Enrollment Services (1-7-01)
Highmark Blue Cross Blue Shield Delaware
P.O. Box 8868
Wilmington, DE 19899

AWAY FROM HOME CARE® GUEST MEMBERSHIP APPLICATION

Application UID:	Away From Home Care (AFHC) Network:	
Application Status:	Application Start Date:	Application End Date:

GUEST MEMBER INFORMATION

Guest Member Name:	Date of Birth:	
Away From Home Address: Street/Apt.#	Gender: ☐ Male ☐ Female	Relationship to Subscriber:
City State Zip Code	Social Security Number:	
Away From Home Telephone:	Guest Member ID:	

SUBSCRIBER INFORMATION / EMPLOYER INFORMATION:

SUBSCRIBER INFORMATION			EMPLOYER INFORMATION:
Subscriber Name:		Date of Birth:	Company Name:
Subscriber Address : Street/Apt.#		Gender: ☐ Male ☐ Female	Company's Address: Street
City State Zip Code		Social Security Number:	City State Zip Code
Primary Telephone:	Work Telephone:	Subscriber ID:	Group Number:

HOME INFORMATION / HOST INFORMATION

HOME INFORMATION		HOST INFORMATION
Plan Code:	Plan Name:	Plan Code:
Plan Address:		Plan Name:
Plan Primary Contact/s:		Plan Address:
Plan Primary Contact/s Telephone:		Plan Primary Contact/s:
Home Primary Care Physician:	PCP Telephone:	Plan Primary Contact/s Telephone:

MEMBERSHIP DETAILS

Type of Guest Membership: (Student / Long-Term Traveler / Families Apart)	Benefit Level: (High / Low)
Memo:	
Drug Card Name:	Drug Card Telephone:
Mental Health Provider Name:	Mental Health Provider Telephone:
Mental Health Benefits Provided By:	

MEDICARE INFORMATION

Medicare Enrollee:

GUARDIAN/AUTHORIZED AGENT INFORMATION

Notes:	Telephone: ______________________ Relationship to Guest: ______________________ Authorized to receive information about Guest? ☐ Yes ☐ No