

Application for Individual Coverage

Instructions:

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

Important: Receipt of your initial payment does not constitute enrollment in this program. Your coverage will not begin until this application has been processed, an effective date assigned, and your payment received. Failure to provide all information requested may result in a delay in the processing of your application. If we are unable to process your application, your check will be returned by mail.

6. Once your materials are complete, be sure to make a copy for your records. Mail your application and check or payment form to:
Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-866-346-2081, Monday through Friday, between 8 a.m. and 8 p.m. You can also apply online by visiting us at www.ibx4you.com/applynow.





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For office use only

Application ID: _____

Account ID: _____

Application/Change Form for Individual Coverage

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

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

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

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

SECTION A — Plan Selections

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

Choice of Plan	
Keystone HMO Plans underwritten by Keystone Health Plan East: <input type="checkbox"/> HMO Platinum <input type="checkbox"/> HMO Gold <input type="checkbox"/> HMO Silver <input type="checkbox"/> HMO Bronze <input type="checkbox"/> HMO Gold Proactive <input type="checkbox"/> HMO Silver Proactive <input type="checkbox"/> HMO Silver Proactive Value	Personal Choice PPO Plans underwritten by QCC Insurance Company: <input type="checkbox"/> PPO Platinum <input type="checkbox"/> PPO Gold <input type="checkbox"/> PPO Silver <input type="checkbox"/> PPO Bronze <input type="checkbox"/> PPO Bronze Reserve <input type="checkbox"/> Catastrophic (EPO)* <small>EPO stands for Exclusive Provider Organization</small>

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

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

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

** Required for all HMO plans. Use our website www.ibx4you.com to find a primary care physician (PCP) or call 1-866-346-2081 to request a PCP directory (HMO plans only).

Form #16913 Rev. 1.17

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SECTION C — Family Information (if applying)

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

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

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

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

** Required for all HMO plans. Use our website www.ibx4you.com to find a primary care physician (PCP) or call 1-866-346-2081 to request a PCP directory (HMO plans only).

SECTION D — Personal Information

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

SECTION E — Contact Information***

Home phone number ()	Mobile phone number ()	Email address
Best time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon		Best location to call: <input type="checkbox"/> Home <input type="checkbox"/> Mobile

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

SECTION F — Other Insurance

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

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

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

Name	Health care carrier	Policy number	Term/ Renewal date

SECTION G — Additional Information

1. Have you used a tobacco product on average four or more times per week within the past 6 months, other than for religious or ceremonial use? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes,": <input type="checkbox"/> Yes, but I am participating in a smoking cessation program. <input type="checkbox"/> Yes, and I am not participating in a smoking cessation program.
The above questions are applicable to members and their dependents age 21 and older.
Name of person: _____ Type and amount: _____ Date last smoked or used tobacco: ____/____/____
Name of person: _____ Type and amount: _____ Date last smoked or used tobacco: ____/____/____

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

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

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

4. HMO Plans Only:

- a) As a condition of coverage, each applicant must select a participating primary care physician.
- b) As a condition of coverage, (with the exception of emergency procedures and certain direct access services as defined in the Subscriber Agreement) all services, in order to be covered by KHPE, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy (if applicable), or other provider as authorized by a referral, or precertification, from a participating primary care physician or KHPE.

5. Catastrophic Plans Only:

Are available to eligible applicants (Individual/Family) under the age of 30 or eligible applicants experiencing a documented hardship and have received a certification from the Federal Government.

- 6. I understand that benefits under this policy will be coordinated with other coverage any covered person may have which is subject to coordination.
- 7. By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-Group policy, the companies will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.
- 8. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- 9. I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

Signature(s) Required

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

<div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(-90deg); transform-origin: left top;">SIGN HERE</div> X _____ / / Applicant/Parent or Legal Guardian signature Date	<div style="border: 1px solid black; padding: 2px; display: inline-block; transform: rotate(-90deg); transform-origin: left top;">SIGN HERE</div> X _____ / / Applicant spouse or domestic partner signature (if applying for coverage) Date
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SECTION I – Statement of Accountability (if applicable)

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

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

SECTION J — Broker Information (if applicable)

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

Independence Sales Representative (if applicable)

National Producer Number (NPN)	Name of sales representative
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SECTION K — Assistance with Completing this Application (if applicable)

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

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

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

Your signature

____/____/____
Date

Mail your application and check or Payment Form to:

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

If you have any questions, contact Independence Blue Cross at
1-866-346-2081, Monday through Friday, between 8 a.m. and 8 p.m.



Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield. Independent licensees of the Blue Cross and Blue Shield Association.

Language Access Services

If you, or someone you're helping, has questions about Independence Blue Cross, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-275-2583 TTY 711.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independence Blue Cross, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-275-2583 TTY 711.

如對 Independence Blue Cross 有任何問題，請您或您所幫助的人聯系我們提供的免費多語言信息服務。翻譯服務請撥打 1-800-275-2583。

Nếu quý vị hoặc người mà quý vị đang trợ giúp có câu hỏi về Independence Blue Cross, quý vị có quyền nhận được trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để yêu cầu thông dịch viên, hãy gọi số 1-800-275-2583.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу программы Independence Blue Cross, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-275-2583.

Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut Independence Blue Cross, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-275-2583 uffrufe.

Independence Blue Cross 와 관련하여 궁금한 사항이 있으신 경우, 귀하 또는 귀하의 지원을 받는 사람은 관련 정보 및 지원을 해당 언어로 무료로 받으실 수 있습니다. 통역사와 상담하시려면 1-800-275-2583 로 전화해 주십시오.

Se tu o qualcuno che stai aiutando avete domande su Independence Blue Cross, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, puoi chiamare il numero 1-800-275-2583.

إذا كان لديك أو لدى شخص تساعد أسئلة بخصوص Independence Blue Cross، فلديك الحق في الحصول على المعلومات الضرورية بلغتك دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-800-275-2583.

Si vous, ou quelqu'un que vous aidez, a des questions à propos d'Independence Blue Cross, vous avez le droit d'obtenir gratuitement de l'aide et l'information dans votre langue. Pour parler à un interprète, appelez 1-800-275-2583.

Wenn Sie selbst oder eine Person, der Sie helfen, Fragen über Independence Blue Cross haben, so haben Sie das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache anzufordern. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-275-2583 an.

જો તમને અથવા તમે કોઈને મદદ કરી રહ્યા તેમાંથી કોઈને Independence Blue Cross વિશે પ્રશ્નો હોય, તો તમને મદદ અને માહિતી તમારી ભાષામાં કોઈપણ ખર્ચ વિના મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, આ 1-800-275-2583 પર કોલ કરો

Jeśli Ty lub osoba, której pomagasz macie pytania odnośnie do programu Independence Blue Cross, mogą Państwo uzyskać bezpłatną informację i pomoc w Waszym języku. Aby porozmawiać z tłumaczem, proszę zadzwonić pod numer 1-800-275-2583.

Si ou menm, oswa yon moun w ap ede, gen kesyon konsènan Independence Blue Cross, ou gen dwa pou resevwa èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-800-275-2583.

បើអ្នក ឬក៏នរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Independence Blue Cross អ្នកមានសិទ្ធិក្នុងការទទួលជំនួយនិង ព័ត៌មានជាភាសារបស់អ្នក ដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅទូរសព្ទទៅលេខ 1-800-275-2583 ។

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Independence Blue Cross, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-275-2583.

Dii kwe'é atah nilínigíí Independence Blue Cross haada yit'éego bína ídílkidgo éi doodago háida bíká anilyeedígíí t'áadoo le'é yína'ídílkidgo bee ná ahóót'i'díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínigóó. Ata' halne'ígíí kojí' bich'í' hodíílnih 1-800-275-2583.

Kung ikaw, o ang taong iyong tinutulungan, ay may mga katanungan tungkol sa Independence Blue Cross, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa 1-800-275-2583.

ご本人やお客様の周りの人が、Independence Blue Cross についてご質問などがある場合、無料でご希望の言語でのサポートや情報を入手することができます。インタプリタをご利用の方は、1-800-275-2583 までお電話ください。

اگر شما یا شخصی که به وی کمک می کنید، در رابطه با Independence Blue Cross سوالی دارید، این حق برای شما محفوظ است که بدون نیاز به پرداخت هر نوع هزینه، اطلاعات مربوطه را به زبان خود دریافت نمایید. جهت گفتگو با یک مترجم، با شماره 1-800-275-2583 تماس حاصل فرمایید.

Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services

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

Independence Blue Cross:

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

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You have five ways to file a grievance directly with Independence Blue Cross: in person or by mail: Independence Blue Cross, ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103; by phone: 888-377-3933 (TTY 711), by fax: 215-761-0245, or by email: civilrightscoordinator@ibx.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800- 537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Effective Date: July 18, 2016, Version 1.0