HIGHMARK® Delaware

Underwriting Services 1-8-10
P.O. Box 1991
Wilmington, DE 19899-1991

APPLICATION FOR CONVERSION COVERAGE

ELIGIBILITY

To be eligible for Conversion coverage, you must meet all of the following requirements:

- Have prior (with no lapse) coverage with Highmark Blue Cross Blue Shield Delaware (Highmark DE) or another Blue Cross and Blue Shield plan
- Must apply within 30 days of your Highmark DE or other Blue Cross and Blue Shield plan coverage ending
- Not currently eligible for, or enrolled in, Highmark DE Group coverage
- Not eligible for Medicare
- Have exhausted COBRA continuation coverage, if available

Important Note: As of January 1, 2012, under Delaware Law, the definition of spouse includes a civil union partner.

INSTRUCTIONS

- Please print all requested information, complete all sections of this application and mail your application with payment to the above address.
- An incomplete application will be returned.

A. PERSONAL INFORMATION

Last Name	First Name	M.I.	Jr., Sr.	Social Security Number

Street Address

Apartment Number	City	State	Zip Code

Birth Date—month, day, year	Home Phone—include area code	Business Phone—include area code

Check one: ☐ Male ☐ Female	Check one: ☐ Single ☐ Married ☐ Other *(specify)*:	Spouse's Social Security Number

I am: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Other *(specify)*:
Name of company:

My Spouse is: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Other *(specify)*:
Name of company:

I am applying for coverage for:
☐ Myself ☐ Myself & family members who were covered on the prior plan

Have you or your spouse smoked, snuffed or chewed tobacco at any time during the past 24 months? ☐ Yes ☐ No

B. REASON FOR APPLICATION

☐ I am transferring from another Highmark DE policy.

Identification No.: _____ Account No.: _____

☐ I am transferring from another Blue Cross Blue Shield Plan.

Identification No.: _____ Termination Date: _____

Name of Blue Cross and Blue Shield Plan: _____

FOR HIGHMARK DE USE ONLY

Account Number	Package Number	C/T	Effective Date

ENR-165 (5-12)

C. INDIVIDUALS TO BE COVERED

Only eligible dependents can be enrolled.

List additional dependents on a separate sheet.

A dependent child's coverage ends automatically at the end of the month in which the child reaches 26.

A disabled dependent is considered eligible beyond the age limit if he or she is incapable of self-support because of a continuous mental or physical handicap which began before the age limit. A *Disabled Dependent Application* must be completed and accepted for coverage to be effective.

Spouse's First Name ☐ Add ☐ Cancel	M.I.	Spouse's Last Name (if different)	Spouse's Birth Date (month, day, year)
Date of Marriage (month, day, year)	Is spouse a full-time student? ☐ Yes ☐ No	Is spouse disabled? ☐ Yes ☐ No	

Dependent's First Name ☐ Add ☐ Son ☐ Cancel ☐ Daughter	M.I.	Dependent's Last Name (if different)	Dependent's Birth Date (month, day, year)
Is this dependent a full-time student? ☐ Yes ☐ No		Is this dependent disabled? ☐ Yes ☐ No	

Dependent's First Name ☐ Add ☐ Son ☐ Cancel ☐ Daughter	M.I.	Dependent's Last Name (if different)	Dependent's Birth Date (month, day, year)
Is this dependent a full-time student? ☐ Yes ☐ No		Is this dependent disabled? ☐ Yes ☐ No	

Dependent's First Name ☐ Add ☐ Son ☐ Cancel ☐ Daughter	M.I.	Dependent's Last Name (if different)	Dependent's Birth Date (month, day, year)
Is this dependent a full-time student? ☐ Yes ☐ No		Is this dependent disabled? ☐ Yes ☐ No	

Dependent's First Name ☐ Add ☐ Son ☐ Cancel ☐ Daughter	M.I.	Dependent's Last Name (if different)	Dependent's Birth Date (month, day, year)
Is this dependent a full-time student? ☐ Yes ☐ No		Is this dependent disabled? ☐ Yes ☐ No	

D. HEALTH-RELATED INFORMATION

1. Are you or any family members covered by other health insurance?
   ☐ Yes ☐ No

   If YES, who is covered?
   ☐ Yourself ☐ Your spouse ☐ Your dependent children

   Name of insurance company where claims are submitted: _____

   _____

   Address of the above-named insurance company: _____

   _____

2. Is this other health insurance through an employer?
   ☐ Yes ☐ No

   If YES, name of employer: _____

   Address of employer: _____

   _____

3. Does your employer (or your spouse's employer) have a group medical plan?
   ☐ Yes ☐ No

   If YES, indicate the reason you are not covered on that plan: _____

   _____

   _____

4. Are you applying for Highmark DE conversion coverage in order to replace another sickness and accident policy (or other health policy) that you presently have in effect?
   ☐ Yes ☐ No

5. Are you or any member of your family currently hospitalized?
   ☐ Yes ☐ No

   If YES, give the name of the person hospitalized: _____

   Name of hospital where this person is an inpatient: _____

   _____

   _____

E. TERMS OF AGREEMENT

I understand and agree that:

1. If Highmark Blue Cross Blue Shield Delaware (Highmark DE) accepts my application for a new contract, a change in coverage or a transfer of coverage, it will provide new coverage effective the first day of the month after it receives my application.

2. The information I have provided to Highmark DE in this application is both true and complete. Highmark DE will void coverage if any part of this application is false or incomplete.

3. Highmark DE alone determines whether it will accept my application and make coverage available to me. My rights to coverage are subject to all terms and conditions of any contract Highmark DE issues, and this application will be part of the contract.

4. Highmark DE has a 12-month waiting period for preexisting conditions. Highmark DE defines preexisting conditions as conditions, diseases or ailments for which anyone covered on my contract received either a diagnosis or treatment within the six (6) months before transferring to Highmark DE conversion coverage. The preexisting condition waiting period does not apply to individuals under age 19.

   If Highmark DE accepts my application, it will determine whether I have satisfied all or any part of the waiting period. I will receive credit for the time covered under my prior contract, provided I had no lapse in my coverage. Without credit, Highmark DE will provide no benefits for services that I, my spouse, or my dependents receive for preexisting conditions.

5. For purposes reasonably related to this contract, I authorize any health care providers to release to Highmark DE or its designee information related to the health care services, diagnoses and treatments they have provided to me or my covered dependents.

6. For administrative purposes or as required by law, I authorize Highmark DE to release appropriate demographic, diagnostic and medical information about myself and my covered dependents to other persons, entities or organizations for audits, claims processing, coordination of benefits, health management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes.

Signature of Applicant	Date of Application

Important: *This application must be signed, and accompanied by a deposit of at least one (1) month's payment.*