual Individual Deductible/$6,400 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ❑ **Health Savings Blue PPO 3400**
  $3,400 Annual Individual Deductible/$6,800 Annual Family Deductible
- ❑ **Health Savings Blue PPO 2500**
  $2,500 Annual Individual Deductible/$5,000 Annual Family Deductible
- ❑ **Health Savings Blue PPO 1300**
  $1,300 Annual Individual Deductible/$2,600 Annual Family Deductible
- ❑ **Comprehensive Care Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ❑ **Comprehensive Care Blue PPO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

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To purchase this plan, complete Step 2c on page 11 for Keystone Health Plan West.

- ❑ **Care Guide Blue HMO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

Applicant's Last Name	First Name	Applicant's Social Security Number

STEP 1a CHOOSE YOUR PLAN

FOR RESIDENTS OF THE FOLLOWING COUNTIES: BLAIR, CAMERON, CLARION, FOREST, JEFFERSON, POTTER

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

I am/we are applying for **new** coverage under:

To purchase one of these plans, complete Step 2a on page 9 for Highmark Blue Cross Blue Shield Insurance.

- ☐ **Major Events Blue PPO 6600 a Community Blue Plan**
  $6,600 Annual Individual Deductible/$13,200 Annual Family Deductible
  Applicants must be under age 30 or have received an exemption certificate from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.
- ☐ **Balance Blue PPO 500 a Community Blue Flex Plan**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible
- ☐ **Balance Blue PPO 1000 a Community Blue Flex Plan**
  $1,000 Annual Individual Deductible/$2,000 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 5500 a Community Blue Flex Plan**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 2100 a Community Blue Flex Plan**
  $2,100 Annual Individual Deductible/$4,200 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 1000 a Community Blue Flex Plan**
  $1,000 Annual Individual Deductible/$2,000 Annual Family Deductible
- ☐ **Flex Blue PPO 1200 PA Mountains Healthcare Region a Community Blue Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible
- ☐ **Total Health Blue PPO 1200 a Community Blue Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible

To purchase one of these plans, complete Step 2b on page 10 for Highmark Health Insurance Company.

- ☐ **Shared Cost Blue PPO 5500**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 3200**
  $3,200 Annual Individual Deductible/$6,400 Annual Family Deductible
- ☐ **Shared Cost Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ☐ **Health Savings Blue PPO 3400**
  $3,400 Annual Individual Deductible/$6,800 Annual Family Deductible
- ☐ **Health Savings Blue PPO 2500**
  $2,500 Annual Individual Deductible/$5,000 Annual Family Deductible
- ☐ **Health Savings Blue PPO 1300**
  $1,300 Annual Individual Deductible/$2,600 Annual Family Deductible
- ☐ **Comprehensive Care Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ☐ **Comprehensive Care Blue PPO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

To purchase this plan, complete Step 2c on page 11 for Keystone Health Plan West.

- ☐ **Care Guide Blue HMO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

Applicant's Last Name	First Name	Applicant's Social Security Number

STEP 1a CHOOSE YOUR PLAN

FOR RESIDENTS OF THE FOLLOWING COUNTIES: CENTRE*, CLEARFIELD, JEFFERSON

***Note:** You must reside in one of the following zip codes in Centre County to enroll in one of these plans — 16666, 16686, 16829, 16845, 16859, 16860, 16874, 16877.

Review the product information to learn what each plan covers. Based on the county in which you live, choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

I am/we are applying for **new** coverage under:

