APPLICATION FOR NEW 2020 INDIVIDUAL/FAMILY PLAN HEALTH INSURANCE

This Application is for coverage during the calendar year 2020.

PLEASE COMPLETE STEPS 1–4.

STEP 1) Tell us about yourself and your household.

STEP 2) Choose your plan.

STEP 3) Tell us about other health insurance. **Incomplete information in STEP 3 may delay the processing of your Application.**

STEP 4) Sign and send your completed Application (ALL PAGES) and first month's premium payment to Highmark Blue Cross Blue Shield Delaware (Highmark Delaware).

If you are an insurance agent/producer, please complete the attached Producer Certificate and return to Highmark with the completed application.

To submit your Application faster, please use one of these options to enroll:

- **Online: www.DiscoverHighmark.com/individuals-families**
- **By phone: 1-855-873-4110**

If you are shopping for conversion or HIPAA coverage, please refer to the Appendix at the conclusion of this Application.

HIGHMARK DELAWARE

Insurance provided by Highmark Blue Cross Blue Shield Delaware, an independent licensee of the Blue Cross and Blue Shield Association.

THANK YOU FOR YOUR INTEREST IN HIGHMARK DELAWARE.

To ensure that your Application is processed as quickly as possible, please be sure to:

- Print letters and numbers clearly.
- Check to make sure that the Application is filled out completely. If a specific section does not apply to you please mark as "N/A".
- Ensure that you, your spouse/domestic partner if both are applying for coverage, or the parent/guardian of a child applicant sign and date the Application.
- Return the completed Application with your payment. **PLEASE RETURN ALL PAGES OF THE APPLICATION.**

Please note: Processing of your Application may be delayed if this form is NOT completed in its entirety. PLEASE RETURN ALL PAGES OF THE APPLICATION. If a specific section does not apply to your situation, please mark as 'N/A'.

WHO CAN ENROLL IN THE PLANS LISTED ON THIS APPLICATION?

You can enroll in one of these plans, regardless of your age, if:

- You reside in the Highmark Delaware service area
- You meet eligibility guidelines listed in Step 4 of this Application
- **You are not entitled to benefits under Medicare Part A, enrolled in Medicare Part B, Medical Assistance, or CHIP**
- You want to purchase directly from Highmark Delaware and NOT through the Health Insurance Marketplace. **Plans available on this Application do not apply Federal Premium Tax Credits or Cost Sharing Reductions.** *If you are unsure if you qualify for federal premium tax credits or cost sharing reductions, go to the Health Insurance Marketplace at www.HealthCare.gov or 1-800-318-2596.

DO YOU NEED CONVERSION COVERAGE?

Are you converting from group to individual coverage because you lost your Highmark Delaware group coverage? You are eligible for an individual Conversion plan that covers you beginning on the date your Highmark Delaware group coverage ends.

To learn more and apply, please refer to the Appendix on page 9 of the Application.

NEED HELP?

- **Call with questions or to enroll over the phone:** 1-855-873-4110
- **Enroll online:** www.DiscoverHighmark.com/individuals-families
- **If you work with an insurance agent/producer:** Please call or visit him/her directly
- **For instructions on how to submit your completed application**, refer to STEP 4 on page 7.

To find more information about Highmark Delaware's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4109.

STEP 1 TELL US ABOUT YOURSELF

Complete this section if:

- You are applying for health insurance through Highmark Delaware.
- You are applying for health insurance on behalf of your dependent(s). You will be the Policy Holder/Subscriber and the contact person for your dependent(s).
- If you are applying on behalf of a child under age 18 for his or her own coverage on an individual policy, please complete this section with YOUR information as you will be the contact person for your child. Check this box ☐ and provide your child's information in STEP 1.

Please note: Processing of your Application may be delayed if this form is NOT completed in its entirety. PLEASE PRINT CLEARLY.

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	☐ Male ☐ Female	/ /

HOME ADDRESS			APARTMENT NUMBER
CITY	**STATE**	**ZIP CODE**	**COUNTY**
MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)			**APARTMENT NUMBER**
CITY	**STATE**	**ZIP CODE**	**COUNTY**

☐ Check here if you don't have a home address. You still need to give a mailing address.

HOME PHONE NUMBER (NON-MOBILE)	MOBILE PHONE NUMBER	PREFERRED CONTACT (SELECT ONLY ONE)
( )	( )	☐ Home ☐ Mobile

EMAIL ADDRESS

PREFERRED LANGUAGE SPOKEN (IF NOT ENGLISH)	PREFERRED LANGUAGE READ (IF NOT ENGLISH)

☐ Check here if person listed in STEP 1 is applying for coverage for himself/herself ONLY.

