# Medical Enrollment/Change Application

LEHIGH UNIVERSITY, Human Resources, 428 Brodhead Ave., BETHLEHEM, PA 18015-1687
(610) 758-3900 -- (610) 758-6226 (fax)

☐ **CMM Plan** – 00515044 (LU01) [LUCMMPLN] ☐ **PPO 80 –** 00515044 (LU02) [LUPPO080] ☐ **PPO 100 –** 00515044 (LU03) [LUPPO100]

☐ **Keystone** – 00515044 (LU04) [LUHMOPLN] LIN: _____ [LUMEM#]

Name: _____ SS#: _____

Home Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

EFFECTIVE DATE: _____ Date of Hire: _____

____ New Enrollment
____ Add (or) Remove Dependent(s)
Reason _____
Date of Event _____
____ Medicare Eligibility
____ Terminate Coverage
Reason _____
Date of Event _____
____ Other _____

**TO BE COMPLETED FOR ALL NEW ENROLLMENTS AND CHANGES**

| MEDCO Person Code (office use only) | | | | | |
|---|---|---|---|---|---|
| | Employee/Contract Holder | Spouse/Partner | Child (Up to 26 yrs old) | Child (up to 26 yrs old) | Child (up to 26 yrs old) |
| Social Security Number | | - - | - - | - - | - - |
| Name (Last, First, Initial) | | | | | |
| Sex | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female | ☐ Male ☐ Female |
| Membership Status | ☐ Single ☐ Married | ☐ Spouse ☐ Domest. Partner | ☐ Disabled | ☐ Disabled | ☐ Disabled |
| Date of Birth | | | | | |
| Employed? | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Medical Insurance Offered by Employer? | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Primary Care Physician # - KHP (check box if current physician) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other Health Insurance | | | | | |
| Policy Number (check if in effect now) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Eligible for Medicare? | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No |

By signing below, I represent that all information supplied in this application is true and complete. I read and agree to the Conditions of Enrollment on the reverse side of this application.

Employee's Signature: _____ Date: _____ Employer's Signature: _____

Remember to make a copy or this document for your files until you receive your identification cards.

# CONDITIONS OF ENROLLMENT

On behalf of myself and the dependents listed on the reverse side, I agree to the following:

1. Applicant acknowledges that coverage in all medical plans is provided by Capital Blue Cross.
2. Enrollment of myself and of the listed dependents into the plan shall be effective on acceptance by the insurance provider.
3. Coverage and benefits are contingent on timely payment of premiums and may be terminated as provided in the Group Master Contract and Group Health Insurance Policy. Employer is hereby authorized to withhold premium payments from applicant's wages as appropriate.
4. As a condition to HMO benefits, applicant understands and agrees that (with the exception of emergency procedures as defined in the Group Master Contract) all services, in order to be covered by the insurance provider, must be performed either by a participating primary care physician or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by prior written referral from a participating primary care physician/dentist.
5. Applicant agrees to make directly to providers of health care such copayments (including deductibles and coinsurance) as are provided for in the Group Master Contract and Group Health Insurance Policy.
6. Applicant authorizes any hospital, physician, or other health care provider to furnish insurance provider or its assignee or designee with such medical information about the applicant and of the listed dependents as the insurance provider or its assignee or designee may require.
7. The Group Master Contract and Group Health Insurance Policy will determine the rights and responsibilities of member(s) and will govern in the event either conflicts with any benefits comparison, summary, or other description of the insurance provider.
8. Unless coverage is terminated, applicant understands that this coverage will remain in effect until the employer's next open enrollment period regardless of the continued availability of a particular primary care physician or other health care provider.
9. Applicant acknowledges that Capital Blue Cross and Keystone's participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of Capital Blue Cross or Keystone.
10. Applicant agrees to notify the employer when applicant or any Member(s) become(s) eligible for Medicare Parts A or B and to complete a Medical Enrollment/Change Application providing Medicare information.
11. Applicant understands and agrees that enrollment is dependent upon receipt and review of disability certification and/or student certification forms if applicable.
12. 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.
13. ***(For KHP participants only)*** I have been offered the option of enrolling in Keystone Health Plan Central's Health Maintenance Organization. I understand that if my place of residence is not within Keystone's service area, all care that I and my dependents receive as Keystone members must be provided or authorized by a Keystone primary care practice according to the terms of the Keystone subscriber agreement. I reviewed Keystone's list of primary care practices and have selected a primary care physician which is sufficiently convenient to provide such care. With these understandings, I wish to enroll in Keystone Health Plan Central.