2020 Application for Small Employer Coverage

Instructions:

Thank you for applying for coverage from Independence Blue Cross. Follow the instructions below to complete your application.

1. Carefully review and complete each section by printing clearly in black ink.
2. Provide information about your spouse, domestic partner, and dependents if they are also applying for coverage (Section C). If you need additional space, please complete an additional application and mail it along with your primary application.

   Important: You must include a Relationship Code (listed at the bottom of page 4) to indicate your relationship to each person covered under the plan.
3. Before signing your application, please carefully read the Declarations and Conditions of Enrollment (Section I) on page 7. Once you have completed and signed your application, be sure to make a copy for your records.
4. Your Group Administrator must complete the box on page 3 before your application can be processed. Appplications can be mailed to:

   Independence Blue Cross
   P.O. Box 8240
   Philadelphia, PA 19101

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-800-ASK-BLUE (1-800-275-2583) (TTY: 711), Monday through Friday, between 8 a.m. and 6 p.m. Brokers and small group employers should call 1-866-272-9684 (TTY: 711), Monday through Friday, 8:30 a.m. to 5 p.m., with any questions. Thank you for taking the time to complete your application. We look forward to having you as a member of the Independence Blue Cross family!

Independence

For employer Group Administrator to complete.

Group Name: _____

Member Effective Date: _____

Group # (medical): _____

Group # (dental): _____

Group # (vision): _____

Group Administrator signature: _____

Application/Change form for Small Employer Coverage

Keystone Health Plan East (KHPE) HMO Plans and QCC Insurance Company PPO Plans*

Thank you for choosing Independence Blue Cross. In order to process your application as quickly as possible, please refer to the instructions on page 1 and provide the information requested.

SECTION A — Plan selections

Type of coverage	Change	Reason for application	Other change
☐ Employee only ☐ Employee and child ☐ Employee and children ☐ Employee and spouse or domestic partner ☐ Family	☐ Address ☐ Last name ☐ Primary care office ☐ Rehire ☐ Primary dental office	☐ Add spouse/domestic partner ☐ Add a dependent ☐ Delete a dependent ☐ Other Life event date: (mm/dd/yy) _____/_____/_____	☐ COBRA Effective date Effective date of coverage _____/_____/_____ mm dd yy

Choice of Plan

Keystone Health Plan East Plans:[1]

- ☐ HMO Platinum Preferred $10/$20/$200
- ☐ HMO Platinum Preferred $20/$40/$250
- ☐ HMO Platinum Preferred $30/$60/$400
- ☐ HMO Gold Preferred $40/$80/$650
- ☐ HMO Gold Secure $1,000/$40/$80 /$650
- ☐ HMO Gold Proactive
- ☐ HMO Gold Classic $1,500/$30/$60/90%
- ☐ HMO Gold Classic $2,500/$40/$80/100%
- ☐ HMO Silver Classic $4,750/$30/$60/70%
- ☐ HMO Silver Secure $5,000/$50/$100/$600
- ☐ HMO Silver Classic $4,500/$50/$100/100%
- ☐ HMO Silver Classic $3,750/$30/$60/50%
- ☐ HMO Silver Proactive
- ☐ HMO Silver Proactive Value
- ☐ HMO Bronze Essential $7,000/$50/$100/$700
- ☐ DPOS Platinum Preferred $10/$20/$200
- ☐ DPOS Platinum Preferred $20/$40/$250
- ☐ DPOS Gold Preferred $40/$80/$650
- ☐ DPOS Gold Classic $1,500/$30/$60/90%
- ☐ DPOS Silver Classic $3,750/$30/$60/50%
- ☐ DPOS Bronze Essential $7,000/$50/$100/$700

Personal Choice PPO Plans:[1]

- ☐ Platinum Preferred $10/$20/$200
- ☐ Platinum Preferred $20/$40/$250
- ☐ Gold Preferred $40/$80/$600
- ☐ Gold Classic $1,500/$20/$40/80%
- ☐ Gold Classic $2,500/$40/$80/100%
- ☐ Silver Secure $4,750/$40/$80/$600
- ☐ Silver Classic $5,000/$50/$100/90%
- ☐ Silver Classic $3,750/$30/$60/70%
- ☐ Platinum HSA-50 $1,800/100%
- ☐ Gold HSA-25 $2,400/$25/$50/90%
- ☐ Gold HSA-0 $2,100/100%
- ☐ Gold HSA-25 $2,600/80%
- ☐ Silver HSA-0 $3,500/100%
- ☐ Silver HSA-0 $2,100/70%
- ☐ Silver HSA-0 $3,000/90%
- ☐ Bronze HSA-0 $5,200/50%
- ☐ Bronze HSA-0 $6,900/100%
- ☐ Gold HRA-25 $3,400/100%

Personal Choice EPO Plans:[1]

- ☐ Silver HSA-0 $3,000/80%

Medicare Supplemental plan:

- ☐ MedigapSecurity

Vision:

- ☐ _____

Dental plans:

HMO & DPOS

- ☐ Adult DHMO[2]

PPO/HSA/HRA/HMO & DPOS

- ☐ Preferred Family PPO
- ☐ Premier Family PPO
- ☐ Deluxe Family PPO
- ☐ Adult Preventive PPO
- ☐ Adult Preferred PPO
- ☐ Adult Premier PPO

*The Keystone Health Plan East HMO/DPOS Plans are underwritten by Keystone Health Plan East. PPO Plans are underwritten by QCC Insurance Company.