PRIMARY CARE PHYSICIAN (OPTIONAL)		PCP ID NUMBER (OPTIONAL) *
	☐ Check here if presently a patient of this physician.	

*To find your PCP ID Number, please visit www.HighmarkBCBSDE.com and click on **Find a Doctor or Rx**.

1. **REQUIRED** If you will be covered under the plan and you are 18 years of age and older:
   Have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No
   If "Yes," when was the last time you used tobacco regularly?_____/_____/_____ (Month/Day/Year)

Question 1 is required and must be completed or your Application will be delayed.

2. ☐ Check the box if you need special assistance due to limited English proficiency or because you have a disability. Call us at 1-855-873-4110. You can also call TTY at 711 to receive assistance free of charge.

GO TO STEP 1 Household

STEP 1 TELL US ABOUT YOUR HOUSEHOLD

Tell us about everyone who is applying for coverage. Attach additional sheets of paper if needed. Eligible dependents include:

- Your spouse
- Your domestic partner
- Your children who are under age 26
- Your spouse's children who are under age 26
- Your domestic partner's children who are under age 26
- Your unmarried child of any age who is medically certified as totally disabled and dependent upon you

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

PERSON 2

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU?

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	☐ Male ☐ Female	/ /

PRIMARY CARE PHYSICIAN (OPTIONAL)		PCP ID NUMBER (OPTIONAL) *
	☐ Check here if presently a patient of this physician.	

1. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No
   If No, list address: _____
2. **REQUIRED** Applicants 18 years of age and older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

Question 2 is required and must be completed or your Application will be delayed.

3. ☐ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
   Call us at 1-855-873-4110. You can also call TTY at 711, or visit one of our Highmark Insurance stores to receive assistance free of charge.

PERSON 3

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU?

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	☐ Male ☐ Female	/ /

PRIMARY CARE PHYSICIAN (OPTIONAL)		PCP ID NUMBER (OPTIONAL) *
	☐ Check here if presently a patient of this physician.	

1. Does PERSON 3 live at the same address as you? ☐ Yes ☐ No
   If No, list address: _____
2. **REQUIRED** Applicants 18 years of age and older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

Question 2 is required and must be completed or your Application will be delayed.

3. ☐ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
   Call us at 1-855-873-4110. You can also call TTY at 711, or visit one of our Highmark Insurance stores to receive assistance free of charge.

PERSON 4

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX	RELATIONSHIP TO YOU?

SOCIAL SECURITY NUMBER OR INDIVIDUAL TAX IDENTIFICATION NUMBER	SEX	DATE OF BIRTH (MONTH/DAY/YEAR)
— —	☐ Male ☐ Female	/ /

PRIMARY CARE PHYSICIAN (OPTIONAL)		PCP ID NUMBER (OPTIONAL) *
	☐ Check here if presently a patient of this physician.	

1. Does PERSON 4 live at the same address as you? ☐ Yes ☐ No
   If No, list address: _____
2. **REQUIRED** Applicants 18 years of age and older, have you smoked or used any form of tobacco regularly (4 or more times per week on average excluding religious or ceremonial use) within the last six months? ☐ Yes ☐ No
   If "Yes," when was the last time you used tobacco regularly? ____/____/____ (Month/Day/Year)

Question 2 is required and must be completed or your Application will be delayed.

3. ☐ Check the box if you need special assistance due to limited English proficiency or because you have a disability.
   Call us at 1-855-873-4110. You can also call TTY at 711, or visit one of our Highmark Insurance stores to receive assistance free of charge.

*To find your PCP ID Number, please visit www.HighmarkBCBSDE.com and click on **Find a Doctor or Rx**.

GO TO STEP 2 Plan Selection

Applicant's Last Name	First Name

STEP 2 CHOOSE YOUR PLAN

Review the product information to learn what each plan covers. Choose only one plan and deductible option. Place an 'X' in the correct check box. The plan and deductible option you choose will apply to everyone covered by your plan.

FOR RESIDENTS OF THE FOLLOWING COUNTIES: Kent, New Castle, Sussex

I am/we are applying for **new** coverage under:

