2024 Application for Small Employer Coverage

Instructions:

Thank you for applying for coverage from Independence Blue Cross. Follow the instructions below to complete your application.

1. Carefully review and complete each section by printing clearly in black ink.
2. Provide information about your spouse, domestic partner, and dependents if they are also applying for coverage (Section C). If you need additional space, please complete an additional application and mail it along with your primary application.

   Important: You must include a Relationship Code (listed at the bottom of page 5) to indicate your relationship to each person covered under the Plan.

3. Before signing your application, please carefully read the Declarations and Conditions of Enrollment (Section I) on page 11. Once you have completed and signed your application, be sure to make a copy for your records.
4. Your Group Administrator must complete the box on page 3 before your application can be processed. Applications can be mailed to:

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

The collection of Race, Ethnicity, and Language data is confidential and voluntary. We are collecting this information as part of our efforts to support equitable, whole-person coverage. This data may be analyzed by our data analysts to support equitable, whole-person health initiatives. For information regarding the Plan's policies and procedures for managing access to and use of race/ethnicity, and language data, including: controls for physical and electronic access to the data, permissible use of the data, as well as impermissible use of the data, please refer to the Notice of Privacy Practices at https://www.ibx.com/privacy-policy.

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-800-ASK-BLUE (1-800-275-2583) (TTY:711), Monday through Friday, between 8 a.m. and 6 p.m. Brokers and small group employers should call 1-866-272-9684 (TTY:711), Monday through Friday, 8:30 a.m. to 5 p.m., with any questions. Thank you for taking the time to complete your application. We look forward to having you as a member of the Independence Blue Cross family!

Independence

For employer Group Administrator to complete (mandatory).

Group Name: _____

Member Effective Date: _____

Group # (medical): _____

Group # (dental): _____

Group # (vision): _____

Group Administrator signature: _____

Application/Change form for Small Employer Coverage

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

Thank you for choosing Independence Blue Cross. In order to process your application as quickly as possible, please refer to the instructions on page 1 and provide the information requested.

SECTION A — Plan Selections

Type of coverage	Change	Reason for application	Other change
☐ Employee only ☐ Employee and child ☐ Employee and children ☐ Employee and spouse or domestic partner ☐ Family	☐ Address ☐ Last name ☐ Primary care office ☐ Rehire ☐ Primary dental office	☐ Add spouse/domestic partner ☐ Add a dependent ☐ Delete a dependent ☐ Other Life event date: (mm/dd/yy) ___/___/___	☐ COBRA Effective date: (mm/dd/yy) ___/___/___ Effective date of coverage: ___/___/___ mm dd yy

Choice of Plan

Keystone Health Plan East Plans:[1]

☐ HMO Platinum Preferred $10/$20/$200
☐ HMO Platinum Preferred $20/$40/$250
☐ HMO Platinum Preferred $25/$50/$400
☐ HMO Platinum Preferred $5/$15/$500
☐ HMO Gold Preferred $40/$80/$650
☐ HMO Gold Proactive
☐ HMO Gold Proactive Value
☐ HMO Gold Classic $1,500/$30/$60/90%
☐ HMO Gold Classic $2,500/$40/$80/100%
☐ HMO Silver Classic $4,750/$40/$80/70%
☐ HMO Silver Secure $5,000/$50/$100/$600
☐ HMO Silver Classic $3,750/$40/$80/50%
☐ HMO Silver Proactive
☐ HMO Silver Proactive Value
☐ HMO Bronze Essential $7,500/$70/$140/$700
☐ DPOS Platinum Preferred $10/$20/$200
☐ DPOS Platinum Preferred $20/$40/$250
☐ DPOS Gold Preferred $40/$80/$650
☐ DPOS Gold Classic $1,500/$30/$60/90%
☐ DPOS Silver Classic $3,750/$40/$80/50%

Personal Choice PPO Plans: [1]

☐ Platinum Preferred $10/$20/$150
☐ Platinum Preferred $10/$20/$200
☐ Platinum Preferred $20/$40/$250
☐ Gold Preferred $40/$80/$500
☐ Gold Preferred $40/$80/$600
☐ Gold Classic $1,500/$20/$40/80%
☐ Gold Classic $2,500/$40/$80/100%
☐ Silver Secure $4,750/$40/$80/$600
☐ Silver Classic $5,000/$50/$100/90%
☐ Silver Classic $3,800/$40/$80/70%
☐ Platinum HSA-50 $1,800/100%
☐ Gold HSA-25 $2,400/$25/$50/90%
☐ Gold HSA-0 $2,200/100%
☐ Silver HSA-0 $4,400/100%
☐ Silver HSA-0 $2,400/70%
☐ Silver HSA-0 $3,600/90%
☐ Bronze HSA-0 $5,600/50%
☐ Bronze HSA-0 $8,000/100%
☐ Gold HRA-20 $4,000/100%

Personal Choice EPO Plans: [1]

☐ Silver HSA-0 $3,000/80%

Medicare Supplemental plan:

☐ MedigapSecurity

Vision:

☐ _____

Dental plans:

HMO & DPOS

☐ Adult Managed Dental Care[2]

PPO/HSA/HRA/HMO & DPOS

☐ Preferred Family PPO
☐ Premier Family PPO
☐ Deluxe Family PPO
☐ Adult Preventive PPO
☐ Adult Preferred PPO
☐ Adult Premier PPO

*The Keystone Health Plan East HMO/DPOS Plans are underwritten by Keystone Health Plan East. PPO Plans are underwritten by QCC Insurance Company.

