Application for Individual Coverage

Instructions:

1. This Application should be used if you wish to enroll in an Individual plan purchased directly from Independence Blue Cross. The health plans available through this Application are not eligible for federal premium tax credits or cost sharing reductions available under the health care reform law. If you are not sure if you qualify for federal premium tax credits or cost sharing reductions programs, please call 1-866-346-2081 (TTY: 711) for further assistance. Keystone Health Plan East HMO Plans are underwritten by Keystone Health Plan East. PPO and EPO (Exclusive Provider Organization) Plans are underwritten by QCC Insurance Company.
2. Please complete all sections and print clearly in black ink.
3. Read carefully and sign the enclosed ***Declarations and Conditions of Enrollment***. Individuals under the age of 18 will require a Parent or Legal Guardian signature.
4. Provide information about your spouse, domestic partner, and dependents if they are also applying for coverage. If you need additional space, attach a separate sheet with your signature and date. (Sections C and G)
5. Choose a payment option in Section A. Payment options are:
   a. monthly billing (you must include a check for the first month's premium)
      - for HMO plans, make your check payable to Keystone Health Plan East
      - for PPO/EPO plans, make your check payable to Independence Blue Cross
   b. credit card/debit card payment — complete the credit/debit card section of the "How to apply and pay" form included in this kit. This payment option is available for first month's premium only (most major credit/debit cards accepted).
   c. pre-paid debit card payment — complete the pre-paid debit card section of the "How to apply and pay" form included in this kit (most major pre-paid debit cards accepted).

   Important: Receipt of your initial payment does not constitute enrollment in this program. Your coverage will not begin until this application has been processed, an effective date assigned, and your payment received. Failure to provide all information requested may result in a delay in the processing of your application. If we are unable to process your application, your check will be returned by mail.
6. Once your materials are complete, be sure to make a copy for your records. Mail your application and check or payment form to:
   Independence Blue Cross
   P.O. Box 8240
   Philadelphia, PA 19101

IMPORTANT: Please remit future premium payments to the address on your invoice, which will be generated after your application has been processed. If your future premium payments are remitted to the P.O. Box noted above, to an incorrect address or without the coupon enclosed, it could result in a delay with applying your payment and may result in disruption of benefits and/or termination.

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-866-346-2081 (TTY: 711), Monday through Friday, between 8 a.m. and 6 p.m. You can also apply online by visiting us at www.ibx.com/applynow.

Independence

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For office use only
Application ID: _____
Account ID: _____

Application/Change Form for Individual Coverage

Keystone Health Plan East (KHPE) HMO Plans and QCC Insurance Company PPO/EPO Plans

KHPE HMO Plans are underwritten by Keystone Health Plan East. PPO/EPO Plans are underwritten by QCC Insurance Company.

In order to be eligible for coverage, the following must be true:

- The primary applicant must be between the ages of 0 and 64.
- Applicants are residents of Bucks, Chester, Delaware, Montgomery, or Philadelphia counties in Pennsylvania.
- Applicants are not eligible for Medicare or Medicare Disability.
- Dependent children must be under age 26.

SECTION A — Plan Selections

Type of Coverage	Reason for application	Payment mode	For office use only
☐ Individual ☐ Individual and spouse or domestic partner ☐ Individual and child(ren) ☐ Family	☐ New enrollment ☐ Change benefit plan ☐ Special Enrollment Reason: _____	☐ Bill me monthly ☐ Credit Card /Debit Card (first payment only) ☐ Pre-paid Debit Card	Effective Date _____

Choice of Plan	
Keystone HMO Plans underwritten by Keystone Heath Plan East:	Personal Choice PPO/EPO Plans underwritten by QCC Insurance Company:
☐ HMO Platinum ☐ HMO Gold ☐ HMO Silver ☐ HMO Bronze ☐ HMO Gold Proactive ☐ HMO Silver Proactive ☐ HMO Silver Proactive Select ☐ HMO Silver Proactive Value	☐ PPO Gold ☐ PPO Silver ☐ PPO Bronze ☐ Platinum (EPO) ☐ Silver Reserve (EPO) ☐ Bronze Reserve (EPO) ☐ Bronze Basic (EPO) ☐ Catastrophic (EPO)*

SECTION B — Primary Applicant Information (must be between the ages of 0 and 64)

Primary applicant name: Last, First, Middle Initial		Social Security Number (required)	
Employer name	Birth date ____/____/____	Age	Gender: ☐ M ☐ F
Primary care office name (HMO only)**	PCP office code (HMO ID#, HMO only)**		Current patient? (HMO only)** ☐ Yes ☐ No

* Available to eligible individuals only (see Section H : Declarations and Conditions of Enrollment).

