



STATE OF DELAWARE APPLICATION FOR COBRA COVERAGE

FOR STATE OF DELAWARE USE ONLY

Name	Phone	Date	Contact	Dept./Agency
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A. REASON FOR APPLICATION (CHECK ALL THAT APPLY). PLEASE PRINT LEGIBLY.

<input type="checkbox"/> New coverage <input type="checkbox"/> Change coverage <input type="checkbox"/> Information change <input type="checkbox"/> Refuse coverage (see Section E)	ADD DEPENDENTS DUE TO: <input type="checkbox"/> Marriage/Civil Union <input type="checkbox"/> Birth <input type="checkbox"/> Adoption/Guardianship <input type="checkbox"/> Non-voluntary coverage loss <input type="checkbox"/> Other Date of event checked: _____	CANCEL DEPENDENTS DUE TO: <input type="checkbox"/> Divorce/Dissolution <input type="checkbox"/> Over age <input type="checkbox"/> No longer dependent <input type="checkbox"/> Death <input type="checkbox"/> Other Date of event checked: _____	REINSTATE COVERAGE DUE TO: <input type="checkbox"/> Rehire <input type="checkbox"/> Return from leave <input type="checkbox"/> Return from layoff <input type="checkbox"/> Administrative error <input type="checkbox"/> Other Date of event checked: _____
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B. PERSONAL INFORMATION

<input type="checkbox"/> Male	<input type="checkbox"/> Retiree	<input type="checkbox"/> Non-employee	Date of Hire/Retirement (month, day, year)	Social Security Number						
<input type="checkbox"/> Female	<input type="checkbox"/> Surviving spouse									
Last Name		First Name		M.I.	Date of Birth (month, day, year)		Home Phone (include area code)		Business Phone (include area code)	
Street Address						City		State	Zip Code	

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: <input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Family PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE: <input type="checkbox"/> First State Basic 10006519 <input type="checkbox"/> IPA/HMO 10006517 <input type="checkbox"/> Comprehensive PPO 10006518 <input type="checkbox"/> CDH Gold Plan 10006520 <input type="checkbox"/> Special Medicfill 10006515 <input type="checkbox"/> Special Medifill without prescription 10006516	MEDICARE INFORMATION: Applicant's Medicare #: _____ Part A Effective Date: _____ Part B Effective Date: _____
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D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

If you choose IPA/HMO coverage, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents.
If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.

Name of Your Primary Care Physician			Physician's ID Number		Is this your current physician? <input type="checkbox"/> YES <input type="checkbox"/> NO					
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N		
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	Dependent's First Name <input type="checkbox"/> Fulltime student <input type="checkbox"/> Male <input type="checkbox"/> Handicapped <input type="checkbox"/> Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? <input type="checkbox"/> Y <input type="checkbox"/> N		

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? <input type="checkbox"/> I am <input type="checkbox"/> My spouse <input type="checkbox"/> My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Highmark DE contract? <input type="checkbox"/> Y <input type="checkbox"/> N
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F. TERMS OF AGREEMENT

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Blue Cross Blue Shield Delaware (Highmark DE). 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark DE, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents to Highmark DE or its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark DE to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law. 6) If covering a spouse, you must go online at and complete a Coordination of Benefits form.

I elect not to participate in the State Health Insurance Program.	I have read and do agree to the above terms.	Date
Signature:	Signature:	