Because Highmark  s keeping it simple.

Apply in 5 steps for your new 2025 individual/family Affordable Care Act (ACA) health plan with this application.

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, you can do this digitally. Just scan here.

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.

These plans are offered by Highmark Benefits Group Inc., an independent licensee of the Blue Cross Blue Shield Association. The Blue Shield symbol is a registered mark of the Blue Cross Blue Shield Association.

5 steps to apply.

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 Pennsylvania Insurance Exchange (Pennie™). 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 Pennie at Pennie.com or **1-844-844-8040**.

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

- ☐ You're not entitled to benefits under Medicare Part A, enrolled in benefits in Medicare Part B, or enrolled with CHIP.
- ☐ You're currently living in the U.S.
- ☐ You live in one of the counties listed on page 13 of this application and select a plan available in the county where you live.
- ☐ 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 to with this application. Here's a quick breakdown:

ACA Plans

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

HIPAA

If you're losing your company's health plan and want a Highmark plan, a HIPAA plan might be for you. Find out more on page 16.

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 1-855-949-1043.

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.

Or, we can help you in person at a **Highmark Direct store**. Find one near you at **HighmarkDirect.com**.

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 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 fill out an electronic version of this form on www.Highmark.com and print it.

- **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 23** — 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 24.

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** — Everyone fills this page out with their personal information, even if applying for someone else like a minor child.
- **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 on behalf of a child under 18 for his or her own individual policy.

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) or visit a Highmark store to get assistance with this application free of charge.
- If you have general questions or would like to enroll by telephone call 1-855-949-1043.
- If you need help with a HIPPA or Conversion plan or need help with prior insurance coverage call 1-888-510-1084.

25827

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

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

0 **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)

0 Home 0 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.

0 Just for you.

0 You and your family.

0 You're applying on behalf of a child under 18 for his or her own coverage as an individual policy holder.

Ahh, didn't that feel good?

All finished? Rip this page out.

25827

Step 1: About you continued.

If you're 21 or older:

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?

0 Yes 0 No

Communication preferences:

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 it at any time or request a digital copy by calling the number on the back of your member identification (ID) card or visiting My**Highmark.com**.

So, what do you think?

0 **Yes,** let's do this digitally.

0 **No,** let's stick to paper.

Go to MyHighmark.com to review the Contact Preferences Term 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 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

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 1 live with you? 0 Yes 0 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?

0 Yes 0 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

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 2 live with you? 0 Yes 0 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?

0 Yes 0 No

Dependent 3

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 3 live with you? 0 Yes 0 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?

0 Yes 0 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

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 4 live with you? 0 Yes 0 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?

0 Yes 0 No

Dependent 5

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 5 live with you? 0 Yes 0 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?

0 Yes 0 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

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 6 live with you? 0 Yes 0 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?

0 Yes 0 No

Dependent 7

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

0 Male 0 Female 0 Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 7 live with you? 0 Yes 0 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?

0 Yes 0 No

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 with the county you live in on it. If you're looking for a **HIPAA** or **Conversion** plan, go right to that page.

Step 2: Find a plan in

Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

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.

These plans are just for Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

Your county? Fill it out, rip it out.

Highmark Benefits Group - Group Number: 108047-67			Annual Deductible	
			Individual	Family
my Blue Access PPO	0	Premier Gold 0	$0	$0
	0	Premier Gold 0 + Adult Dental and Vision		
	0	Gold 0		
	0	Gold 0 + Adult Dental and Vision		
	0	Gold 1500	$1,500	$3,000
	0	Gold 1700 HSA	$1,700	$3,400
	0	Premier Silver 0	$0	$0
	0	Premier Silver 0 + Adult Dental and Vision		
	0	Silver 3500	$3,500	$7,000
	0	Silver 3500 + Adult Dental and Vision		
	0	Silver 7000	$7,000	$14,000
	0	Bronze 3800	$3,800	$7,600
	0	Bronze 3800 + Adult Dental and Vision		
	0	Bronze 7400 HSA - Custom Drug Benefit	$7,400	$14,800
	0	Bronze 8900	$8,900	$17,800
	0	Major Events PPO Catastrophic 9200 - 3 Free PCP Visists [Applicants must be under age 30 or have received an exemption certification from the Pennsylvania Insurance Exchange. 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.

These plans are for residents of: Bucks, Chester, Delaware, Montgomery, and Philadelpia counties.

Highmark Benefits Group - Group Number: 108047-67			Annual Deductible	
			Individual	Family
my Blue Access PPO	0	Bronze 3800	$3,800	$7,600

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 2: Find a HIPAA plan.

Are you losing an employer's coverage and want to get a Highmark HIPAA (Health Insurance Portability and Accountability Act) plan? Welcome. Your plan can start when your current plan ends.

First, a few questions:

1. If your most recent coverage offered you "COBRA" or similar state required benefits, did you elect that coverage?

0 Yes 0 No

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

0 Yes 0 No

2. If you include your most recent coverage, have you had some type of creditable health care coverage continuously for at least 18 months?

0 Yes 0 No

*To find this, count periods of creditable coverage that you had before any breaks in coverage. Count them only if the break in coverage was less than 63 days. Do not count days during a waiting period when you had no coverage. Do not count days in a waiting period to determine if you had a break in coverage.

3. Did your most recent health care coverage terminate because you did not pay your premium? This includes contributions or fraud.

0 Yes 0 No

Now, you need to **attach** your "Certificate of Prior Coverage" form to this application.

Don't have it?

Here are some other ways you can prove you had prior coverage:

1. Send us your signed written statement about your last coverage. Include names of the plans that covered you in the last 18 months and the beginning and end dates of coverage. Attach copies of papers proving that you had coverage during those times — something like an ID card, explanation of benefits, premium invoice, or paystubs proving you paid for health coverage. You must also cooperate with us to prove that you had coverage.
2. Complete and send us a HIPAA Prior Coverage Disclosure and Authorization Form instead of a written statement. You can get this form by calling Member Service at 1-888-510-1084.
3. Call us at 1-888-510-1084 to establish that you had coverage. Give us as much information as you can, then sign the form to let us contact your prior plans to prove that you had coverage.

SOCIAL SECURITY OR TAX ID NUMBER | APPLICANT'S LAST NAME | FIRST NAME

Next up, choose your HIPAA plan.

Highmark offers the following HIPAA 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.

These plans are for residents of: Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

Highmark Benefits Group - Group Number: 108047-67			Annual Deductible	
			Individual	Family
my Blue Access PPO	O	Bronze 3800	$3,800	$7,600

APPLICATION DUE DATE (MM/DD/YYYY)

FIRST PREMIUM AMOUNT

$

HIPAA 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.

Look at that, another check.

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 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

$

GROUP NUMBER

(Group number is the bold, blue eight-digit number; listed above plan selection.)

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 HIPAA 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.

MONTHY 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 $ x DAYS LEFT IN THE MONTH = TOTAL

Done? Tear this out.

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?

0 Yes 0 No

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

0 Yes 0 No

2. Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in **Medicare Part B**?

0 Yes 0 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.

0 Yes 0 No

SOCIAL SECURITY OR TAX ID NUMBER | APPLICANT'S LAST NAME | FIRST NAME

That was a great sound.

Step 4: Current coverage.

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

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

Everyone fills this in:

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*?

0 Yes 0 No 0 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:

0 A family member

0 An Indian Tribe, tribal organization, or urban Indian organization

0 An employer (Non-ICHRA and Non-QSEHRA)

0 A local, State or Federal government program, including a grantee thereof

0 A Ryan White HIV/AIDS program

0 An IRS-recognized 501(c)(3) organization (nonprofit)

0 A health care provider or supplier

0 Other (please specify):

0 An Individual Coverage Health Reimbursement Arrangement (ICHRA)

EMPLOYER NAME:

0 A Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

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.

0 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

RIIIIPPPPPPPPP

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.

You signed. Now seal and deliver.

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. 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 or delivery-related admissions, 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 if any information I supplied on this Application changes. I must call 1-888-510-1084 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 or any of Highmark'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. 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. Pennsylvania 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.
- **HIPAA or 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

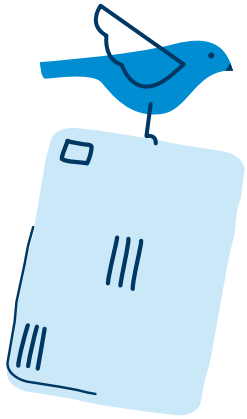
DATE

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.**

One more time now.



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.

1 **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 Shield
P.O. Box 382178
Pittsburgh, PA 15251-8178

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.

Notes

Notes

Notes

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.

NATIONAL PRODUCER NUMBER (NPN)

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

AGENCY NAME

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?

0 Yes 0 No

PRODUCER SIGNATURE

DATE

AGENCY

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

0 Yes 0 No

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

0 Yes 0 No

4. Is this applicant a current customer of Highmark?

0 Yes 0 No

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

0 Yes 0 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's rights or requirements.

Highmark Inc., d/b/a
Highmark Blue Shield
120 Fifth Avenue
Pittsburgh, PA 15222-3099

Internal use only

NATIONAL PRODUCER NUMBER (NPN)

HIGHMARK.
An Independent Licensee 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.

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: 한국어을(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 مجانًا. 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.

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 visit Highmark.com, scroll to the bottom of the page and click on Quality Assurance or for a paper copy, call 1-855-873-4106.

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