Capital BlueCross
Independent Licensees of the BlueCross BlueShield Association

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

1-800-962-2242 www.capbluecross.com

Keystone HEALTH PLAN CENTRAL
A Capital BlueCross Company
Independent Licensees of the BlueCross BlueShield Association

1-800-669-7061

GROUP ADMINISTRATOR: You must complete all areas in the box below before submitting this application to Capital BlueCross.

Employer's Name

Group Name *(if different from above)*

Group Number | Subgroup Number | Class

Does Employer employ 20 or more employees under the MSP laws? ☐ Yes ☐ No

Does Employer employ 100 or more employees under the MSP laws? ☐ Yes ☐ No

Employer's Address *(for Association Groups Only)*

Member Firm ID

Effective Date of Above

Effective Date of Coverage/Change:

Date Hired:

Has waiting period been met? ☐ Yes ☐ No

TYPE OF ACTIVITY

☐ Enrollment ☐ Change of Enrollment ☐ Termination

REASON CODES *(See back for codes and descriptions)*

☐ Open Enrollment
☐ Initial Eligibility Change: CODE Date of Change
☐ Life Status Change: CODE Date of Change
☐ Termination: CODE Date of Change
☐ Other (Please Explain) Date of Change

SUBSCRIBER: Please refer to the attached Instruction Sheet when completing sections 1 through 10 of this form.

1. SUBSCRIBER INFORMATION

Subscriber Identification | Birth Date | ☐ Male ☐ Female

Subscriber Name (Last, First, M.I.) | ☐ Single ☐ Married

Mailing Address (Include street address, city, state and ZIP Code) | New Address? ☐ Yes ☐ No | County

Home Phone Number | Cell Phone Number | Work Phone Number / Ext. | Home Email Address

Employment Status:
☐ Active (Full-Time) ☐ Retired—(Date) _____ ☐ Hourly ☐ Exempt ☐ Union
☐ Active (Part-Time) ☐ Other—(Explain) _____ ☐ Salary ☐ Non-Exempt ☐ Non-Union

Average Number of Hours Worked Per Week

2. ENROLLMENT/CHANGE INFORMATION

3. COVERAGE SELECTION/CHANGE

4. PHYSICIAN OF CHOICE

First Name & Middle Initial (Show Last Name if different from Subscriber)	Social Security Number	Birth Date	ADD or REMOVE?	Trad.	Comp.	*PPO*	PPO *Plus*	*POS*	*HMO*	*Senior*	Drug	Dental	Vision	Indicate Practice Names & Codes (Refer to Applicable Provider Directory)
SUBSCRIBER			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
Spouse ☐ Male ☐ Female			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No
☐ Other			☐ ADD ☐ REMOVE											Physician of Choice Code #: Current Patient? ☐ Yes ☐ No

If you need an alternate address for a spouse or dependent, please see No. 2 on the INSTRUCTION SHEET.

Physician of Choice selection required for *POS* and *HMO*, optional for PPO *Plus*.

5. MEDICARE COVERAGE INFORMATION

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. Please list the starting date for each reason in the applicable date field. *(Refer to your red, white and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.)*

Name of Subscriber or Dependent	Medicare Claim Number	Effective Date(s) Hospital (Part A)	Effective Date(s) Medical (Part B)	Reason/Effective Date for Medicare coverage ☐ Age	☐ Disabled	☐ ESRD
				Effective Date:	Effective Date:	Effective Date:
				Effective Date:	Effective Date:	Effective Date:

6. HANDICAPPED DEPENDENTS

Name of Handicapped Dependent

7. OTHER INSURANCE COVERAGE

Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with **any other** insurance company. If completed, you may receive additional information. *(Please attach a separate sheet of paper if additional space is needed.)*

Name of Subscriber or Dependent	Name of Health Care Plan/Insurance Co.	Identification/Policy Number

8. STUDENT INFORMATION

Complete the following information for DEPENDENTS who are enrolled as a full-time student at an accredited school or college/university. *(Please attach a separate sheet of paper if additional space is needed.)*

Student's Name	Name of School or College/University	Expected Graduation Date

9. CHANGE THE FOLLOWING INFORMATION

Change is for ☐ Subscriber ☐ Dependent (Name)

	From	To
Name		
Birth Date		
Social Security Number		

10. STATEMENT OF APPLICATION

By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.

Subscriber's Signature Date

White - Capital BlueCross Copy Yellow - Group Administrator Copy Pink - Subscriber Copy