- ❑ **Major Events Blue PPO 6600 a Community Blue Plan**
  $6,600 Annual Individual Deductible/$13,200 Annual Family Deductible
  Applicants must be under age 30 or have received an exemption certificate from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.
- ❑ **Balance Blue PPO 500 a Community Blue Flex Plan**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible
- ❑ **Balance Blue PPO 1000 a Community Blue Flex Plan**
  $1,000 Annual Individual Deductible/$2,000 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 5500 a Community Blue Flex Plan**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 2100 a Community Blue Flex Plan**
  $2,100 Annual Individual Deductible/$4,200 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 1000 a Community Blue Flex Plan**
  $1,000 Annual Individual Deductible/$2,000 Annual Family Deductible
- ❑ **Flex Blue PPO 1200 Penn Highlands Region a Community Blue Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible
- ❑ **Total Health Blue PPO 1200 a Community Blue Plan**
  $1,200 Annual Individual Deductible/$2,400 Annual Family Deductible

To purchase one of these plans, complete Step 2a on page 9 for Highmark Blue Cross Blue Shield Insurance.

- ❑ **Shared Cost Blue PPO 5500**
  $5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 3200**
  $3,200 Annual Individual Deductible/$6,400 Annual Family Deductible
- ❑ **Shared Cost Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ❑ **Health Savings Blue PPO 3400**
  $3,400 Annual Individual Deductible/$6,800 Annual Family Deductible
- ❑ **Health Savings Blue PPO 2500**
  $2,500 Annual Individual Deductible/$5,000 Annual Family Deductible
- ❑ **Health Savings Blue PPO 1300**
  $1,300 Annual Individual Deductible/$2,600 Annual Family Deductible
- ❑ **Comprehensive Care Blue PPO 1500**
  $1,500 Annual Individual Deductible/$3,000 Annual Family Deductible
- ❑ **Comprehensive Care Blue PPO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

To purchase one of these plans, complete Step 2b on page 10 for Highmark Health Insurance Company.

- ❑ **Care Guide Blue HMO 500**
  $500 Annual Individual Deductible/$1,000 Annual Family Deductible

To purchase this plan, complete Step 2c on page 11 for Keystone Health Plan West.

Applicant's Last Name	First Name	Applicant's Social Security Number

STEP 1b CHOOSE YOUR PLAN - CONVERSION OR HIPAA ONLY

Choose only one plan and deductible option. Place an 'X' in the correct check box.
The plan and deductible option you choose will apply to everyone covered by your plan.

You **MUST** choose the plan below if:

You are applying for a Conversion plan to cover you from the date your **Highmark Blue Cross Blue Shield** group plan ended OR

You are applying for a Health Insurance Portability & Accountability Act (HIPAA) plan to cover you from the date your last employer coverage ended.

❑ **Shared Cost Blue PPO 5500 a Community Blue Flex Plan**
$5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
Note: Your proposed first premium amount is based on not using tobacco products.
You agree to pay any adjustment to the rate if you use tobacco products.

To purchase this plan, complete Step 2a on page 9 for Highmark Blue Cross Blue Shield Insurance.

APPLICATION DUE DATE: ____________________ FIRST PREMIUM AMOUNT DUE: ____________________

Requested Effective Date of Coverage:

❑ Conversion Policy - Effective from: ____________________ Effective to: ____________________

❑ HIPAA Policy - Effective from: ____________________ Effective to: ____________________

You **MUST** choose the plan below if:

You are applying for a Conversion plan to cover you from the date your **Highmark Health Insurance Company** Group policy ended.

❑ **Shared Cost Blue PPO 5500**
$5,500 Annual Individual Deductible/$11,000 Annual Family Deductible
Note: Your proposed first premium amount is based on not using tobacco products.
You agree to pay any adjustment to the rate if you use tobacco products.

To purchase this plan, complete Step 2b on page 10 for Highmark Health Insurance Company.

APPLICATION DUE DATE: ____________________ FIRST PREMIUM AMOUNT DUE: ____________________

Requested Effective Date of Coverage:

❑ Conversion Policy - Effective from: ____________________ Effective to: ____________________

You **MUST** choose the plan below if:

You are applying for a Conversion plan to cover you from the date your **Keystone Health Plan West** Group ended.

❑ **Care Guide Blue HMO 500**
$500 Annual Individual Deductible/$1,000 Annual Family Deductible
Note: Your proposed first premium amount is based on not using tobacco products.
You agree to pay any adjustment to the rate if you use tobacco products.

To purchase this plan, complete Step 2c on page 11 for Keystone Health Plan West Insurance.

APPLICATION DUE DATE: ____________________ FIRST PREMIUM AMOUNT DUE: ____________________

Requested Effective Date of Coverage:

❑ Conversion Policy - Effective from: ____________________ Effective to: ____________________

Applicant's Last Name	First Name	Applicant's Social Security Number

STEP 2a TELL US ABOUT YOURSELF

Complete this section if:

You are applying for Highmark Blue Cross Blue Shield health insurance.

You are applying for health insurance on behalf of your dependent(s). You will be the Policy Holder/Subscriber and the contact person for your dependent(s).

If you are applying on behalf of a child under age 18 for his or her own coverage on an individual policy, please complete this section with YOUR information as you will be the contact person for your child. Provide your child's information in STEP 3 and check this box ❑.

FIRST NAME, MIDDLE NAME, LAST NAME & SUFFIX

SOCIAL SECURITY NUMBER — —	SEX ❑ Male ❑ Female	DATE OF BIRTH (MONTH/DAY/YEAR)	
HOME ADDRESS			APARTMENT NUMBER
CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)			APARTMENT NUMBER
CITY	STATE	ZIP CODE	COUNTY

❑ Check here if you don't have a home address. You still need to give a mailing address.

PRIMARY PHONE NUMBER	OTHER PHONE NUMBER	CELL PHONE NUMBER
( )	( )	( )

Indicate how you would like to receive your member materials including Welcome Book, Member Handbook, Agreement/Endorsements, Summary of Benefits and Coverage and Explanation of Benefits:

❑ Electronically by logging into the www.HighmarkBCBS.com website.

❑ In the mail at the address noted above.

If you provide your email address, Highmark Blue Cross Blue Shield may, from time to time, provide you, via email, with important information about health-related products and services that add value to your benefits plan.

Email: ❑ Yes ❑ No Email address: ______________________

Text: ❑ Yes ❑ No Cell phone number: ______________________

PREFERRED LANGUAGE SPOKEN (IF NOT ENGLISH)	PREFERRED LANGUAGE READ (IF NOT ENGLISH)

If you will be covered under the plan and you are 18 years of age and older:

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)

❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
Call us at 1-877-959-2550. You can also call TTY at 711 or visit one of our Highmark Direct stores to receive assistance free of charge.

PAYMENT AND BILLING INFORMATION

Please indicate the Payment Enclosed for your coverage and fill in your Social Security Number in the boxes below.

This Agreement renews on an annual basis. You can pay your premium monthly in advance to Highmark Blue Cross Blue Shield. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your premium payment is not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

Make your check or money order payable to Highmark Blue Cross Blue Shield for your first full premium due. See Rate Guide for details. Please include the Group Number below on the payment.

Payment Enclosed	Group Number	Applicant's Social Security Number
$	037000-00	

STEP 2b TELL US ABOUT YOURSELF

Complete this section if:

You are applying for Highmark Health Insurance Company health insurance.

You are applying for health insurance on behalf of your dependent(s). You will be the Policy Holder/Subscriber and the contact person for your dependent(s).

If you are applying on behalf of a child under age 18 for his or her own coverage on an individual policy, please complete this section with YOUR information as you will be the contact person for your child. Provide your child's information in STEP 3 and check this box ❑..

FIRST NAME, MIDDLE NAME, LAST NAME & SUFFIX

SOCIAL SECURITY NUMBER — —	SEX ❑ Male ❑ Female	DATE OF BIRTH (MONTH/DAY/YEAR)

HOME ADDRESS			APARTMENT NUMBER
CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)			APARTMENT NUMBER
CITY	STATE	ZIP CODE	COUNTY

❑ Check here if you don't have a home address. You still need to give a mailing address.

