HIGHMARK. Delaware

Mail completed form and supporting documents to:
Highmark Blue Cross Blue Shield Delaware
ATTN: Enrollment Services
P.O. Box 8868
Wilmington, DE 19899-8868
Phone: 1-866-835-8977

DELAWARE CHILDREN'S CARE PLAN: APPLICATION FOR COVERAGE – IMPORTANT INFORMATION

Delaware Children's Care Plan (DCCP) is a health care insurance plan provided by Highmark Blue Cross Blue Shield Delaware, and is offered to qualified children residing in Delaware and who are not eligible for Medicaid, Medicare or the Delaware Healthy Children Program. Monthly premiums are based on family income, and certain eligibility criteria must be met to qualify for coverage. To be eligible, children must:

- be under age 19
- be a Delaware resident
- meet the income guidelines (below)
- be a United States citizen or permanent legal alien
- have not had health coverage in the last three months (some exceptions apply)

A custodial parent/legal guardian must apply for DCCP; however, only one parent/guardian may apply. The parent/legal guardian completing the application must select the child(ren)'s primary care physician and is the only person who may change the selection. The address you provide on this application will be used for identification cards, premium billing statements and other correspondence.

Before coverage can begin, you must send a completed application and the appropriate documentation as noted within the application. Incomplete applications or applications with missing documentation will slow the enrollment process. You will receive written notice of the decision, and coverage will begin the first of the month following verification of eligibility and payment of premium.

Premium payment must be made by the applying parent/legal guardian. No checks from any third party (provider, hospital, social service, etc.) will be accepted as payment for this coverage. Checks or money orders must be made out to Highmark Blue Cross Blue Shield Delaware (Highmark Delaware).

INCOME GUIDELINES AND MONTHLY PREMIUMS				
Federal Poverty Level Range	201-225%	226-250%	251-300%	Over 300%
Household Income (Based on a family of 4)	$46,105 – $51,863	$51,864 – $57,625	$57,626 – $69,150	Above $69,151
Monthly Premium per child*	$80.56	$134.27	$187.97	$268.53

*For families with four or more children, the fourth child and any additional children are covered at no cost.

ENR-162 (6-12)

Highmark Delaware

DELAWARE CHILDREN'S CARE PLAN

Application for health benefits coverage from Highmark Blue Cross Blue Shield Delaware

WHO'S COMPLETING THIS APPLICATION?

Please attach two items to prove Delaware residency, such as a copy of a driver's license or state ID, and a utility bill or credit card statement dated within the last 60 days.

Last Name	First Name		
Street Address (Residence)	City	State	Zip
Daytime Telephone Number ( )	Email address (if we may contact you by email)		

WHO'S IN YOUR HOUSEHOLD?

List everyone who lives in your household, starting with yourself. Please attach a copy of a birth certificate, or proof of citizenship, for each child you are applying for.

Last Name	First Name	M.I.	Relation (spouse, child, friend)	Applying for this person?	Date of Birth	Gender	Social Security Number	U.S. Citizen or Legal Alien (applicants only)
			Self	☐ Y ☑ N	____/____/____	☐ M ☐ F		☐ Y ☐ N
				☐ Y ☐ N	____/____/____	☐ M ☐ F		☐ Y ☐ N
				☐ Y ☐ N	____/____/____	☐ M ☐ F		☐ Y ☐ N
				☐ Y ☐ N	____/____/____	☐ M ☐ F		☐ Y ☐ N
				☐ Y ☐ N	____/____/____	☐ M ☐ F		☐ Y ☐ N
				☐ Y ☐ N	____/____/____	☐ M ☐ F		☐ Y ☐ N
				☐ Y ☐ N	____/____/____	☐ M ☐ F		☐ Y ☐ N

WHO ARE YOUR PRIMARY CARE PHYSICIANS?

List the primary care physicians for each child you are applying for:

Name of child	Primary Care Physician	Primary Care Physician ID*	Current Patient?
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

*Please visit highmarkbcbsde.com for physician information.

WHAT'S YOUR EARNED INCOME?

Tell us about your household's earned income from paychecks, tips, self-employment, in-home sales, odd jobs, etc. Please attach proof of each income type listed below, along with a copy of your federal tax return.

Person Working	Student?	Employer/Source of Earnings	Frequency	Amount paid before taxes/deductions
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			
	☐ Y ☐ N			

DO YOU HAVE OTHER INCOME?

Tell us about any other income your household has, like Social Security, SSI, child support, Veteran's benefits, unemployment compensation, pension or cash given to you. Please attach proof of each income type listed below.

Person Receiving Income	Source of Money	Frequency	Amount paid before taxes/deductions

DOES ANYONE IN YOUR HOUSEHOLD CURRENTLY HAVE HEALTH INSURANCE?

Tell us about any health insurance you, or someone in your household, currently have.

Name of Policy Holder	Name of Insurance Carrier or Program	Who is Covered?	What Kind of Coverage? (check all that apply)	Policy Number
			☐ Doctor ☐ Hospital ☐ Lab ☐ Tests ☐ X-ray	
			☐ Doctor ☐ Hospital ☐ Lab ☐ Tests ☐ X-ray	

HAS ANYONE IN YOUR HOUSEHOLD HAD HEALTH INSURANCE IN THE LAST THREE MONTHS?

Name of Person with Insurance	When Did Insurance Stop?	Why Did Insurance Stop?	What Kind of Coverage? (check all that apply)
			☐ Doctor ☐ Hospital ☐ Lab ☐ Tests ☐ X-ray
			☐ Doctor ☐ Hospital ☐ Lab ☐ Tests ☐ X-ray

DO YOU HAVE ANY DAYCARE EXPENSES?

Name of child in daycare	How much is paid?	Frequency?	Who pays for this care?

TERMS OF AGREEMENT

I hereby apply on behalf of my dependent children listed on this application for a Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) health insurance contract.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I have the authority to act on behalf of my dependent children; including those who have reached the age of 18.
2. The contract will be effective only for those applicants approved by Highmark Delaware.
3. If Highmark Delaware accepts this application, I will receive a copy of the contract and an identification card. The contract will state plan benefits for insureds and define the conditions under which the benefits will be available. The carrier holding the ID card will specify the effective date of coverage.
4. The contract, application and any attached amendments shall constitute the entire agreement and shall supersede any previous agreements.
5. I will pay the premiums to Highmark Delaware when due.
6. In the event there is an error made in any payment of benefits, I agree to refund to Highmark Delaware the amount of any overpayment of benefits to which I am not entitled.
7. All statements made on this application are complete, true, and correctly stated to the best of my knowledge. I intend for Highmark Delaware to rely on these representations in deciding to issue the contract, and for them to be part of this contract.
8. Failure to enter accurate and complete information in writing, as well as failure to update that information prior to the acceptance of the application by Highmark Delaware, may be a material or fraudulent misrepresentation. If so, Highmark Delaware may void or cancel my contract, deny benefits for the affected individual or condition, and report fraud to the Delaware Department of Insurance.
9. I authorize the release of personal financial and medical information for the purpose of determining eligibility and for review of the Delaware Children's Care Plan (DCCP).

SIGNATURE

Signature	Date