

This form must be completed if you answered "yes" to any of the questions in "Section 2. Dependent Information" of the "Enrollment Application/Change Form." Please complete only the sections that pertain to your covered dependents and attach to your completed "Enrollment Application/Change Form." Please be sure to sign the back of this form.

Applicant last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		First name:	Middle name:	Applicant Social Security Number: _____	
<b>Is the address for dependents different from the primary residence address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:</b>					
<b>Dependent 1</b> Last name: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:	Daytime phone:	
Residential address:		City:	State:	ZIP:	County:
<b>Dependent 2</b> Last name: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:	Daytime phone:	
Residential address:		City:	State:	ZIP:	County:
<b>Dependent 3</b> Last name: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:	Daytime phone:	
Residential address:		City:	State:	ZIP:	County:
<b>Dependent 4</b> Last name: <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:	Daytime phone:	
Residential address:		City:	State:	ZIP:	County:
<b>Do any dependents have other group health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:</b>					
Dependent name:		Social Security Number: _____		Date of birth: (mm/dd/yyyy) ___/___/___	
Insurance company name:			Insurance policy ID #:		
Insurance company address:			Type of coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx		
<b>Is anyone covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes:</b>					
Dependent name:		Social Security Number: _____		Date of birth: (mm/dd/yyyy) ___/___/___	
Medicare/HIC #:					
Do you have Medicare Part A? <input type="checkbox"/> Yes <input type="checkbox"/> No		Part A begin date: ___/___/___		Part A end date: ___/___/___	
Do you have Medicare Part B? <input type="checkbox"/> Yes <input type="checkbox"/> No		Part B begin date: ___/___/___		Part B end date: ___/___/___	

**Is anyone covered on this application disabled?**  Yes  No **If yes:**

Please complete a disabled dependent application, which you can get from your group administrator, from our website, www.bcnepa.com or by calling our service representatives at 1-800-829-8599 or (TTY) 1-866-280-0486.

**Do any dependents have a custodial parent who is responsible for their care?**  Yes\*  No **If yes:**

Dependent name:		Social Security Number: ____ _		Date of birth: (mm/dd/yyyy) ___/___/___	
Last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:		Daytime phone:
Residential address:		City:	State:	ZIP:	County:

**Is there someone who is financially responsible for the dependent?**  Yes\*  No **If yes:**

Dependent name:		Social Security Number: ____ _		Date of birth: (mm/dd/yyyy) ___/___/___	
Organization/last name: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Sr. <input type="checkbox"/> Jr.		Middle name:	First name:		Daytime phone:
Residential address:		City:	State:	ZIP:	County:

**Are any dependents continuing coverage as full-time students?**  Yes  No **If yes:**

**When your dependent child is no longer a full-time student, you must notify the employer through which you are enrolled. Failure to do so may result in the dependent not being able to continue his or her protection on a direct-payment basis without a lapse in coverage.**

Dependent name:		Social Security Number: ____ _		Date of birth: (mm/dd/yyyy) ___/___/___	
Dependent marital status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Married/date of marriage: ___/___/___					
Dependent employment status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Not working		Dependent student status: <input type="checkbox"/> Full-time student <input type="checkbox"/> Part-time student Expected date of graduation: ___/___/___ Name of school: _____			

**Conditions of Enrollment** Please sign this section of the form. The form will not be processed without your signature.

I hereby apply for enrollment as checked hereon, made available to me through the groups with which I am affiliated. I understand that if this application is accepted, you will provide me with an identification card and group literature indicating the benefits and conditions of enrollment. I acknowledge that I will be bound by the terms and conditions of the group contract. I am authorized by my dependents, listed above, to enroll them in a Blue Cross of Northeastern Pennsylvania/Highmark Blue Shield/ First Priority Health\*/First Priority Life Insurance Company\* health care plan. I authorize the Social Security Administration to furnish Blue Cross of Northeastern Pennsylvania/Highmark Blue Shield/First Priority Health, First Priority Life Insurance Co. medical or any other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under my agreement. 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. If enrolled in a First Priority Health product, I understand that treatment rendered by a provider in the First Priority Health provider network will be paid at the highest level of benefits. I also understand that if I directly access care from a provider in the BlueCard network, my out-of-pocket expenses may be significantly higher than if I receive care from a provider within the First Priority Health network and I will be responsible for the applicable deductible and coinsurance, I understand that if I directly access care from a non-participating provider, I will be solely responsible for all costs incurred.

**Applicant Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Group Administrator Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*A copy of a power of attorney or court-initiated document must be attached to this form in order for the custodial parent or responsible person to be applied.