PRIMARY PHONE NUMBER	OTHER PHONE NUMBER	CELL PHONE NUMBER
( )	( )	( )

Indicate how you would like to receive your member materials including Welcome Book, Member Handbook, Agreement/Endorsements, Summary of Benefits and Coverage and Explanation of Benefits:

❑ Electronically by logging into the www.HighmarkBCBS.com website.

❑ In the mail at the address noted above.

If you provide your email address, Highmark Health Insurance Company may, from time to time, provide you, via email, with important information about health-related products and services that add value to your benefits plan.

Email: ❑ Yes ❑ No Email address: ____________________

Text: ❑ Yes ❑ No Cell phone number: ____________________

PREFERRED LANGUAGE SPOKEN (IF NOT ENGLISH)	PREFERRED LANGUAGE READ (IF NOT ENGLISH)

If you will be covered under the plan and you are 18 years of age and older:

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)

❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability.

Call us at 1-877-959-2550. You can also call TTY at 711 or visit one of our Highmark Direct stores to receive assistance free of charge.

PAYMENT AND BILLING INFORMATION

Please indicate the Payment Enclosed for your coverage and fill in your Social Security Number in the boxes below.

This Agreement renews on an annual basis. You can pay your premium monthly in advance to Highmark Health Insurance Company. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your premium payment is not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

Make your check or money order payable to Highmark Health Insurance Company for your first full premium due. See Rate Guide for details. Please include the Group Number below on the payment.

Payment Enclosed	Group Number	Applicant's Social Security Number
$	036000-00	

APP-I/F-W-1

STEP 2c TELL US ABOUT YOURSELF

KEYSTONE HEALTH PLAN WEST
A HIGHMARK COMPANY

Complete this section if:

You are applying for Keystone Health Plan West health insurance.

You are applying for health insurance on behalf of your dependent(s). You will be the Policy Holder/Subscriber and the contact person for your dependent(s).

If you are applying on behalf of a child under age 18 for his or her own coverage on an individual policy, please complete this section with YOUR information as you will be the contact person for your child. Provide your child's information in STEP 3 and check this box ❑..

FIRST NAME, MIDDLE NAME, LAST NAME & SUFFIX

SOCIAL SECURITY NUMBER — —	SEX ❑ Male ❑ Female	DATE OF BIRTH (MONTH/DAY/YEAR)

HOME ADDRESS			APARTMENT NUMBER
CITY	STATE	ZIP CODE	COUNTY
MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)			APARTMENT NUMBER
CITY	STATE	ZIP CODE	COUNTY

❑ Check here if you don't have a home address. You still need to give a mailing address.

PRIMARY PHONE NUMBER	OTHER PHONE NUMBER	CELL PHONE NUMBER
( )	( )	( )

Indicate how you would like to receive your member materials including Welcome Book, Member Handbook, Agreement/Endorsements, Summary of Benefits and Coverage and Explanation of Benefits:

❑ Electronically by logging into the www.HighmarkBCBS.com website.

❑ In the mail at the address noted above.

If you provide your email address, Keystone Health Plan West may, from time to time, provide you, via email, with important information about health-related products and services that add value to your benefits plan.

Email: ❑ Yes ❑ No Email address: ______________________

Text: ❑ Yes ❑ No Cell phone number: ______________________

PREFERRED LANGUAGE SPOKEN (IF NOT ENGLISH)	PREFERRED LANGUAGE READ (IF NOT ENGLISH)

If you will be covered under the plan and you are 18 years of age and older:

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)

❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
Call us at 1-877-959-2550. You can also call TTY at 711 or visit one of our Highmark Direct stores to receive assistance free of charge.

PAYMENT AND BILLING INFORMATION

Please indicate the Payment Enclosed for your coverage and fill in your Social Security Number in the boxes below.

This Agreement renews on an annual basis. You can pay your premium monthly in advance to Keystone Health Plan West. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your premium payment is not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

Make your check or money order payable to Keystone Health Plan West for your first full premium due. See Rate Guide for details. Please include the Group Number below on the payment.