[1] Includes prescription drug, pediatric and adult vision, and pediatric dental benefits.

[2] Managed Dental Care is available for HMO and DPOS Plans only. This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage.

SECTION B — Primary Applicant Information

Primary applicant name: Last, first, middle initial			Social Security Number
Employer name	Birth date (mm/dd/yy) ____/____/____	Age ____	Sex assigned at birth: ☐ M ☐ F ☐ Intersex

Racial Identity (select all that apply)*

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese
☐ Italian ☐ Portuguese ☐ Other
☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care office/ PCP name†	Primary care physician office ID# (HMO ID#)†
Current patent of PCP?† ☐ Yes ☐ No	Primary dental office ID# (Managed Dental Care only)†

*The information regarding demographic factors: (1) will be maintained as private; (2) may not be used by the insurer for eligibility determinations, underwriting, or rating purposes; and (3) the insurer will not deny an application based on the applicant's refusal to answer the questions related to demographic data.
†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage. You can also called 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS Plans only).

SECTION C — Family Information (if applying)*

Spouse/Domestic Partner name: Last, first, middle initial	Social Security Number

Employer name	Birth date (mm/dd/yy)	Age	Sex assigned at birth:	Relationship Code:‡
	/ /		☐ M ☐ F ☐ Intersex	

Racial Identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese
☐ Italian ☐ Portuguese ☐ Other
☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care office/ PCP name†	Primary care physician office ID# (HMO ID#)†
Current patent of PCP?† ☐ Yes ☐ No	Primary dental office ID# (Managed Dental Care only)†

*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage. You can also called 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS Plans only).

SECTION C — Family Information (continued)*

Dependent†† name: Last, first, middle initial	Social Security Number

Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:	Relationship Code:‡
_____	____/____/____	_____	☐ M ☐ F ☐ Intersex	_____

Racial Identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese
☐ Italian ☐ Portuguese ☐ Other
☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care office/ PCP name†	Primary care physician office ID# (HMO ID#)†
Current patent of PCP?† ☐ Yes ☐ No	Primary dental office ID# (Managed Dental Care only)†

*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

††Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage. You can also called 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS Plans only).

SECTION C — Family Information (continued)*

Dependent†† name: Last, first, middle initial	Social Security Number

Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:	Relationship Code:‡
_____	____/____/____	_____	☐ M ☐ F ☐ Intersex	_____

Racial Identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese
☐ Italian ☐ Portuguese ☐ Other
☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care office/ PCP name†	Primary care physician office ID# (HMO ID#)†
Current patent of PCP?† ☐ Yes ☐ No	Primary dental office ID# (Managed Dental Care only)†

††Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage. You can also called 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS Plans only).

SECTION C — Family Information (continued)*

Dependent†† name: Last, first, middle initial	Social Security Number

Relationship (e.g., son, stepdaughter)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:	Relationship Code:‡
_____	____/____/____	_____	☐ M ☐ F ☐ Intersex	_____

Racial Identity (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown
☐ Other ☐ Prefer not to answer

Ethnic Identity

☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Other
☐ Unknown ☐ Prefer not to answer

Preferred Language

☐ English ☐ Spanish ☐ Chinese
☐ Italian ☐ Portuguese ☐ Other
☐ Prefer not to answer

Cultural Identity (Select up to 5)

☐ Cherokee	☐ Asian Indian	☐ African	☐ Guamanian or Chamorro	☐ English	☐ Cuban
☐ Nanticoke Lenni-Lenape	☐ Chinese	☐ Haitian	☐ Micronesian	☐ German	☐ Dominican (Dominican Republic)
☐ Navajo	☐ Filipino	☐ Jamaican	☐ Native Hawaiian	☐ Irish	☐ Guatemalan
☐ Powhatan Renape Nation	☐ Korean	☐ Nigerian	☐ Polynesian	☐ Italian	☐ Mexican
☐ Ramapough Lenape Indian Nation	☐ Vietnamese	☐ West Indian	☐ Samoan	☐ Polish	☐ Puerto Rican
☐ Other	☐ Prefer not to answer				

Primary care office/ PCP name†	Primary care physician office ID# (HMO ID#)†
Current patent of PCP?† ☐ Yes ☐ No	Primary dental office ID# (Managed Dental Care only)†

††Children under the age of 26 who meet eligibility requirements. Coverage can be applicable past age 26 if they are not self-supportive because of a mental or physical disability.

