62404

Step 1: Tell us about you.

Please fill everything in clearly and mark "N/A" if you need to. Otherwise, the processing of this form might be delayed.

Some basics:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

– –

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

0 **Fill in this oval if you don't have a home address. You still need to give a mailing address where we can reach you.**

HOME ADDRESS

APARTMENT NUMBER

CITY, STATE, ZIP CODE

COUNTY

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)

APARTMENT NUMBER

CITY, STATE, ZIP CODE

COUNTY

HOME PHONE NUMBER (NON-MOBILE)

( ) -

MOBILE PHONE NUMBER

( ) -

PREFERRED CONTACT (SELECT ONLY ONE)

0 Home 0 Mobile

EMAIL ADDRESS

PREFERRED LANGUAGE SPOKEN (IF NOT ENGLISH)

PREFERRED LANGUAGE READ (IF NOT ENGLISH)

Who is this plan for?

Just fill in the oval that applies.

0 Just for you.

0 You and your family.

0 You're applying on behalf of a child under 18 for his or her own coverage as an individual policy holder.

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

Ahh, didn't that feel good?

All finished? Rip this page out.

62404

Step 1: About you continued.

Communication preferences:

We can send you electronic communications consisting of email alerts and notifications, if you want. Those communications could include your agreement and outline of coverage, insurance plan notices, member newsletters, and health and wellness notices such as wellness, savings, and more. It'll be easier and faster to review. You can change your preference to paper or digital at any time, or request a print or digital copy by calling **1-800-700-8482** or visiting **MyHighmark.com.**

So, what do you think?

0 **Yes,** let's do this digitally.

0 **No,** let's stick to paper.

Go to **MyHighmark.com** to review the Contact Preferences Terms and Conditions for complete details regarding selecting or changing communication preferences.

To ensure that you receive your member materials by your preferred method, you must notify Highmark if your phone number or email address change.

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Tell us about the rest of your family.

Just you? Go to page 14.

If you're applying for coverage for anyone else (let's call them dependents), fill their info in on this sheet. You can add more sheets if you need to. **Eligible dependents include:**

- Your spouse or domestic partner
- Your children under the age of 26
- Your spouse or domestic partner's children under the age of 26

The plan and deductible option you choose will apply to everyone covered by your plan.

Dependent 1

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

– –

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

Does dependent 1 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

Dependent 2

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

/ /

Does dependent 2 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

SOCIAL SECURITY OR TAX ID NUMBER

– –

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Family continued.

Dependent 3

Basic info:

FIRST NAME | MIDDLE NAME

LAST NAME | SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – – | RELATIONSHIP TO YOU

SEX: 0 Male 0 Female 0 Other | DATE OF BIRTH (MM/DD/YYYY) / /

Does dependent 3 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

Dependent 4

Basic info:

FIRST NAME | MIDDLE NAME

LAST NAME | SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – – | RELATIONSHIP TO YOU

SEX: 0 Male 0 Female 0 Other | DATE OF BIRTH (MM/DD/YYYY) / /

Does dependent 4 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

Dependent 5

Basic info:

FIRST NAME | MIDDLE NAME

LAST NAME | SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – – | RELATIONSHIP TO YOU

SEX: 0 Male 0 Female 0 Other | DATE OF BIRTH (MM/DD/YYYY) / /

Does dependent 5 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

SOCIAL SECURITY OR TAX ID NUMBER – – | APPLICANT'S LAST NAME | FIRST NAME

Step 1: Family continued.

Dependent 6

Basic info:

FIRST NAME | MIDDLE NAME

LAST NAME | SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – – | RELATIONSHIP TO YOU

SEX 0 Male 0 Female 0 Other | DATE OF BIRTH (MM/DD/YYYY) / /

Does dependent 3 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

Dependent 7

Basic info:

FIRST NAME | MIDDLE NAME

LAST NAME | SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – – | RELATIONSHIP TO YOU

SEX 0 Male 0 Female 0 Other | DATE OF BIRTH (MM/DD/YYYY) / /

Does dependent 4 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

Dependent 8

Basic info:

FIRST NAME | MIDDLE NAME

LAST NAME | SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – – | RELATIONSHIP TO YOU

SEX 0 Male 0 Female 0 Other | DATE OF BIRTH (MM/DD/YYYY) / /

Does dependent 5 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

SOCIAL SECURITY OR TAX ID NUMBER – – | APPLICANT'S LAST NAME | FIRST NAME

Step 1: Family continued.