Payment Enclosed	Group Number	Applicant's Social Security Number
$	058000-00	

STEP 3 TELL US ABOUT YOUR HOUSEHOLD

Tell us about everyone who is applying for coverage. Attach additional sheets of paper if needed. Eligible dependents include:

- Your spouse
- Your domestic partner
- Your children who are under age 26
- Your spouse's children who are under age 26
- Your domestic partner's children who are under age 26

PERSON 1

❑ Check here if person listed in STEP 2 is applying for coverage.

PRIMARY CARE PHYSICIAN (FOR HMO ONLY)	❑ Check here if presently a patient of this physician.	PCP NUMBER (FOR HMO ONLY)

PERSON 2

FIRST NAME, MIDDLE NAME, LAST NAME & SUFFIX		RELATIONSHIP TO YOU?
SOCIAL SECURITY NUMBER (If no SS#, write N/A) — —	SEX ❑ Male ❑ Female	DATE OF BIRTH (MONTH/DAY/YEAR) / /
PRIMARY CARE PHYSICIAN (FOR HMO ONLY)	❑ Check here if presently a patient of this physician.	PCP NUMBER (FOR HMO ONLY)

Does this PERSON 2 live at the same address as you? ❑ Yes ❑ No

If No, list address: ____________________

Applicants 18 years of age and older, 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)

❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability.

Call us at 1-877-959-2550. You can also call TTY at 711, or visit one of our Highmark Direct stores to receive assistance free of charge.

PERSON 3

FIRST NAME, MIDDLE NAME, LAST NAME & SUFFIX		RELATIONSHIP TO YOU?
SOCIAL SECURITY NUMBER (If no SS#, write N/A) — —	SEX ❑ Male ❑ Female	DATE OF BIRTH (MONTH/DAY/YEAR) / /
PRIMARY CARE PHYSICIAN (FOR HMO ONLY)	❑ Check here if presently a patient of this physician.	PCP NUMBER (FOR HMO ONLY)

Does this PERSON 3 live at the same address as you? ❑ Yes ❑ No

If No, list address: ____________________

Applicants 18 years of age and older, 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)

❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability.

Call us at 1-877-959-2550. You can also call TTY at 711, or visit one of our Highmark Direct stores to receive assistance free of charge.

PERSON 4

FIRST NAME, MIDDLE NAME, LAST NAME & SUFFIX		RELATIONSHIP TO YOU?
SOCIAL SECURITY NUMBER (If no SS#, write N/A) — —	SEX ❑ Male ❑ Female	DATE OF BIRTH (MONTH/DAY/YEAR) / /
PRIMARY CARE PHYSICIAN (FOR HMO ONLY)	❑ Check here if presently a patient of this physician.	PCP NUMBER (FOR HMO ONLY)

Does this PERSON 4 live at the same address as you? ❑ Yes ❑ No

If No, list address: ____________________

Applicants 18 years of age and older, 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)

❑ Check the box if you need special assistance due to limited English proficiency or because you have a disability.

Call us at 1-877-959-2550. You can also call TTY at 711, or visit one of our Highmark Direct stores to receive assistance free of charge.

GO TO STEP 4

Applicant's Last Name	First Name	Applicant's Social Security Number

STEP 4 TELL US ABOUT OTHER HEALTH INSURANCE INFORMATION

Complete the information requested about your current health insurance.

1. Are you or any of your family members who are applying for this coverage enrolled in any private or governmental group or individual health plan or program at the time of this Application? ❑ Yes ❑ No
2. Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in Medicare Part B? ❑ Yes ❑ No
3. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have? This includes any current Highmark policy. ❑ Yes ❑ No

If you answered "Yes" to any question above, complete question 4. If you answered "No," skip question 4 and go to the next section.

