

**INSTRUCTIONS FOR COMPLETING YOUR INDEPENDENCE BLUE CROSS ENROLLMENT FORM**

**Please complete both sides of the form. Group Administrators/Subscribers: Both signatures are required on page 2**

NOTE: See back of this page for terms and definitions.

PLEASE KEEP A COPY OF BOTH SIDES FOR YOUR RECORDS. ADDITIONALLY, A COPY CAN BE USED AS A TEMPORARY IDENTIFICATION CARD.

**Please print carefully in capital letters as shown below. DO NOT USE RED INK OR PENCIL.**

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z 0 1 2 3 4 5 6 7

Thank you for choosing IBC. In order to process your application as quickly as possible, please **read the following instructions and provide the information requested.**

Section 1: Fill out this section if you are a new or current subscriber. If you are making any changes, additions or deletions, please check the boxes that apply. Please see your Group Administrator if you are making a change to COBRA or Conversion. If you are deleting a family member, please check "Delete a Dependent" in Section 1 and indicate **only** the family member for which coverage is to terminate in Section 4.

Section 2: This section should be completed by your Group Administrator. If this is an application for a new applicant or a member changing plans, please indicate the type of coverage elected. For example, your group has Personal Choice C2F3O1, Select Drug Program 20/40/60 and \$100 Vision. This would be indicated as:

PPO	HMO	POS	RX	Vision	Dental	CMM	Traditional	Security 65
C 2 F 3 0 1	<input type="checkbox"/>	<input type="checkbox"/>	2 0 4 0 6 0	1 0 0	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The Effective Date of Coverage and Terminate Contract Information should be completed by your Group Administrator.

Section 3: This section requires information about YOU, the employee. Please complete each area. If you are an HMO/POS plan member, you must choose a Primary Care Physician Office identification number from the booklets provided or by using our on-line provider directories ([www.ibx.com](http://www.ibx.com)). We cannot issue an identification card without the selection of a Primary Care Office.

Section 4: The following sections pertain to those subscribers with dependents. If you are a single person, you may skip to section 5A. Sections 4 and 4A request information about the dependents you are adding, deleting or changing. Please provide us with the information pertaining to your spouse first and then your children, beginning with the oldest child. And 4A: When deleting dependents, only indicate those dependents that are being removed from the policy.

If available, please provide the Social Security number for each dependent. If any of the listed dependents have insurance coverage in addition to IBC, please complete Section 5A. If you are adding a dependent that has a full-time student, please attach verification from an accredited educational institution where the child is enrolled full time. If you are adding a dependent that is handicapped, please contact your group administrator for a Handicapped Dependent Verification Form which should be completed and returned with your application. See Sections 5A and 5B to list any additional insurance that may cover the dependent(s).

Members of HMO/POS plans should list the Primary Care Office identification number for each member of the family.

Section 5: This section includes important information regarding other health insurance coverage you may have for you and/or your family which will continue after you enroll in IBC. And 5B: Part 5A asks you to indicate the other health insurance policy information of those family members that have Additional Insurance. If you selected "yes" to Additional Insurance in section 4 for any of the listed dependents, 5A must be completed. Part 5B asks whether you or any member of your family is eligible for Medicare benefits and for what reason.

Section 6: This section must be completed by your Group Administrator.

Section 7: **Please sign and date your enrollment/change form. Failure to do so will delay processing of your application and coverage cannot be activated. Please Complete The Subscriber County Of Residence Section Under Your Signature.**

**IMPORTANT NOTE TO GROUP ADMINISTRATORS: SECTION 6 MUST BE COMPLETED BY YOU BEFORE SUBMISSION TO IBC. ENSURE THAT BOTH SIDES OF THE APPLICATION ARE COMPLETED.**

Thank you for taking the time to complete your application. We look forward to having you as a member of the IBC family!

## EXPLANATION OF TERMS

- COBRA or Conversion . . . . . COBRA or Conversion coverage is offered to certain employees and their beneficiaries when their employment terminates. Please see your Group Administrator for additional information.
- Contract . . . . . The agreement between IBC and your group whereby subscribers and their dependents elect IBC coverage.
- Dependent . . . . . Spouse, or unmarried child of a subscriber, who meet eligibility requirements.
- Group Administrator . . . . . This refers to your Employer's Benefits Manager, Human Resources Representative, Group Leader or Employer Representative.
- Handicapped Dependent . . . . . An unmarried dependent child 19 years of age, or older, who, in the judgement of IBC, is incapable of self-support because of a mental or physical disability (for which continuing justification is required).
- IBC . . . . . Independence Blue Cross
- Life Event Change . . . . . This refers to any change in your personal circumstances which enables you to enroll in IBC outside the open enrollment period. Examples of a Life Event Change are: newborn, termination of previous coverage (must be continuous), court order that requires the subscriber to provide health care coverage for a dependent child, etc.
- Member . . . . . The subscriber or dependent for whom the appropriate forms and premium payments have been received by IBC.
- New Application . . . . . This applies if you have never had coverage with IBC before, or you have terminated your employment and are applying for coverage with IBC under a different employer group.
- Subscriber . . . . . YOU, the employee or person who is eligible and has enrolled for coverage as the policyholder.
- Termination . . . . . This is the date that a group contract expires, and/or the date that a subscriber and/or member ceases to be eligible or chooses to discontinue their coverage.