Dependent 9

Basic info:

FIRST NAME | MIDDLE NAME

LAST NAME | SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – – | RELATIONSHIP TO YOU

SEX | DATE OF BIRTH (MM/DD/YYYY)

0 Male 0 Female 0 Other | / /

Does dependent 3 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

Dependent 10

Basic info:

FIRST NAME | MIDDLE NAME

LAST NAME | SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – – | RELATIONSHIP TO YOU

SEX | DATE OF BIRTH (MM/DD/YYYY)

0 Male 0 Female 0 Other | / /

Does dependent 4 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

Dependent 11

Basic info:

FIRST NAME | MIDDLE NAME

LAST NAME | SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER – – | RELATIONSHIP TO YOU

SEX | DATE OF BIRTH (MM/DD/YYYY)

0 Male 0 Female 0 Other | / /

Does dependent 5 live with you? 0 Yes 0 No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed)
Would you like to be added to the Donate Life Registry? 0 Yes 0 Skip this question

Your county? Fill it out, rip it out.

Step 2: Find a plan in Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.

Choose one plan and deductible option. **Fill in the oval next to the plan you've selected.** Your selection will apply to everyone covered by your plan.

These plans are just for Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren and Washington counties.

Highmark Blue Shield: 107075-56			Annual Deductible	
			Individual	Family
	0	Platinum Standard	$0	$0
	0	Gold Standard	$600	$1,200
	0	Gold Destination 65	$0	$0
	0	Gold Destination 65 + Adult Dental and Vision	$0	$0
	0	Silver Standard	$2,100	$4,200
	0	Silver Destination 65	$2,500	$5,000
	0	Silver Destination 65 + Adult Dental and Vision	$2,500	$5,000
	0	Bronze Standard HSAQ	$6,100	$12,200

SOCIAL SECURITY OR TAX ID NUMBER — –

APPLICANT'S LAST NAME

FIRST NAME

Hooray. One step closer.

Look at that, another check.

Step 3: Your first payment.

Start by filling in this information:

POLICY HOLDER NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY OR TAX ID NUMBER

Now locate your premium rate in your product brochure, or visit shop.highmark.com to view it electronically.

Find the monthly premium for your plan based on the amount of people you listed in STEP 1 (that's you + any dependents you listed).

You'll need a check for that amount attached to this form, but fill the details of that check in below.

PAYMENT ENCLOSED

$

GROUP NUMBER

(Group number is the bold, blue eight-digit number; listed above plan selection.)

Once you receive your first invoice, you can head to **MyHighmark.com** to sign up for automatic payments. Auto payments are a more secure and convenient way to pay your bill that eases any stress about making on-time payments. Plus, you won't have to write more pesky checks like this one.

Done? Tear this out.

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

Step 4: Current coverage.

The hard part is over.

Now we just need to know about any current health insurance you have (coverage you had for 2023).

Everyone fills this in:

1. **Are you or anyone else listed in Step 1** enrolled in a private or governmental group or individual health plan or program at the time of this application?

0 Yes 0 No

If YES, have you used up all your benefits under that coverage?

0 Yes 0 No

2. Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in **Medicare Part B**?

0 Yes 0 No

If anyone listed in Step 1 is entitled to benefits under Medicare Part A or enrolled in Medicare Part B, you need to remove them. Those entitled to or enrolled in Medicare can't apply for benefits through this application. Learn more at **ssa.gov** or visit the nearest Social Security Administration office.

3. Is the coverage you're applying for **intended to replace** any accident or health insurance you or anyone in Step 1 currently have? This includes a Highmark policy.

0 Yes 0 No

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

That was a great sound.

Step 4: Current coverage.

If you answered yes to 1, 2, or 3:

4. Tell us about any other coverage you and/or your family members have or have applied for:

NAME OF INSURANCE CARRIER

GROUP NUMBER

NAME OF POLICY HOLDER

EFFECTIVE DATE (MM/DD/YYYY)

/ /

POLICY NUMBER

RELATIONSHIP TO APPLICANT

POLICY HOLDER'S DATE OF BIRTH (MM/DD/YYYY)

/ /

POLICY HOLDER'S EMPLOYMENT STATUS

Everyone fills this in:

5. Will you or any of your family members who are applying for this coverage be receiving premium payment assistance or grants from a third-party payer?*

0 Yes 0 No 0 Not Sure

If you answered Yes or I'm Not Sure, please indicate the type of third-party making payments to you or to Highmark on your behalf:

0 A family member

0 An Indian Tribe, tribal organization, or urban Indian organization

0 An employer (Non-ICHRA or Non-QSEHRA)

0 A local, State or Federal government program, including a grantee thereof

0 A Ryan White HIV/AIDS program

0 An IRS-recognized 501(c)(3) organization (nonprofit)

0 A health care provider or supplier

0 Other (please specify):

0 An Individual Coverage Health Reimbursement Arrangement (ICHRA)

EMPLOYER NAME:

0 A Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

EMPLOYER NAME:

*A third-party payer would be any person, employer, organization or entity, that is paying all or some portion of your/your family's premium to Highmark, or directly to you/your family by means such as cash, check, money order, prepaid debit card, credit card or electronic fund transfers.

0 I/we acknowledge that I/we have an ongoing obligation to report to Highmark any changes relating to premium payment assistance or grants made by a third-party payer.

SOCIAL SECURITY OR TAX ID NUMBER – –

APPLICANT'S LAST NAME

FIRST NAME

RIIIIPPPPPPPPP

You signed. Now seal and deliver.

Step 5: Your signature.

My/our signature on this Application indicates that I/we have read and fully understand the following statements:

I/we hereby apply for health care plan coverage for myself and/or my eligible dependents listed on this Application. I/we understand and agree that the terms and conditions of our coverage will be controlled by the written Subscription Agreement and that they may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I/we recognize that our coverage will only apply to admissions that occur and services that are provided on or after the effective date of our coverage.

I/we understand that the Agreement is available only to residents of the geographic area in which the product for which this Application is completed is available and that this Application is subject to the provisions of this Agreement. This Agreement renews on an annual basis. **If the first payment is not made with this Application, the first premium payment is due by the due date printed on your first invoice.** Failure to pay before this due date will result in your Application being canceled. You can also pay your premium monthly in advance to Highmark Blue Shield. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

I/we understand that the receipt of the benefits under this program is subject to the determination that the services were medically necessary and appropriate. Except for emergencies or delivery-related admissions, all inpatient admissions are subject to review prior to the proposed admission.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your ongoing monthly premium payments are not received in the full amount within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full.

I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

I know that I must tell Highmark Blue Shield if any information I supplied on this Application changes. I must call 1-855-344-3425 to report any changes.

If your Application is accepted, you agree to resolve any and all disputes, claims, or controversies arising out of or relating in any way to the Agreement that is issued or any service for which benefits are provided thereunder through binding arbitration rather than litigation in court. Your agreement to arbitrate applies to disputes between you and Highmark Blue Shield or any of Highmark Blue Shield's parents, subsidiaries, affiliates, officers, directors, employees, or agents. Any such disputes, claims, or controversies may only be brought individually and not in concert with other individuals who are not covered under the Agreement, unless otherwise agreed to by Highmark Blue Shield. Judgment may be entered on any arbitration award in any court having jurisdiction. The party filing arbitration may choose to file before JAMS, the American Arbitration Association, or any other organization or arbitrator mutually agreed to by the parties. New York law will apply.

Effective Date Of Coverage

Your plan is effective based on the type of enrollment.

- **If you apply between November 16 and December 15,** your plan will begin January 1, 2024. If you apply between December 16 and January 15, your plan will begin February 1, 2024. If you apply between January 16 and January 31, your plan will begin March 1, 2024.
- **If you're applying during a Special Enrollment Period (SEP),** the effective plan date is based on the application laws for each eligible SEP.

To the best of my/our knowledge and belief, the information provided on this Application is true and correct. I also understand that any attempts to qualify for the program chosen through fraud or other intentional misrepresentation of a material fact will result in termination of my insurance contract.

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 MATERIALTHERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

APPLICANT'S SIGNATURE	DATE
	/ /
SPOUSE/DOMESTIC PARTNER/PARENT'S SIGNATURE	**DATE**
	/ /

NOTICE TO ALL APPLICANTS: If you are applying for coverage that includes your spouse or domestic partner, both you and your spouse/domestic partner must sign this Application form. If you are unmarried, under the age of 18, and applying for a policy that only covers yourself, your parent or guardian must sign. **This application is valid only when completed and signed by the applicant.**

One more time now.

Only producers need to bother with this next section.
If you aren't a producer, you do not need to fill this page out.

Producers Certificate

If this section is not fully completed, we will not pay a commission.

NATIONAL PRODUCER NUMBER (NPN)

PRODUCER'S NAME (LAST, FIRST, MIDDLE INITIAL)

AGENCY NAME

PRODUCER'S SIGNATURE

BUSINESS PHONE NUMBER

( ) -

A PRODUCER must complete this section to act on the applicant's behalf.

1. Consider how the applicant answered your questions. Do you know of any factors impacting the applicant's eligibility? What about the applicant's dependents applying for this coverage?

0 Yes 0 No

PRODUCER SIGNATURE

DATE

AGENCY

2. Have you provided the applicant with all relevant marketing materials?

0 Yes 0 No

3. Have you advised the applicant of the features of the selected product, including satisfying the applicant's deductible(s)?

0 Yes 0 No

4. Is this applicant a current customer of Highmark?

0 Yes 0 No

5. Have you retained a signed copy of this application for your records?

0 Yes 0 No

Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the Application or policy; or
3. Waive any of Highmark Blue Shield's rights or requirements.

HIGHMARK

Highmark
120 Fifth Avenue
Pittsburgh, PA 15222-3099

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Internal use only

NATIONAL PRODUCER NUMBER (NPN)