4. Please provide the following information about any other coverage you and/or your family members currently have or have applied for:

Name of Insurance Carrier: ______________________ Group Number: ____________

Name of Policy Holder: ______________________ Effective Date: ____________

Policy Number: ______________ Relationship to Applicant: ______________

Policy Holder's Date of Birth: ______________ Policy Holder's Employment Status: ______________

ANSWER QUESTIONS 5-9 ONLY IF YOU ARE APPLYING FOR HIPAA COVERAGE.

5. If your most recent coverage offered you "COBRA" or similar continuation of coverage benefits required by the state, did you elect that coverage? ❑ Yes ❑ No If YES, have you used up all your benefits under that coverage? .... ❑ Yes ❑ No
6. If you include your most recent coverage, have you had some type of creditable health care coverage continuously for at least 18 months? * ❑ Yes ❑ No

   * Here's how to find out if you have the required 18 months of prior creditable coverage: Count periods of creditable coverage that you had before any breaks in coverage. Count them only if the break in coverage was less than 63 days. Do not count days during a waiting period when you had no coverage. Do not count days in a waiting period to determine if you had a break in coverage.
7. Did your most recent health care coverage end within the last 63 days? .... ❑ Yes ❑ No
8. Did your most recent health care coverage terminate because you did not pay your premium? This includes contributions or fraud.

   ❑ Yes ❑ No
9. Are you attaching a copy of your "Certificate of Prior Creditable Coverage" form? .... ❑ Yes ❑ No

   If you answered "No" to question 9 above, you can still prove that you had prior coverage in one of the following ways:

   a) Send us your signed written statement about your last coverage. Include names of the plans that covered you in the last 18 months. Include the beginning and end dates of coverage. Attach copies of papers proving that you had coverage during those times. This can be a copy of an identification card or an explanation of benefits. It can also be premium invoices or pay stubs proving that you paid for health coverage. You must also cooperate with us to prove that you had coverage.

   \- OR -

   b) Complete and send us a HIPAA Prior Coverage Disclosure and Authorization Form instead of a written statement. You can get this form by calling Customer Service at 1-800-544-6679. You can also call us to establish that you had coverage. Give us as much information as you can. Sign the form to let us contact your prior plans to prove that you had coverage.

Monthly Premium for the plan you selected, based on applicants indicated on this Application: ______________

GO TO STEP 5

Applicant's Last Name	First Name	Applicant's Social Security Number

STEP 5 SIGN, AUTHORIZE AND DATE APPLICATION

NOTIFICATION AND AUTHORIZATION

My/our signature on this Application indicates that I/we have read and fully understand the following statements:

I/we hereby apply for health care plan coverage for myself and/or my eligible dependents listed on this Application. I/we understand and agree that the terms and conditions of our coverage will be controlled by the written Subscription Agreement and that they may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I/we recognize that our coverage will only apply to admissions that occur and services that are provided on or after the effective date of our coverage.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations.

A copy of Highmark's Notice of Privacy Practices is available on the Highmark Website or from the Highmark Privacy Office.

I/we understand that the Agreement is available only to residents of the 29-county area of western Pennsylvania served by Highmark, and that this Application is subject to the provisions of the Agreement.

I/we understand that the receipt of the benefits under this program is subject to the determination that the services were medically necessary and appropriate. Except for emergencies or delivery-related admissions, all inpatient admissions are subject to review prior to the proposed admission.

I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

I know that I must tell Highmark if any information I supplied on this Application changes. I can call 1-800-544-6679 to report any changes.

EFFECTIVE DATE OF COVERAGE

I/we understand/agree that, subject to the conditions of enrollment on this Application, coverage will be effective for individuals listed on this Application following receipt of a completed Application and payment of the first premium in full:

a) on the first day of the following month if the Application and premium payment are received between the first and 15th of the month

- OR -

b) on the first day of the second month if Application and premium payment are received between the 16th and the last day of the month

- OR -

c) in the case of HIPAA coverage or a Conversion policy, on the Effective Date indicated on this Application

To the best of my/our knowledge and belief, the information provided on this Application is true and correct.

