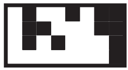

25425

| For office use only |
| --- |
| Application ID: ______________________ |
| Account ID: ______________________ |

## Application/Change Form for Individual Coverage

### Keystone Health Plan East (KHPE) HMO Plans and QCC Insurance Company PPO/EPO Plans

Keystone Health Plan East HMO Plans are underwritten by Keystone Health Plan East. PPO/EPO Plans are underwritten by QCC Insurance Company.

In order to be eligible for coverage, the following must be true:

- The primary applicant must be between the ages of 0 and 64.
- Applicants are residents of Bucks, Chester, Delaware, Montgomery, or Philadelphia counties in Pennsylvania.
- Applicants are not eligible for Medicare or Medicare Disability.
- Dependent children must be under age 26.

## SECTION A — Plan Selections

| Type of Coverage | Reason for application | Payment mode | For office use only |
| --- | --- | --- | --- |
| ☐ Individual<br>☐ Individual and spouse or domestic partner<br>☐ Individual and child(ren)<br>☐ Family | ☐ New enrollment<br>☐ Change benefit plan<br>☐ Special Enrollment Reason: ______________ | ☐ Bill me monthly<br>☐ Credit Card /Debit Card (first payment only)<br>☐ Pre-paid Debit Card | Effective Date<br>______________ |

| Choice of Plan | | | |
| --- | --- | --- | --- |
| Keystone HMO Plans underwritten by Keystone Heath Plan East: | | Personal Choice PPO/EPO Plans underwritten by QCC Insurance Company: | |
| ☐ HMO Platinum | ☐ HMO Gold Proactive | ☐ PPO Gold | ☐ Platinum (EPO) |
| ☐ HMO Gold | ☐ HMO Silver Proactive | ☐ PPO Silver | ☐ Silver Reserve (EPO) |
| ☐ HMO Silver | ☐ HMO Silver Proactive Select | ☐ PPO Bronze | ☐ Silver Reserve Select (EPO) |
| ☐ HMO Bronze | ☐ HMO Silver Proactive Value | | ☐ Bronze Reserve (EPO) |
| | | | ☐ Bronze Basic (EPO) |
| | | | ☐ Catastrophic (EPO)* |

## SECTION B — Primary Applicant Information (must be between the ages of 0 and 64)

| Primary applicant name: Last, First, Middle Initial | | Social Security Number (required) | |
| --- | --- | --- | --- |
| Employer name | Birth date<br>_____/_____/_____ | Age | Gender:<br>☐ M ☐ F |
| Primary care office name (HMO only)** | PCP office code (HMO ID#, HMO only)** | | Current patient? (HMO only)**<br>☐ Yes ☐ No |

* Available to eligible individuals only (see Section H : Declarations and Conditions of Enrollment).

** Required for all HMO plans. Use our website www.ibx4you.com to find a primary care physician (PCP) call 1-844-BLUE-4ME (or 1-844-258-3463) (TTY:711) to request a PCP directory (HMO plans only).

Form #18736 (Rev. 1.18)

25425

## SECTION C — Family Information (if applying)

| Spouse or Domestic Partner name: Last, First, Middle Initial | | Social Security Number (required) | |
|---|---|---|---|
| Employer name | Birth date ____/____/____ | Age | Gender: ☐ M ☐ F |
| Primary care office name (HMO only)** | PCP office code (HMO ID#, HMO only)** | | Current patient? (HMO only)** ☐ Yes ☐ No |

| Dependent name: Last, First, Middle Initial | | Social Security Number (required) | |
|---|---|---|---|
| Relationship (e.g., son, stepdaughter) | Birth date ____/____/____ | Age | Gender: ☐ M ☐ F |
| Primary care office name (HMO only)** | PCP office code (HMO ID#, HMO only)** | | Current patient? (HMO only)** ☐ Yes ☐ No |

| Dependent name: Last, First, Middle Initial | | Social Security Number (required) | |
|---|---|---|---|
| Relationship (e.g., son, stepdaughter) | Birth date ____/____/____ | Age | Gender: ☐ M ☐ F |
| Primary care office name (HMO only)** | PCP office code (HMO ID#, HMO only)** | | Current patient? (HMO only)** ☐ Yes ☐ No |

| Dependent name: Last, First, Middle Initial | | Social Security Number (required) | |
|---|---|---|---|
| Relationship (e.g., son, stepdaughter) | Birth date ____/____/____ | Age | Gender: ☐ M ☐ F |
| Primary care office name (HMO only)** | PCP office code (HMO ID#, HMO only)** | | Current patient? (HMO only)** ☐ Yes ☐ No |

** Required for all HMO plans. Use our website www.ibx4you.com to find a primary care physician (PCP) or call 1-844-BLUE-4ME (or 1-844-258-3463) (TTY:711) to request a PCP directory (HMO plans only).