** Required for all HMO plans. Use our website www.ibx.com/providerfinder to find a primary care physician (PCP) call 1-844-BLUE-4ME (or 1-844-258-3463) (TTY:711) to request a PCP directory (HMO plans only).

Form #18736 (Rev. 1.20)

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SECTION C — Family Information (if applying)

Spouse or Domestic Partner name: Last, First, Middle Initial			Social Security Number (required)
Employer name	Birth date ____/____/____	Age	Gender: ☐ M ☐ F
Primary care office name (HMO only)**	PCP office code (HMO ID#, HMO only)**		Current patient? (HMO only)** ☐ Yes ☐ No

Dependent name: Last, First, Middle Initial			Social Security Number (required)
Relationship (e.g., son, stepdaughter)	Birth date ____/____/____	Age	Gender: ☐ M ☐ F
Primary care office name (HMO only)**	PCP office code (HMO ID#, HMO only)**		Current patient? (HMO only)** ☐ Yes ☐ No

Dependent name: Last, First, Middle Initial			Social Security Number (required)
Relationship (e.g., son, stepdaughter)	Birth date ____/____/____	Age	Gender: ☐ M ☐ F
Primary care office name (HMO only)**	PCP office code (HMO ID#, HMO only)**		Current patient? (HMO only)** ☐ Yes ☐ No

Dependent name: Last, First, Middle Initial			Social Security Number (required)
Relationship (e.g., son, stepdaughter)	Birth date ____/____/____	Age	Gender: ☐ M ☐ F
Primary care office name (HMO only)**	PCP office code (HMO ID#, HMO only)**		Current patient? (HMO only)** ☐ Yes ☐ No

** Required for all HMO plans. Use our website www.ibx.com/providerfinder to find a primary care physician (PCP) or call 1-844-BLUE-4ME (or 1-844-258-3463) (TTY:711) to request a PCP directory (HMO plans only).

SECTION D — Personal Information

Residence address			Mailing address (if different from residence address)		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			County		

SECTION E — Contact Information***

Home phone number ( )	Mobile phone number ( )	Email address
Best time to call: ☐ Morning ☐ Afternoon	Best location to call: ☐ Home ☐ Mobile	

*** By voluntarily giving Independence Blue Cross my mobile phone number and/or e-mail address, I authorize Independence Blue Cross and its subsidiaries (collectively "Independence") to send me information/data about Independence, including, but not limited to, information about my account and other insurance products and services. Independence may contact me via e-mail, automated text, and/or phone call. For text, message and data rates may apply. I understand that my consent is not a condition of any benefit or purchase. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/ibx. Any information provided by me to Independence is subject to Independence's Privacy Policy.

SECTION F — Other Insurance

A. Are you or any of your dependents seeking coverage enrolled in Medicare Part A and/or B? Note: If you answered yes to the question above you and/or your dependents are not eligible for this coverage.	☐ Yes ☐ No
B. Do you currently have any health insurance?	☐ Yes ☐ No
C. Are you replacing the health insurance plan referenced in B above? If "Yes," termination date: _____/_____/_____	☐ Yes ☐ No

Important: Do not cancel any existing coverage until you have received notification that your application has been processed.

If you answered "Yes" to question B, provide the following information for each applicant.

Name	Health care carrier	Policy number	Term/ Renewal date

SECTION G — Additional Information

1. Have you used a tobacco product on average four or more times per week within the past 6 months, other than for religious or ceremonial use? ☐ Yes ☐ No

If "Yes,": ☐ Yes, but I am participating in a smoking cessation program.
☐ Yes, and I am not participating in a smoking cessation program.