Highmark Blue Cross Blue Shield Delaware

- ☐ **Shared Cost Blue EPO Platinum 200 - 2 Free PCP Visits –** Annual Deductible: $200 Individual/$400 Family
- ☐ **Shared Cost Blue EPO Gold 0 – 2 Free PCP Visits –** Annual Deductible: $0 Individual/$0 Family
- ☐ **Shared Cost Blue EPO Gold 800 - 2 Free PCP Visits –** Annual Deductible: $800 Individual/$1,600 Family
- ☐ **Health Savings Blue EPO Silver 1750 HSA –** Annual Deductible: $1,750 Individual/$3,500 Family
- ☐ **Shared Cost Blue EPO Silver 2900 - 2 Free PCP Visits –** Annual Deductible: $2,900 Individual/$5,800 Family
- ☐ **Health Savings Embedded Blue EPO Silver 3950 HSA –** Annual Deductible: $3,950 Individual/$7,900 Family
- ☐ **Health Savings Embedded Blue EPO Silver 6750 HSA –** Annual Deductible: $6,750 Individual/$13,500 Family
- ☐ **Shared Cost Blue EPO Bronze 3900 –** Annual Deductible: $3,900 Individual/$7,800 Family
- ☐ **Shared Cost Blue EPO Bronze 7800 – 1 Free PCP Visit –** Annual Deductible: $7,800 Individual/$15,600 Family
- ☐ **Shared Cost Blue EPO Bronze 7900 –** Annual Deductible: $7,900 Individual/$15,800 Family
- ☐ **Major Events Blue EPO 8150 – 3 Free PCP Visits –** Annual Deductible $8,150 Individual/$16,300 Family

[Applicants must be under age 30 or have received an exemption certification from the Health Insurance Marketplace. Attach a copy of the certificate if you have one.]

GO TO STEP 3 Other Health Insurance

Please complete the form below.

Policy Holder Name (First, Middle, Last): _____

Social Security Number: _____

Monthly Premium for the plan you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $ _____

Failure to provide complete information in the above form may result in a delay in Application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 8.

STEP 3 TELL US ABOUT OTHER HEALTH INSURANCE

Complete the information requested about your current health insurance.

1. Are you or any of your family members who are applying for this coverage enrolled in any private or governmental group or individual health plan or program at the time of this Application? ☐ Yes ☐ No

2. Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in Medicare Part B? ☐ Yes ☐ No

   Individuals entitled to benefits under Medicare Part A or enrolled in Medicare Part B are not permitted to enroll in new coverage made available through this application. If you have included any Medicare enrolled/entitled individuals in STEP 1 of this Application they must be removed. To learn more about Medicare options, go to www.ssa.gov or visit the nearest Social Security Administration (SSA) office.

3. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have? This includes any current Highmark Delaware policy. ☐ Yes ☐ No

If you answered "Yes" to any question above, complete question 4. If you answered "No," skip question 4 and go to question 5.

4. Please provide the following information about any other coverage you and/or your family members currently have or have applied for:

   Name of Insurance Carrier: _____ Group Number: _____

   Name of Policy Holder: _____ Effective Date: _____

   Policy Number: _____ Relationship to Applicant: _____

   Policy Holder's Date of Birth: _____ Policy Holder's Employment Status: _____

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*? ☐ Yes ☐ No ☐ I'm 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 Delaware on your behalf:

   ☐ A family member
   ☐ An employer
   ☐ A Ryan White HIV/AIDS program
   ☐ A health care provider or supplier
   ☐ An Indian Tribe, tribal organization, or urban Indian organization
   ☐ A local, State or Federal government program, including a grantee thereof
   ☐ An IRS-recognized 501(c)(3) organization (nonprofit)
   ☐ Other (please specify): _____

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

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

GO TO STEP 4 Submission

Applicant's Last Name	First Name

STEP 4 SIGN AND SEND YOUR COMPLETED APPLICATION

Send in your completed Application and payment to Highmark Delaware by one of the following methods. **PLEASE RETURN ALL PAGES OF THE APPLICATION.** If a specific section does not apply to you, please mark as 'N/A'. Make your check or money order payable to Highmark Delaware for your first full premium due. See rates for details.

U.S. MAIL:

Include your completed, signed Application along with your first premium payment to:
Highmark Blue Cross Blue Shield Delaware
P.O. Box 382185
Pittsburgh, PA 15251-8185

NEED HELP?

- **Call with questions or to enroll over the phone:** 1-855-873-4110
- **Enroll online:** www.DiscoverHighmark.com/individuals-families
- **If you work with an insurance agent/producer:** Please call or visit him/her directly

SAVE TIME BY SIGNING UP FOR SECURE AUTOMATIC PAYMENTS:

When you sign up for e-Bill, your monthly premium payments are automatically deducted from the account you specify.

e-Bill:

- provides a quick, convenient and secure way to receive and pay your monthly premium invoices
- reduces the chances of identity theft and eliminates the need to write and send checks
- allows you to focus on the important things in life – like keeping yourself and your family healthy – instead of worrying about whether your health insurance premium has been paid for the month.

There is no fee to use e-Bill. Set up your account as soon as you receive your first invoice.
Visit **www.highmarkbcbsde.com** to learn more.

GO TO STEP 4 Submission

To find more information about Highmark Delaware's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4110.