[1] Includes prescription drug, pediatric and adult vision, and pediatric dental benefits.

[2] Available for HMO and DPOS plans only.

SECTION B — Primary applicant information

Primary applicant name: Last, first, middle initial		Social Security Number (required)	
Employer name	Birth date (mm/dd/yy) ____/____/_____	Age	Gender: ☐M ☐F
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†		
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†		

† A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. You can also call 1-800-ASK-BLUE (1-800-275-2583) (TTY: 711) to request a PCP or PDO directory (for HMO/DPOS plans only).

SECTION C — Family information (if applying)*

Spouse / domestic partner name: Last, first, middle initial		Social Security Number (required)		
Employer name	Birth date (mm/dd/yy) _____/_____/_____	Age	Gender: ☐M ☐F	Relationship code:‡
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†			
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†			

Dependent†† name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) _____/_____/_____	Age	Gender: ☐M ☐F	Relationship code:‡
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†			
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†			

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. You can also call 1-800-ASK-BLUE (1-800-275-2583) (TTY: 711) to request a PCP or PDO directory (for HMO/DPOS plans only).

††Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

SECTION C — Family information (continued)*

Dependent†† name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) _____/_____/_____	Age	Gender: ☐M ☐F	Relationship code:‡
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†			
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†			

Dependent†† name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) _____/_____/_____	Age	Gender: ☐M ☐F	Relationship code:‡
Primary care office/ PCP name (HMO/DPOS only)†	Primary care physician office ID# (HMO ID#, HMO/DPOS only)†			
Current patient of PCP? (HMO/DPOS only)† ☐Yes ☐No	Primary dental office ID# (DHMO only)†			

† A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. You can also call 1-800-ASK-BLUE (1-800-275-2583) (TTY: 711) to request a PCP or PDO directory (for HMO/DPOS plans only).
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01 = Spouse
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10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

* If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

SECTION D — Personal information

Residence address			Mailing address (if different from residence address)		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			County		

SECTION E — Contact information**

Home phone number ( )	Business phone number ( )	Best time to call: ☐Morning ☐Afternoon
Mobile phone number ( )	Email address	Best location to call: ☐Home ☐Business ☐Mobile

** By providing my phone number and/or email address, I authorize Independence Blue Cross, its subsidiaries and affiliates (collectively "Independence"), and my employer to contact me via email, automated text and/or phone call. I understand that my consent is not a condition of any benefit or purchase. Message and data rates may apply.

SECTION F — Household information

Do all applicants reside in the same household? ☐ Yes ☐ No

If no, provide reason: _____

Applicant's name _____	Applicant's address _____
Applicant's name _____	Applicant's address _____

SECTION G — Other insurance

A. Are you or any applicants currently insured with Independence Blue Cross or an affiliate of Independence Blue Cross, or another Blue Cross and Blue Shield plan?	☐ Yes ☐ No
B. Do you have any health insurance in effect?	☐ Yes ☐ No
C. Are you replacing the health insurance plan listed in A or B above?	☐ Yes ☐ No
If "Yes," termination date (mm/dd/yy): _____/_____/_____	

Important: Confirm group coverage prior to cancelling any existing coverage.

If you answered "Yes" to question A or B, provide the following information for each applicant.

Name	Health care carrier	Policy number	Term/ Renewal date

SECTION H - Additional information

1. Have you, your spouse / domestic partner, or any dependents used a tobacco product on average four or more times per week within the past 6 months, other than for religious or ceremonial use? ☐ Yes ☐ No

If "Yes,": ☐ Yes, but I am participating in a smoking cessation program. ☐ Yes, and I am not participating in a smoking cessation program.

The above questions are applicable to members and their dependents age 21 and older.

Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco (mm/dd/yy): _____/_____/_____

SECTION I — Declarations and Conditions of Enrollment *Please read carefully before signing below.*

Your application cannot be processed without your signature.

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.

For PPO members:

By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically-related facility, insurance company, or other organization or institute that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and its affiliate, QCC Insurance Company, Highmark Blue Shield, and ancillary service providers who are responsible for administrating certain covered services. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my employer, association, or welfare board and Independence Blue Cross and Highmark Blue Shield.

For HMO and DPOS members:

I understand that the provision of services to me and my dependents as members of Keystone Health Plan East ("Keystone") is governed by the applicable master group contract, which provides that:

1. Except for emergencies and select DPOS services, all medical or dental care must be initiated at the primary care office or primary dental office we have selected; and,
2. I and my dependents authorize any person or organization provider services to furnish Keystone, its affiliates, and ancillary service providers who are responsible for administrating certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, Keystone quality and utilization review.

I further understand that I can change health plans only at the time my employer and Keystone specify.

Keystone DPOS program self-referred benefits may be underwritten by QCC Insurance company. Referred benefits underwritten or administered by Keystone Health Plan East.

SIGN HERE

X _____ __/__/____

Applicant/Parent or legal guardian signature — Date (mm/dd/yy)

Group Administrator: Mail application to:

Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101

NOTE: Please make sure your Group Administrator has completed the gray-shaded section on page 2 of this application.

To get the Summary of Benefits and Coverage, you can visit ibx.com or call 1-800-ASK-BLUE (1-800-275-2583) (TTY:711) to request a copy in paper form free of charge.

19248 IBC Small Employer - 2020 669052

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.