The above questions are applicable to members and their dependents age 21 and older.

Name of person: _____	Type and amount: _____	Date last smoked or used tobacco: _____/_____/_____
Name of person: _____	Type and amount: _____	Date last smoked or used tobacco: _____/_____/_____

SECTION H — Declarations and Conditions of Enrollment *Please read carefully before signing below.*

By applying to Keystone Health Plan East or QCC Insurance Company ("the companies") for coverage for myself and the dependents listed in Section C, I understand and agree as follows:

1. a) Effective date of coverage will be the 1st day of each month.
   b) Coverage does not begin until this application is processed by the companies with an effective date of coverage assigned and payment has been received.
   c) If selecting Bill Me Monthly, a check for the first monthly premium must be submitted with your paper application.
   d) Credit card/debit card payments are acceptable for the first month's premium payment only. Pre-paid debit card payments are accepted for ongoing payments.
   e) Receipt of the initial payment does not constitute enrollment under any program.
   f) This coverage is provided only to residents of the geographical area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, Pennsylvania, served by the companies. The companies reserve the right to investigate and confirm your residence.
2. The companies may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by intentionally supplying a material misrepresentation of fact, except in the case of fraud, for which there is no time limit for voiding the policy.
3. The terms and conditions of the coverage will be controlled by the written agreement with the companies, and the companies may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.

4. **HMO Plans Only:**
   a) As a condition of coverage, each applicant must select a participating primary care physician.
   b) As a condition of coverage, (with the exception of emergency procedures and certain direct access services as defined in the Subscriber Agreement) all services, in order to be covered by KHPE, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy (if applicable), or other provider as authorized by a referral, or precertification, from a participating primary care physician or KHPE.
5. **Catastrophic Plans Only:**
   Are available to eligible applicants (Individual/Family) under the age of 30 or eligible applicants experiencing a documented hardship and have received a certification from the Federal Government.
6. I understand that benefits under this policy will be coordinated with other coverage any covered person may have which is subject to coordination.
7. By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-Group policy, the companies will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.
8. 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.
9. I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

Signature(s) Required

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

SIGN HERE X_____ Applicant/Parent or Legal Guardian signature __/__/____ Date

SIGN HERE X_____ Applicant spouse or domestic partner signature (if applying for coverage) __/__/____ Date

SECTION I — Statement of Accountability (if applicable)

To be completed if the applicant cannot complete or has not completed the application:

I, _____, have read and completed the application form for the primary applicant for the following reason(s):	
☐ Applicant does not speak English	☐ Applicant does not read English
☐ Applicant does not write in English	☐ Other (please explain)
I translated and fully explained the "Declarations and Conditions of Enrollment." I also translated the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by:	
_____ Name	_____ Signature of translator (required)
____/____/____ Date (required)	_____ Relationship to applicant

SECTION J — Broker Information (if applicable)

Agent National Producer Number (NPN)	
Primary broker code	Producer broker code
Primary broker name	Producer name
Telephone number	Telephone number

Independence Sales Representative (if applicable)

National Producer Number (NPN)	Name of sales representative

SECTION K — Assistance with Completing this Application (if applicable)

You can choose an authorized representative. You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Independence Blue Cross. If you're a legally appointed representative for someone on this application, submit proof with the application.

Name of authorized representative (First name, Middle name, Last name)		
Address		Apartment or Suite number
City	State	ZIP code
Phone number ( )		
Organization name (if applicable)		ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with Independence Blue Cross.

_____ Your signature

____/____/____ Date

Mail your application and check or Payment Form to:

Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101

IMPORTANT: Please remit future premium payments to the address on your invoice, which will be generated after your application has been processed. If your future premium payments are remitted to the P.O. Box noted above, to an incorrect address or without the coupon enclosed, it could result in a delay with applying your payment and may result in disruption of benefits and/or termination.

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-866-346-2081 (TTY: 711), Monday through Friday, between 8 a.m. and 6 p.m.

Independence

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Y0041_HM_17_47643 Accepted 10/14/2016

Taglines as of 10/14/2016

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

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

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.