STEP 4 SIGN AND SEND YOUR COMPLETED APPLICATION

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 Delaware. 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, delivery-related admissions, or in-patient treatment of drug and alcohol dependencies, 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.

If you are applying for a Conversion plan to cover you from the date your group plan ended or you are applying for a HIPAA plan to cover you from the date your employer plan ended, your final premium payment will include a prorated amount for the days remaining in the month your group coverage ended.

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 Delaware if any information I supplied on this Application changes. I must call 1-888-200-9621 to report any changes.

If your Application for other than HMO coverage 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 Delaware or any of Highmark Delaware'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 Delaware. 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. Delaware law will apply.

EFFECTIVE DATE OF COVERAGE

I/we understand/agree that, subject to the conditions of enrollment on this Application, coverage will be effective for individuals listed on this Application following receipt of the completed Application and payment in full of the first premium payment:

If you apply during:	Open Enrollment	A Special Enrollment Period (SEP)	For HIPAA or Conversion Coverage
Your effective date is:	January 1, 2020	Based upon the application laws for each eligible SEP	The Effective Date indicated on this application

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 such 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 material thereto, commits a fraudulent insurance act, which is a crime & subjects such person to criminal & civil penalties.

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.

GO TO Appendix

THIS APPLICATION IS VALID ONLY WHEN COMPLETED AND SIGNED BY THE APPLICANT.

APPENDIX: CHOOSE YOUR PLAN

Choose only one plan and deductible option. Place an 'X' in the correct check box.
The plan and deductible option you choose will apply to everyone covered by your plan.

You **MUST** choose the plan below if:

You are applying for a Conversion plan to cover you from the date your **Highmark Blue Cross Blue Shield Delaware** group plan ended. A Conversion plan is typically purchased when the requested effective date is a date other than the first of the month. Be sure to fill in the date that you are requesting coverage to become effective below.

Highmark Blue Cross Blue Shield Delaware group plan termination Date: _____

I am/we are applying for **new** coverage under:

☐ **Shared Cost Blue EPO Bronze 4000 –** Annual Deductible: $4,000 Individual/$8,000 Family
Note: Your proposed first premium amount is based on not using tobacco products.
You agree to pay any adjustment to the rate if you use tobacco products.

Requested Effective Date of Coverage: _____

Please complete the form below.

Policy Holder Name (First, Middle, Last): _____

Social Security Number: _____

Monthly Premium for the plan you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $ _____

Failure to provide complete information in the above form may result in a delay in Application processing and incorrect crediting of your payment. For additional payment and billing information, please refer to page 8.

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. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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, 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.

If you speak English, language assistance services, free of charge, are available to you. Call 1-877-959-2563.

Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-877-959-2563.

如果您说中文，可向您提供免费语言协助服务。 請致電 1-877-959-2563.

Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-877-959-2563.

한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-877-959-2563 로 전화.

Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-877-959-2563.

Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-877-959-2563.

إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-877-959-2563 .

Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan 1-877-959-2563.

Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-877-959-2563.

Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-877-959-2563.

Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-877-959-2563.

Se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-877-959-2563.

Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-877-959-2563.

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。 1-877-959-2563 を呼び出します。

اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-877-959-2563 .

FOR PRODUCER USE ONLY

PRODUCER'S CERTIFICATE

ATTENTION PRODUCER: If you have questions about completing this Application, please call the Producer Line at 1-866-602-1248.

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

Blue Cross Blue Shield Agency No. | | | | | | | |

Producer No. | | | | | | | |

Agency Name _____

Producer's Name _____
LAST *FIRST* *MI*

Producer's Signature _____

Business Phone ( ) _____
Area Code

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 his/her dependents applying for this coverage? ☐ No ☐ Yes

Producer Signature _____ Date _____

Agency _____

2. Have you provided the applicant with all relevant marketing materials? ☐ No ☐ Yes

3. Have you advised the applicant of the features of the product that he/she has selected, including satisfying his/her deductible(s)? ☐ No ☐ Yes

4. Is this applicant a current customer of Highmark Blue Cross Blue Shield Delaware? ☐ No ☐ Yes

5. Have you retained a signed copy of this Application for your records? ☐ No ☐ Yes

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 Cross Blue Shield Delaware's rights or requirements.

HIGHMARK DELAWARE

Highmark Inc., d/b/a
Highmark Blue Cross Blue Shield Delaware
P.O. Box 1991
Wilmington, DE 19899-1991

Highmark Blue Cross Blue Shield Delaware is an Independent Licensee of the Blue Cross and Blue Shield Association.

INTERNAL USE ONLY

Blue Cross Blue Shield Agency No. | | | | | | | |

Producer No. | | | | | | | |

Applicant's Last Name	First Name