I also understand that any attempts to qualify for the program chosen through fraud or other intentional misrepresentation of a material fact will result in termination of such contract.

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.

Applicant's Signature ______________________________ Date ______________

Spouse/Domestic Partner/Parent's Signature ______________________________ Date ______________

NOTICE TO ALL APPLICANTS: If you are applying for coverage that includes your spouse or domestic partner, both you and your spouse/domestic partner must sign this Application form. If you are unmarried, under the age of 18 and applying for a policy that only covers yourself, your parent or guardian must sign.

THIS APPLICATION IS VALID ONLY WHEN COMPLETED AND SIGNED BY THE APPLICANT.

GO TO STEP 6

Applicant's Last Name	First Name	Applicant's Social Security Number

STEP 6 SEND YOUR COMPLETED APPLICATION AND PAYMENT TO HIGHMARK

Send in your completed Application and payment to Highmark by one of the following methods:

U.S. MAIL:

Include your completed, signed Application along with your first premium payment to:
Highmark Blue Cross Blue Shield
P.O. Box 382555
Pittsburgh, PA 15250-8555

FAX:

Fax your completed, signed Application to 1-866-224-5403 -- *and* --
Mail your first premium payment to:
Highmark Blue Cross Blue Shield
P.O. Box 382555
Pittsburgh, PA 15250-8555

DROP YOUR APPLICATION AND PAYMENT OFF IN PERSON AT YOUR LOCAL HIGHMARK DIRECT STORE:

For locations, please visit www.HighmarkDirect.com or call 1-877-959-2550.

PLEASE NOTE:

This Agreement renews on an annual basis. You can pay your premium monthly in advance to Highmark. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your premium payment is not received within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

If you are applying for a Conversion plan to cover you from the date your group plan ended or you are applying for a HIPAA plan to cover you from the date your employer plan ended, your first premium payment will include a prorated amount for the days remaining in the month your group coverage ended.

NEED HELP?

Call: 1-877-959-2550

Click: www.DiscoverHighmark.com

Visit: Your local Highmark Direct store (www.HighmarkDirect.com)

Agent: Call or visit your local insurance agent

You can also complete this Application online at: www.DiscoverHighmark.com

STEP 7 - FOR PRODUCER USE ONLY

PRODUCER'S CERTIFICATE

ATTENTION PRODUCER:

If you have questions about completing this Application, please call the Producer Line at 1-866-602-1248.

If this section is not fully completed, we will not pay a commission.

Blue Cross Blue Shield Agency No.

Producer No.

Agency Name ______________________________

Producer's Name ______________________________
LAST *FIRST* *MI*

Producer's Signature ______________________________

Business Phone ( ) ______________________________
Area Code

A PRODUCER must complete this section to act on the applicant's behalf.

1. Consider how the applicant answered your questions. Do you know of any factors impacting the applicant's eligibility? What about his/her dependents applying for this coverage?
   ❑ No ❑ Yes

   ____
   Producer Signature Date

   ____
   Agency

2. Have you provided the applicant with all relevant marketing materials? ❑ No ❑ Yes

3. Have you advised the applicant of the features of the product that he/she has selected, including satisfying his/her deductible(s)? ❑ No ❑ Yes

4. Is this applicant a current customer of Highmark?
   ❑ No ❑ Yes

5. Have you retained a signed copy of this Application for your records? ❑ No ❑ Yes

Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the Application or policy; or
3. Waive any of Highmark's rights or requirements.

Highmark Inc., d/b/a
Highmark Blue Cross Blue Shield
120 Fifth Avenue
Pittsburgh, PA 15222-3099

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Keystone Health Plan West. Highmark Blue Cross Blue Shield, Highmark Health Insurance Company and Keystone Health Plan West are independent licensees of the Blue Cross and Blue Shield Association.

INTERNAL USE ONLY

Blue Cross Blue Shield Agency No.

Producer No.