25425

Independence

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

KHPE 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	For office use only
☐ Individual ☐ Individual and spouse or domestic partner ☐ Individual and child(ren) ☐ Family	☐ New enrollment ☐ Change benefit plan ☐ Special Enrollment Reason: _____	Effective Date _____

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

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 _____/_____/_____	Age	Gender: ☐ M ☐ F
Primary care office name (HMO only)**	PCP office code (HMO ID#, HMO only)**		Current patient? (HMO only)** ☐ Yes ☐ No

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

** Required for all HMO plans. Use our website www.ibx.com/providerfinder 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).

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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.ibx.com/providerfinder 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 providing my cell 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 cell phone call. I understand that my consent is not a condition of any benefit or purchase and that I can opt out at any time. Message and data rates may apply.

SECTION F — Other Insurance

A. Are you or any of your dependents seeking coverage enrolled in Medicare Part A and/or B? 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? 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 Check, 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 and/or Commonwealth of Pennsylvania.
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 (if applying for coverage) — Date

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:	
_____ Name	_____ Signature of translator (required)
_____/_____/_____ Date (required)	_____ Relationship to applicant

SECTION J — Payment Mode

☐ Check ☐ Credit Card/Debit Card (first payment only) ☐ Pre-paid Debit Card

Credit or Debit Card Type: ☐ American Express ☐ Discover ☐ Mastercard ☐ Visa

Credit or Debit Card No: Expiration Date: Security Code:

Cardholder Name: