



If you need assistance completing this application, please contact The Administrators, Inc. at (800)634-4428.

If you are applying for coverage for a business, please send applications to our Sales Department. If your application is for a change to an existing plan, please contact our Enrollment Department.

**Please complete, sign and return your application:**

**MAIL TO:**

**The Administrators, Inc.**  
867 Sussex Blvd.  
Broomall, PA 19008

**FAX TO:**

(610)604-4922

Please be aware, additional materials may be necessary to complete your enrollment. If you are applying for coverage for a business, please contact our Sales Department. If your application is for a change to an existing plan, please contact our Enrollment Department.  
You can call (800)634-4428.

Upon receipt of your application your request will be submitted for the carrier's approval.  
Please be aware, coverage does not begin until the carrier approves your application.  
Upon approval, you will be contacted by TAI and the carrier.



## 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 judgment of IBC, is incapable of self support because of 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.



**4A Dependent Information – If you listed dependents, you MUST answer these questions.**

Do any dependents listed live at another address? Yes  No

Is any dependent's last name different from yours? Yes  No

If you answered yes to either question, please explain.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**5 Other Insurance Information**

5A Please list health insurance information if you or any dependents listed in Section 4 have other coverage.

Insurance Company Name	Policy Number	Type of Benefits	Effective Date

5B Are you or any of your dependents currently receiving Medicare Benefits? Yes  No  If yes, please give details.

Name	Medicare Number	Part A Effective Date	Part B Effective Date	Reason
Self				Check all that apply. Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/>
Spouse				
Child				
Child				

**6 Group and Employer Information**

Your Group Administrator MUST complete this section. Your application CANNOT be processed unless this section is complete.

Group Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Account Number: \_\_\_\_\_ Payroll/Work Location: \_\_\_\_\_

Employer or Group Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**7 Signature and Verification**

Please read carefully and sign below. Your application CANNOT be processed without your signature. 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.

**For PPO and CMMI Members** - By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically related facility, insurance company or other organization that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and its affiliates, QCC Insurance Company, Highmark Blue Shield and ancillary service providers who are responsible for administering certain covered services. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my Employer, Association or Welfare board and Independence Blue Cross and Highmark Blue Shield.

**For HMO and POS Members** - I understand that the provision of services to me and my dependents as Members of Keystone Health Plan ("Keystone") is governed by the applicable Master Group Contract, which provides that: 1) except for emergencies, all medical or dental care must be initiated at the primary care office or primary care dental office we have selected; and, 2) I and my dependents authorize any person or organization providing services to furnish Keystone, its affiliates and ancillary service providers who are responsible for administering certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, Keystone quality and utilization review. I understand that if I choose a Point of Service Product, I will be subject to applicable deductibles, coinsurance and other copayments for all self referred services, as specified in the contract. I further understand that I can change health plan coverage only at the time my employer and Keystone specify. Keystone POS program Self-Referred benefits may be underwritten by QCC Insurance Company. Referred benefits underwritten or administered by Keystone Health Plan East and QCC Insurance Company and with Highmark Blue Shield. Independent licensees of the Blue Cross and Blue Shield Association.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Subscriber's County of Residence