

Because Highmark s keeping it simple.

**Apply for your new 2025 individual or family
Affordable Care Act (ACA) health plan in just five steps.**

If you are applying because you have a Special Enrollment Period, please
include this completed application along with the Special Enrollment Period
form and all necessary, supporting documentation.



If you're enrolling during Open
Enrollment, scan the QR code
above to apply online.



Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield serves the state of Delaware and is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

The Blue Cross and Blue Shield symbols are registered marks of the Blue Cross Blue Shield Association.

5 steps to apply.

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We're glad you're thinking of Highmark.

Let's make sure this is the application you need.

This application is for purchasing directly with Highmark, not if you're looking to purchase through the Health Insurance Marketplace. These plans don't apply federal premium tax credits or cost-sharing reductions. If you're not sure if you qualify for financial help, contact the Health Insurance Marketplace at **HealthCare.gov** or **1-800-318-2596**.

You're eligible to enroll in these plans, regardless of your age, as long as you meet these requirements:

- 0 You reside in the Highmark Delaware service area.

- 0 You're not entitled to benefits under Medicare Part A, enrolled in benefits in Medicare Part B, or enrolled with CHIP.

- 0 You're currently living in the U.S.

- 0 You meet eligibility guidelines listed in Step 5 of this application.

In the right place? Great.

There are a few kinds of plans you can apply for with this application. Here's a quick breakdown:

ACA Plans

These are your individual or family plans. You can read more about these on **Highmark.com** or in the plan brochure.

Conversion

If you lost your Highmark group plan and want to move to an individual plan, you might want a Conversion plan. Find out more on page 15.

If you have any questions or want to enroll faster:

Call 1-855-882-6533.

Visit www.Highmark.com.

Scan the QR code on the front if you're applying during Open Enrollment. If you're applying during a Special Enrollment Period, we'll need you to complete the paper application.

Talk to your insurance agent/producer if you're working with one.



Instructions:

We've made this application as easy as possible with just **5 steps**.

It might look like a lot, but these tips will make this application easier and help to avoid any processing delays.

- **Follow all 5 steps and make sure you fill everything in.**

Once you finish a section, tear it out to send back to us.

- **Print letters and numbers clearly with blue or black ink.**

If you're applying during Open Enrollment, you can visit **Highmark.com** to fill out this form. You can either submit it electronically or print it out and mail it to us.

- **If there's a box for your name at the bottom of a page,** make sure you fill it in. That helps us keep track of your application.
-

- **Sign and date the application on page 21** — If you are applying for coverage for yourself and your spouse/domestic partner, you both must sign this application. If you are not married, under the age of 18, and applying for a policy that covers only you, a parent or guardian must sign this application.
-

- **Tear out your completed application pages and return them to Highmark.** We'll outline all the ways you can do that on page 22.



Step 1: Tell us about you.

You + Highmark = one healthy 2025.

If you're applying for health insurance, you need to complete the next page.

- **Page 6** — Each applicant must fill out this page with their personal information, even those who are applying for someone else — like a minor.
- **Page 8** — Fill out this page if you're applying for yourself and anyone else, you're applying on behalf of your dependents and you'll be the policy holder, or you're applying for an individual policy on behalf of a child under 18.

If you have questions, we are only a phone call away. Keep these important phone numbers handy while you complete your application:

- If you have limited English proficiency or a disability call 1-833-521-1424 (TTY users can call 711) to get assistance with this application free of charge.
 - If you have general questions or would like to enroll by telephone call 1-855-882-6533.
 - If you need help with a Conversion plan or need help with prior insurance coverage call 1-888-200-9621.
-

Step 1: Tell us about you.

And just a reminder to 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

☐ Male ☐ Female ☐ Other

DATE OF BIRTH (MM/DD/YYYY)

☐ 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)

☐ Home ☐ 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.

☐ Just for you.☐ You and your family.☐ You're applying for an individual policy on behalf of a child under 18.

Step 1: About you, continued.

If you're 21
or older:

Communication
preferences:

Just a few more questions if you're 21 or older and this plan is for you.

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 6 months?

☐ Yes ☐ No

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 this at any time or request a digital copy by calling the Member Service number on the back of your member identification (ID) card upon receipt or visiting **MyHighmark.com**.

So, what do you think?

☐ Yes, let's do this digitally.

☐ 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 12.

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
- 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.

Are there any unmarried dependents included in this application who, as medically certified by a physician are totally disabled and incapable of self-support due to intellectual or physical disability, mental illness, or developmental disability that started before the age of 26?

If yes, please state their name(s)

Highmark may require proof of such disability as deemed necessary.

Dependent 1

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)
☐ Male ☐ Female ☐ Other	
Does dependent 1 live with you? ☐ Yes ☐ No	
IF NO, LIST ADDRESS:	

21 or 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 6 months?

☐ Yes ☐ No

Room for more dependents on the next page.

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Family, continued.

Dependent 2

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

☐ Male ☐ Female ☐ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 2 live with you? ☐ Yes ☐ No

IF NO, LIST ADDRESS:

21 or 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 6 months?

☐ Yes ☐ No

Dependent 3

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

☐ Male ☐ Female ☐ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 3 live with you? ☐ Yes ☐ No

IF NO, LIST ADDRESS:

21 or 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 6 months?

☐ Yes ☐ No

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Family, continued.

Dependent 4

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

☐ Male ☐ Female ☐ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 4 live with you? ☐ Yes ☐ No

IF NO, LIST ADDRESS:

21 or 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 6 months?

☐ Yes ☐ No

Dependent 5

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

☐ Male ☐ Female ☐ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 5 live with you? ☐ Yes ☐ No

IF NO, LIST ADDRESS:

21 or 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 6 months?

☐ Yes ☐ No

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

☐ Male ☐ Female ☐ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 6 live with you? ☐ Yes ☐ No

IF NO, LIST ADDRESS:

21 or 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 6 months?

☐ Yes ☐ No

Dependent 7

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

☐ Male ☐ Female ☐ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 7 live with you? ☐ Yes ☐ No

IF NO, LIST ADDRESS:

21 or 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 6 months?

☐ Yes ☐ No

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Race & Ethnicity Information

The following questions will be used by Highmark to gain a better understanding of the demographics and health needs of our members. By collecting this data, Highmark can assess whether, and the extent to which, our health solutions, policies and practices address systematic disparities in health and healthcare for our members and communities. These assessments will better equip Highmark to deepen our knowledge around the health challenges of our members in order to develop and provide unique services to meet the specific needs of our members and communities. Race and Ethnicity data will be shared with the U.S. Department of Health and Human Services to support a broader understanding of health needs across the U.S. population. **Your answers to the following questions are completely voluntary.** In collecting the below data, Highmark will: 1) maintain all the below data as private; 2) not use the below data for eligibility determination, underwriting, or rating purposes; and 3) not deny your application based on whether you choose to answer these questions.

	Policyholder	Dependent 1	Dependent 2	Dependent 3	Dependent 4	Dependent 5	Dependent 6	Dependent 7
1) Is the applicant of Hispanic, Latino, or Spanish origin?								
Yes	☐	☐	☐	☐	☐	☐	☐	☐
No	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐
Prefer Not to Answer	☐	☐	☐	☐	☐	☐	☐	☐
1a) If you selected "Yes" to the above question, please answer below:								
Cuban	☐	☐	☐	☐	☐	☐	☐	☐
Mexican, Mexican American, or Chicano/a	☐	☐	☐	☐	☐	☐	☐	☐
Puerto Rican	☐	☐	☐	☐	☐	☐	☐	☐
Other Hispanic, Latino or Spanish origin	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐
Prefer Not to Answer	☐	☐	☐	☐	☐	☐	☐	☐
2) If you answered "No" or "Other" in Question 1 above, please specify Race and Ethnicity by selecting one of the options below:								
American Indian or Alaskan Native	☐	☐	☐	☐	☐	☐	☐	☐
Asian Indian	☐	☐	☐	☐	☐	☐	☐	☐
Black or African American	☐	☐	☐	☐	☐	☐	☐	☐
Chinese	☐	☐	☐	☐	☐	☐	☐	☐
Filipino	☐	☐	☐	☐	☐	☐	☐	☐
Guamanian or Chamorro	☐	☐	☐	☐	☐	☐	☐	☐
Japanese	☐	☐	☐	☐	☐	☐	☐	☐
Korean	☐	☐	☐	☐	☐	☐	☐	☐
Native Hawaiian	☐	☐	☐	☐	☐	☐	☐	☐
Samoan	☐	☐	☐	☐	☐	☐	☐	☐
Vietnamese	☐	☐	☐	☐	☐	☐	☐	☐
White	☐	☐	☐	☐	☐	☐	☐	☐
Asian race not listed above	☐	☐	☐	☐	☐	☐	☐	☐
Pacific Islander race not listed above	☐	☐	☐	☐	☐	☐	☐	☐
Race not listed above	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐
Prefer not to answer	☐	☐	☐	☐	☐	☐	☐	☐

Step 2: Find a plan.

Coverage that
makes you .

In this next step, you're going to select your plan.

Or, take a look through the plan brochure. All of the information you need is there.

You only need to fill out the page that shows the county you live in. If you're looking for a **Conversion** plan, go right to page 15.

Step 2: Find a plan.

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.

		Annual Deductible	
		Individual	Family
my Blue Access PPO	☐ Platinum 0	\$0	\$0
	☐ Platinum 0 + Adult Dental and Vision		
	☐ Standard Platinum 0		
	☐ Premier Gold 0		
	☐ Premier Gold 0 + Adult Dental and Vision		
	☐ Gold 0		
	☐ Gold 0 + Adult Dental and Vision		
	☐ Gold 1700 HSA	\$1,700	\$3,400
	☐ Standard Gold 1500	\$1,500	\$3,000
	☐ Silver 3500	\$3,500	\$7,000
	☐ Silver 3500 + Adult Dental and Vision		
	☐ Silver 7000	\$7,000	\$14,000
	☐ Standard Silver 5000	\$5,000	\$10,000
	☐ Standard Silver 5000 + Adult Dental and Vision		
	☐ Bronze 3800	\$3,800	\$7,600
	☐ Bronze 3800 + Adult Dental and Vision		
	☐ Bronze 7400 HSA - Custom Drug Benefit	\$7,400	\$14,800
	☐ Bronze 8900	\$8,900	\$17,800
	☐ Standard Bronze 7500	\$7,500	\$15,000
	☐ Major Events PPO Catastrophic 9200 - 3 Free PCP Visits [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.]	\$9,200	\$18,400

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT’S LAST NAME

FIRST NAME

Step 2: Find a Conversion plan.

Are you losing your Highmark group coverage and want to get Highmark individual coverage? Great, you may want a Conversion plan. It can start the day your group plan ends.

Highmark offers the following Conversion plan. Fill in the oval next to this plan if you would like to apply for enrollment. Enrollment in this plan will apply to everyone covered by your plan.

			Annual Deductible	
			Individual	Family
my Blue Access PPO	0	Bronze 3800	\$3,800	\$7,600

**Find this
info here:**
www.Highmark.com

APPLICATION DUE DATE (MM/DD/YYYY)

FIRST PREMIUM AMOUNT

Conversion Policy

EFFECTIVE FROM (MM/DD/YYYY):

EFFECTIVE TO (MM/DD/YYYY):

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Step 3: Your first payment.

The plan? 
Now, the check.

When you send this application in, you need to have your first premium payment included with it. We'll walk you through how to calculate that on the next page. If the first payment is not made with your application, your first premium payment will be due by the date printed on your first invoice.

Step 3: Your first payment.

Start by filling in this information:

POLICY HOLDER NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY OR TAX ID NUMBER

Now grab your rate guide, or visit [Highmark.com](https://www.highmark.com).

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

\$

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.

If you're applying for a Conversion plan and want your plan to start in the middle of the month, you'll need to prorate this first payment for the days remaining in the month your group coverage ended. You can figure that out like this:

Monthly premium divided by number of days in the month.

MONTHLY PREMIUM		DAYS IN THE MONTH		TOTAL
\$	÷		=	

Then multiply that number by the number of days left in the month after your coverage starts.

TOTAL FROM ABOVE		DAYS LEFT IN THE MONTH		TOTAL
\$	x		=	

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 2024).

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?

☐ Yes ☐ No

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

☐ 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

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.

☐ Yes ☐ No

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Step 4: Current coverage.

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

Everyone fills this in:

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

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 ☐ 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:

☐ A family member	☐ Other (please specify):
☐ An Indian Tribe, tribal organization, or urban Indian organization	
☐ An employer (Non-ICHRA and Non-QSEHRA)	☐ An Individual Coverage Health Reimbursement Arrangement (ICHRA)
☐ A local, State or Federal government program, including a grantee thereof	EMPLOYER NAME:
☐ A Ryan White HIV/AIDS program	
☐ An IRS-recognized 501(c)(3) organization (nonprofit)	☐ A Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)
☐ A health care provider or supplier	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.

☐ 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

Step 5: Your signature.

One last thing.



This is going to be a lot of legal language to read. Take a deep breath, you can do this. Once you read it, sign at the bottom to let us know that you agree.

Ready? Let's finish this.

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 Cross 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, 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 Blue Cross Blue Shield 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 Blue Cross Blue Shield or any of Highmark Blue Cross Blue Shield 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 Cross 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. Delaware law will apply.

Effective Date Of Coverage

Your plan is effective based on the type of enrollment.