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

*** By voluntarily giving Independence Blue Cross my mobile phone number and/or e-mail address, I authorize Independence Blue Cross and its subsidiaries (collectively ''Independence'') to send me information/data about Independence, including, but not limited to, information about my account and other insurance products and services. Independence may contact me via e-mail, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from Independence. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/ibx. Any information provided by me to Independence is subject to Independence's Privacy Policy.

## SECTION F — Other Insurance

| | | |
|---|---|---|
| A. Are you or your dependents enrolled in Medicare Part A and/or B?<br>Note: If you answered yes to the question above you and/or your dependents are not eligible for this coverage. | ☐ Yes | ☐ No |
| B. Do you currently have any health insurance? | ☐ Yes | ☐ No |
| C. Are you replacing the health insurance plan referenced in B above?<br>If "Yes," termination date: ______/______/______ | ☐ Yes | ☐ No |

*Important: Do not cancel any existing coverage until you have received notification that your application has been processed.*

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

| Name | Health care carrier | Policy number | Term/ Renewal date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## SECTION G — Additional Information

1. Have you 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: _____/_____/_____ |
| Name of person: ____________________ | Type and amount: ____________________ | Date last smoked or used tobacco: _____/_____/_____ |

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

By applying to Keystone Health Plan East or QCC Insurance Company ("the companies") for coverage for myself and the dependents listed in Section C, I understand and agree as follows:

1. a) Effective date of coverage will be the 1st day of each month.
   b) Coverage does not begin until this application is processed by the companies with an effective date of coverage assigned and payment has been received.
   c) If selecting Bill Me Monthly, a check for the first monthly premium must be submitted with your paper application.
   d) Credit card/debit card payments are acceptable for the first month's premium payment only. Pre-paid debit card payments are accepted for ongoing payments.
   e) Receipt of the initial payment does not constitute enrollment under any program.
   f) This coverage is provided only to residents of the geographical area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, Pennsylvania, served by the companies. The companies reserve the right to investigate and confirm your residence.
2. The companies may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by intentionally supplying a material misrepresentation of fact, except in the case of fraud, for which there is no time limit for voiding the policy.
3. The terms and conditions of the coverage will be controlled by the written agreement with the companies, and the companies may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.

4. **HMO Plans Only:**
   a) As a condition of coverage, each applicant must select a participating primary care physician.
   b) As a condition of coverage, (with the exception of emergency procedures and certain direct access services as defined in the Subscriber Agreement) all services, in order to be covered by KHPE, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy (if applicable), or other provider as authorized by a referral, or precertification, from a participating primary care physician or KHPE.
5. **Catastrophic Plans Only:**
   Are available to eligible applicants (Individual/Family) under the age of 30 or eligible applicants experiencing a documented hardship and have received a certification from the Federal Government.
6. I understand that benefits under this policy will be coordinated with other coverage any covered person may have which is subject to coordination.
7. By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-Group policy, the companies will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.
8. 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.
9. I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

**Signature(s) Required**

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

SIGN HERE X______________________________ ___/___/_____
Applicant/Parent or Legal Guardian signature Date

SIGN HERE X______________________________ ___/___/_____
Applicant spouse or domestic partner signature Date
(if applying for coverage)

## SECTION I — Statement of Accountability (if applicable)

To be completed if the applicant cannot complete or has not completed the application:

| I, ________________________, have read and completed the application form for the primary applicant for the following reason(s): | |
|---|---|
| ☐ Applicant does not speak English | ☐ Applicant does not read English |
| ☐ Applicant does not write in English | ☐ Other (please explain) |
| I translated and fully explained the "Declarations and Conditions of Enrollment." I also translated the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by: | |
| ______________________________<br>Name | ______________________________<br>Signature of translator (required) |
| _____/_____/_____<br>Date (required) | ______________________________<br>Relationship to applicant |