

# 2021 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. Applications 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!

For employer Group Administrator to complete (mandatory).

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
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee and child <input type="checkbox"/> Employee and children <input type="checkbox"/> Employee and spouse or domestic partner <input type="checkbox"/> Family	<input type="checkbox"/> Address <input type="checkbox"/> Last name <input type="checkbox"/> Primary care office <input type="checkbox"/> Rehire <input type="checkbox"/> Primary dental office	<input type="checkbox"/> Add spouse/domestic partner <input type="checkbox"/> Add a dependent <input type="checkbox"/> Delete a dependent <input type="checkbox"/> Other Life event date: (mm/dd/yy) ____/____/____	<input type="checkbox"/> COBRA Effective date ____/____/____ mm    dd    yy

#### Choice of Plan

##### Keystone Health Plan East Plans:<sup>1</sup>

- ☐ 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 \$7,500/\$70/\$140/\$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 \$7,500/\$70/\$140/\$700

##### Personal Choice PPO Plans:<sup>1</sup>

- ☐ 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%
- ☐ Silver HSA-0 \$3,700/100%
- ☐ Silver HSA-0 \$2,100/70%
- ☐ Silver HSA-0 \$3,000/90%
- ☐ Bronze HSA-0 \$5,600/50%
- ☐ Bronze HSA-0 \$7,000/100%
- ☐ Gold HRA-20 \$3,700/100%

##### Personal Choice EPO Plans:<sup>1</sup>

- ☐ Silver HSA-0 \$3,000/80%

##### Medicare Supplemental plan:

- ☐ Medigap Security

Vision:

☐ \_\_\_\_\_

##### Dental plans:

##### HMO & DPOS

- ☐ Adult DHMO<sup>2</sup>

– This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage.

##### 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.

<sup>1</sup> Includes prescription drug, pediatric and adult vision, and pediatric dental benefits.

<sup>2</sup> 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: <input type="checkbox"/> M <input type="checkbox"/> F
Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>	Primary care physician office ID# (HMO ID#, HMO/DPOS only) <sup>†</sup>		
Current patient of PCP? (HMO/DPOS only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary dental office ID# (DHMO only) <sup>†</sup>		

<sup>†</sup> 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](http://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: <input type="checkbox"/> M <input type="checkbox"/> F
Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>	Primary care physician office ID# (HMO ID#, HMO/DPOS only) <sup>†</sup>		
Current patient of PCP? (HMO/DPOS only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary dental office ID# (DHMO only) <sup>†</sup>		

  

Dependent <sup>††</sup> name: Last, first, middle initial		Social Security Number (required)	
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>	Primary care physician office ID# (HMO ID#, HMO/DPOS only) <sup>†</sup>		
Current patient of PCP? (HMO/DPOS only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary dental office ID# (DHMO only) <sup>†</sup>		

<sup>†</sup>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](http://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).

<sup>††</sup>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.

<sup>‡</sup>Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse	17 = Stepchild
02 = Child	20 = Subscriber / Self
09 = Adopted child	29 = Domestic Partner
10 = Foster child	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 <sup>††</sup> name: Last, first, middle initial		Social Security Number (required)		
Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy) ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Relationship code: <sup>‡</sup>
Primary care office/ PCP name (HMO/DPOS only) <sup>†</sup>		Primary care physician office ID# (HMO ID#, HMO/DPOS only) <sup>†</sup>		
Current patient of PCP? (HMO/DPOS only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No		Primary dental office ID# (DHMO only) <sup>†</sup>		

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

<sup>†</sup> 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](http://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  
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 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: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon
Mobile phone number (       )	Email address	Best location to call: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Do you have any health insurance in effect?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Are you replacing the health insurance plan listed in A or B above?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes," <input type="checkbox"/> Yes, but I am participating in a smoking cessation program. <input type="checkbox"/> 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 administering 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 administering 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](http://ibx.com) or call 1-800-ASK-BLUE (1-800-275-2583) (TTY:711) to request a copy in paper form free of charge.