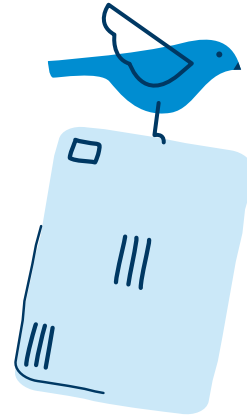
- **If you apply between November 1st and December 15th**, your plan will begin January 1st. If you apply between December 16th and January 15th, your plan will begin February 1st.
- **Conversion plans** will begin on the effective date marked on this application.
- **If you're applying during a Special 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 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 and subjects such person to criminal and 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. This Application is valid only when completed and signed by the applicant.	



Time to send this away.

Woohoo! You did it. You finished the application. Now, tear out the pages you completed and send them back to us. Here's how to do that:

By mail:

Pack this completed, signed application into an envelope with a check for your first payment. Then send it to us here:

Highmark Blue Cross Blue Shield
P.O. Box 382185
Pittsburgh, PA 15251-8185

That's it, you're done! We can't wait to spend 2025 with you.

All done?

Double-check these items to make sure your application isn't delayed:

- ☐ Make sure you've provided your full Social Security number.
- ☐ If you have a group number, make sure it's filled in.
- ☐ Your check must be included with the application.

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>.

Pennsylvania, Delaware, West Virginia, and New York: 1-833-521-1424 (TTY: 711)

ATTENTION: If you speak English, assistance services, free of charge, are available to you. Call the number provided for your state of residence.

ATENCIÓN: Si habla español, tiene servicios de asistencia lingüística sin cargo. Llame al número correspondiente a su estado de residencia.

注意: 如果您说中文, 您可获得免费的语言援助服务。请拨打您所在州相应的电话号码。

توجه کنید: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی به صورت رایگان در دسترس شما هستند. با شماره ارائه شده برای ایالت محل سکونتتان تماس بگیرید.

주의: 한국어(를) 사용하는 경우, 언어 지원 서비스를 무료로 이용할 수 있습니다. 거주하시는 주의 전화 번호로 문의하십시오.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo telefòn ki koresponn ak Eta kote w rete a.

ATTENZIONE: Se parla italiano, avrà a disposizione un servizio di assistenza linguistica gratuito. Chiami il numero fornito per il suo stato di residenza.

אכטונג: אויב איר רעדט אידיש, זענען שפראך הילף סערוויסעס, פריי פון אפצאל, אוועילעבל פאר אייך. רופט די נומער וואס איז צוגעשטעלט פאר אייער סטעיט וואו איר וואוינט.

মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ রয়েছে। আপনি বসবাসরত রাজ্যের জন্য দেওয়া নম্বরে ফোন করুন।

تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بالرقم المقدم للولاية التي تقيم فيها.

UWAGA: jeżeli posługuje się Pan/Pani językiem polsku, udostępniamy bezpłatne usługi wsparcia językowego. Prosimy zadzwonić pod numer podany dla stanu, w którym Pan/Pani mieszka.

ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le numéro de téléphone pour votre État de résidence.

توجہ دیں: اگر آپ اردو بولتے ہیں، تو لسانی مدد کی خدمات آپ کے لیے مفت دستیاب ہیں۔ اپنی رہائش والی ریاست کے لیے فراہم کردہ نمبر پر کال کریں۔

CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí được cung cấp sẵn cho quý vị. Gọi số được cung cấp cho tiểu bang cư trú của quý vị.

PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numerong ibinigay para sa estadong tinitirhan mo.

ΠΡΟΣΟΧΗ: Αν μιλάτε Ελληνικά, έχετε πρόσβαση σε δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό που παρέχεται για την περιοχή σας.

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 you have questions about completing this application, please call the Producer Line at 1-800-652-9459.

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

BLUE CROSS BLUE SHIELD AGENCY NUMBER

PRODUCER NUMBER

AGENCY NAME

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

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 his/her dependents applying for this coverage?

☐ Yes ☐ No

PRODUCER SIGNATURE

DATE

AGENCY

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

☐ Yes ☐ No

- 3.** Have you advised the applicant of the features of the product that he/she has selected, including satisfying his/her deductible(s)?

☐ Yes ☐ No

- 4.** Is this applicant a current customer of Highmark Blue Cross Blue?

☐ Yes ☐ No

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

☐ Yes ☐ 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 Cross Blue Shield's rights or requirements.



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

Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield serves the state of Delaware and is an independent licensee of the Blue Cross Blue Shield Association.

Internal use only

NATIONAL PRODUCER NUMBER

Notes

2025
is looking pretty great.



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

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

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The Blue Cross and Blue Shield symbols are registered marks of the Blue Cross Blue Shield Association.