‡Relationship codes: (for dependents, value identifies relationship to the subscriber)

01 = Spouse
02 = Child
09 = Adopted child
10 = Foster child
17 = Stepchild
20 = Subscriber / Self
29 = Domestic Partner
31 = Court appointed guardian

†A primary care physician (PCP) office/provider ID number is required for all HMO/DPOS medical plans. A primary dental office (PDO)/provider ID selection is not required with your application but must be selected prior to receiving treatment. Use our website www.ibx.com/providerfinder to find a PCP or PDO provider. This plan requires the selection of a Primary Dental Office (PDO) from the Plan's dental HMO network. The Member's PDO provides routine care and arranges or provides most other Dentally Necessary services. Except for emergency services, benefits are covered only when provided or properly referred by the Member's PDO. The manner of accessing benefits through the PDO is made clear in the terms of the Group Contract and Certificate of Coverage. You can also called 1-800-ASK-BLUE (1-800-275-2583)(TTY:711) to request a PCP or PDO directory (for HMO/DPOS 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 ( )	Business phone number ( )	Best time to call: ☐ Morning ☐ Afternoon
Mobile phone number ( )	Email address	Best location to call: ☐ Home ☐ Business ☐ Mobile

SECTION F — Household Information

Do all applicants reside in the same household? ☐ Yes ☐ No

If no, provide reason: _____

_____

Applicant's name: _____ Applicant's address: _____

Applicant's name: _____ Applicant's address: _____

SECTION G — Other Insurance

A. Are you or any applicants currently insured with Independence Blue Cross or an affiliate of Independence Blue Cross, or another Blue Cross and Blue Sheild plan?	☐ Yes ☐ No
B. Do you have any health insurance in effect?	☐ Yes ☐ No
C. Are you replacing the health insurance plan listed in A or B above? If "Yes," termination date: (mm/dd/yy) ____/____/____	☐ Yes ☐ No

Important: Confirm group coverage prior to cancelling any existing coverage.

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

Name	Health care carrier	Policy number	Term/ Renewal date

** By providing my phone number and/or email address, I authorize Independence Blue Cross, its subsidiaries and affiliates (collectively "Independence"), and my employer to contact me via email, automated text and/or phone call. I understand that my consent is not a condition of any benefit or purchase. Message and data rates may apply.

SECTION H — Additional Information

1. Have you, your spouse / domestic partner, or any dependents used a tobacco product on average four or more times per week within the past six months, other than for religious or ceremonial use? ☐ Yes ☐ No

   If "Yes,": ☐ Yes, but I am participating in a smoking cessation program.
   ☐ 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: (mm/dd/yy)
		/ /
Name of person:	Type and amount:	Date last smoked or used tobacco: (mm/dd/yy)
		/ /
Name of person:	Type and amount:	Date last smoked or used tobacco: (mm/dd/yy)
		/ /
Name of person:	Type and amount:	Date last smoked or used tobacco: (mm/dd/yy)
		/ /
Name of person:	Type and amount:	Date last smoked or used tobacco: (mm/dd/yy)
		/ /

SECTION I — Declarations and Conditions of Enrollment

Please read carefully before signing below.

Your application cannot be processed without your signature.

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.

For PPO members:

By signing this application, I elect coverage under the plan specified on this form and for the persons listed here and agree to abide by the conditions of the agreement and to pay required premiums for the selected plan. I authorize my licensed physician, medical or medically-related facility, insurance company, or other organization or institute that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and its affiliate, QCC Insurance Company, Highmark Blue Shield, and ancillary service providers who are responsible for administrating certain covered services. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my employer, association, or welfare board and Independence Blue Cross and Highmark Blue Shield.

For HMO and DPOS members:

I understand that the provision of services to me and my dependents as members of Keystone Health Plan East (''Keystone'') is governed by the applicable master group contract, which provides that:

1. Except for emergencies and select DPOS services, all medical or dental care must be initiated at the primary care office or primary dental office we have selected; and,
2. I and my dependents authorize any person or organization provider services to furnish Keystone, its affiliates, and ancillary service providers who are responsible for administrating certain covered services with medical or dental records or other information concerning such services for purposes including, but not limited to, Keystone quality and utilization review.

I further understand that I can change health plans only at the time my employer and Keystone specify.

Keystone DPOS program self-referred benefits may be underwritten by QCC Insurance company. Referred benefits underwritten or administered by Keystone Health Plan East.

SIGN HERE

X _____ Applicant/Parent or legal guardian signature

_____/_____/_____ Date (mm/dd/yy)

Group Administrator: Mail application to:

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

Note: Please make sure your Group Administrator has completed the gray-shaded section on page 3 of this application.

Independence

17000 IBC Small Employer 2024 2380434 21439

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Telugu: శ్రద్ధ పెట్టం డి: ఒకవేళ మీరు తెలుగు భాష మాట్లా డుతున్న ట్టయితే, మీ కొరకు తెలుగు భాషాసహాయక సేవలు ఉచితంగాలభిన్న యి. 1-800-275-2583 (TTY: 711) కు కాల చేయండి.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Taglines as of 12/31/2022

Discrimination is Against the Law

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

This Plan 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).
- 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 This Plan 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 can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.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*.

Taglines as of 12/31/2022