ENROLLMENT/CHANGE FORM

Keystone HEALTH PLAN EAST

Enrollment Department
P.O. Box 8240
Philadelphia, PA 19103-8240
(215) 241-2240 (Marketing)
(215) 241-2001 (Main)

1A Group/Employer Information

Your **Group Administrator** must complete this section. This form **cannot be processed** without this information.

Group Number | Group Name | Subscriber Employment Status ☐ Active ☐ Retiree

Site Name | Site Number | Date of Hire

Date Coverage/Change is Effective | Employer Signature and Date

1 Plan (please specify);

☐ Keystone 2 ☐ Keystone 5 ☐ Keystone 10 ☐ Keystone 15
☐ Keystone Point of Service ☐ Keystone Select ☐ Keystone Plus

2 Subscriber/Member Enrollment or Change - Employee Must Complete in Full

☐ **New**
- ☐ Open Enrollment
- ☐ Life Event
- ☐ New Hire

☐ **Change**
- ☐ Address
- ☐ Primary Care Office
- ☐ Last Name
- ☐ Dental Office
- ☐ Rehire

☐ **Dep. Membership Change**
- ☐ Add Dependent
  If adding spouse, indicate marriage date.
- ☐ Delete Dependent

☐ **Other Change**
- ☐ COBRA Effective
- ☐ Conversion:

☐ **Terminate Contract**
- ☐ Terminated Employment
- ☐ Full-time to Part-time
- ☐ Deceased, date
- ☐ Other, Please Explain

3 Subscriber Information - Note: Please complete this section in its entirety, whether you are a new applicant or are making a change to an existing contract.

Social Security Number/ID Number | Last Name | First Name | M.I. | Sex: M/F | Date of Birth

Street Address | Apt./Suite | City | State | Zip

Telephone Number (include area code)
Home: ( ) —
Work: ( ) —

Marital Status
☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed

Primary Care Office Number | Primary Care Office Name | If current Physician Check this Box ☐

Primary Dental Office Number | Primary Dental Office Name | If current Dentist Check this Box ☐

4 Dependent Information - Please provide all information for each person to be covered.

	Last Name	First Name	Sex M/F	Date of Birth month/day/year	Primary Care Office Number and Name	Check if current patient	Full-time Student over 19? (If yes, please attach student verification.)	Handicapped? If yes, please refer to instructions.
Spouse					Number: / Name:	☐		
Oldest Child					Number: / Name:	☐	☐ Y ☐ N	☐ Y ☐ N
Child					Number: / Name:	☐	☐ Y ☐ N	☐ Y ☐ N
Child					Number: / Name:	☐	☐ Y ☐ N	☐ Y ☐ N

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(over) ↓

4A If you have listed any dependents in the Dependent Information Section, you must answer the questions below. Do any of the dependents listed in this section live at another address? ☐ Y ☐ N
If yes, who and at what address? Explain the circumstances on separate sheet.
If any dependent's last name is different from yours, explain the circumstances. _____

5 Other Insurance Information. To be sure that you receive all the benefits to which you are entitled, you must complete the following:

5A Is your spouse employed? ☐ Yes ☐ No If yes, please give name, address and phone number of spouse's employer.

Social Security # | Employer Name | Telephone Number ( ) –

Street Address | City | State | Zip –

5B Are any persons listed on this form covered by another health insurance policy? ☐ Yes ☐ No

Who is covered by this policy? List names of those covered.

Ins. Co. Name
Policy Number
Policy Holder

(1)
(2)
(3)
(4)

Type of benefits: ☐ Health ☐ Rx ☐ Dental ☐ Vision

5C Are you or any of your dependents currently receiving Medicare benefits? ☐ Yes ☐ No If yes, please give name of recipient.

	Medicare Number	Part A Effective Date	Part B Effective Date
Sub. Name		/ /	/ /
Spouse		/ /	/ /
Dep.		/ /	/ /

Reason
☐ Age
☐ Disability
☐ ESRD
☐ DI & ESRD
☐ Age & ESRD
☐ Age & DI
☐ Age, DI & ESRD

Important: Please read and sign below. *I understand that the provision of services to me and my dependents as Members of Keystone Health Plan is governed by the applicable Group Master Contract, which provides that: 1) except for emergencies, all medical or dental care must be initiated at the primary care office or primary dental office (as appropriate) we have selected; and 2) I and my dependents authorize any person or organization providing services to furnish Keystone with medical or dental records or other information concerning such services for purposes of Keystone quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductible, coinsurance and other copayments for all self referred services, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and Keystone specify.*

*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 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. *Keystone Point of Service program Self-Referred benefits may be underwritten by QCC Insurance Company.*

Employee's Signature _____ **Date** / /

Benefits underwritten or administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association.

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