



# ENROLLMENT/WAIVE FORM

## I. EMPLOYEE INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer Name			Group Number	Payroll Location
Last Name	First Name	MI	Social Security No.		
Address				Product Selection: <input type="checkbox"/> Medical Product Name: _____ <input type="checkbox"/> Vision Product Name: _____	
City	State	Zip	Home Phone		
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> COBRA <input type="checkbox"/> Disabled	Date of Full-Time Hire Mo Day Yr	Hours Worked Per Week	<input type="checkbox"/> COBRA Start Date _____ End Date _____	COBRA REASON: <input type="checkbox"/> Deceased <input type="checkbox"/> Involuntary Lay-Off Date of Event _____ <input type="checkbox"/> Left Employment <input type="checkbox"/> Other _____	

## II ENROLLMENT INFORMATION AND COVERAGE SELECTION

List ALL Dependents, Relationship to Employee and Coverage Selection	First Name & Middle Initial (show Last Name if different from Subscriber)	Social Security #	Birthdate	Gender	Dependent Status If Over Age 26	Product Selection	
						Med**	Vis
Employee			/ /	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.* <u>  </u> <u>  </u>			/ /	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other* <u>  </u> <u>  </u>			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other* <u>  </u> <u>  </u>			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other* <u>  </u> <u>  </u>			/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\*If "domestic partner" or "other" applies, complete using one of the following codes: (02) Adopted Child, (05) Grandchild, (07) Nephew or Niece, (17) Stepson or Stepdaughter and (29) Domestic Partner. Legal Documentation (Court Decree, Guardianship Papers, Domestic Partner Affidavit, etc.) must be provided prior to enrollment.  Other: \_\_\_\_\_

If you answered No to Med\*\* under Product Selection, please list reason: \_\_\_\_\_

I hereby certify that I have been given the opportunity to participate in the group insurance plan provided by my employer. If I and/or any of my Eligible Dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a qualifying event occurs before coverage will be offered.

By entering your name on the signature line below, you understand that you are creating an electronic signature which has the same effect as a written signature, and you are representing that you have reviewed and submitted this form accordingly.

Employee Signature ONLY SIGN IF YOU ARE WAIVING COVERAGE \_\_\_\_\_ Date \_\_\_\_\_

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, as long as you are covered by the group's health insurance plan provided by your employer, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross and Blue Shield Association.

## Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。  
请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyonong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المساعدة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.