Away From Home Care Guest Membership Application

Please print clearly. Application must be completed and signed by the subscriber.

Today's date: _____ Guest membership termination date:

Subscriber information

Subscriber

Subscriber's address: Street/Apt. #

City State Zip code

Telephone: _____

Group name:

Group ID #

Subscriber ID #

The applicant is not eligible for guest membership if the subscriber has moved outside of the Keystone service area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

Guest member information

Name:

Social Security number

Gender: ☐ Male ☐ Female

Relationship to subscriber

Away from home address:

Street Apt #

City State Zipcode

County

Phone Cell phone

Other guest members

Name	Social Security No.	Gender	Relationship to subscriber
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

Provide full address to ensure receipt of ID cards and other information. If each guest member has a separate mailing address, provide address information for each member. Please include P.O. box, dorm room number, or mail stop number.

Guardian information

Guardian name

Guardian's relationship to guest member

When applying for guest membership for a minor under age 18, you must supply the name of guardian with whom that minor resides, and state the relationship.

Away From Home Care Guest Membership Application

Guest membership details

Length of guest membership

How long will the member be out of the area? _____ (date range)

Members must be away for a *minimum* of 90 days to be eligible for a guest membership. The maximum time for a guest membership is:

- Long-term Traveler: 6 months (nonrenewable)
- Families Apart: 1 year (renewable)
- Students: 1 year (renewable while enrolled in an accredited program until the age limitation is met).

Reason for applying for guest membership

Please select the type of guest membership that you are seeking:

☐ **Long-term Traveler**. Available to qualified subscribers, their spouses, and dependents. This type of guest membership is typically used for long-term work assignments or for a retiree with a dual residence.

☐ **Families Apart.** Available to spouses or dependents only who do not reside with the subscriber; the subscriber is not eligible. This type of guest membership is typically used when divorced or separated families permanently reside outside the Keystone service area.

☐ **Student.** Available to qualified dependents who are temporarily residing outside of the Keystone service area while attending an accredited education institution. The dependent may not reside with the subscriber.

Name of the out-of-area host plan :
(Potential guest members must reside in the service area of another participating HMO plan in order to obtain guest membership).

Additional instructions

- **Preventing delays in your application.** Please complete and attach the Other Insurance Questionnaire to help prevent delays in processing your application.
- **Confirming when guest membership starts and ends.** Call Customer Services at the phone number on your member ID card to confirm the effective and termination dates of the guest membership. (The effective date of the guest membership coverage is 15 days after a correctly completed and signed application is received and processed by the Away From Home Care Department.) Guest memberships are approved for a specified period of time that depends on the type of guest membership and the employer's group renewal date.
- **Making sure your guest membership coverage is active.** For coverage to remain effective, the subscriber's coverage must remain active with the employer group. In addition:
  - If the guest member is a dependent, he or she must remain an eligible dependent of the subscriber for coverage to be effective.
  - For student guest membership, remember to keep up with the student verification requirements of your plan.
- **Renewing guest membership.** You must renew your guest membership for a spouse or dependent 30 days before the one-year guest membership period ends or before your group's open enrollment (renewal) date, whichever is sooner.
- **Notifying us each time you move in or out of the area.** Call Customer Service each time guest members move in or out of the Keystone service area so that we may ensure the guest member may receive services and is assigned the proper primary care physician. You must notify us whenever the following happens:
  - When a guest member comes home for break or a short period of time.
  - When a guest member returns to the away-from-home area.

If you have questions and need help, call Customer Service at the number on the back of your ID card.

Away From Home Care Guest Membership Application

Subscriber signature

I hereby certify that all information in the guest membership application is truthful and correct to the best of my knowledge. I acknowledge that the benefits program providing coverage to me or eligible dependents as guest members of the host HMO may vary from the benefits program at my home HMO. I understand that as a guest member, the host HMO benefits program's scope and levels of coverage apply.

Subscriber's signature _____ Date _____

AFHC coordinator's use only

Date received _____ Effective date _____ Approved by _____

Other Insurance Questionnaire

Please complete the following questionnaire for all members of your household. Completion of this questionnaire, which concerns other insurance coverage, is required to process your request for guest membership.

Section 1

Do you or someone else in your household have other insurance?

- ☐ No. If *no*, please proceed to Section 2.
- ☐ Yes. If *yes*, please complete Section 1 before going to Section 2.

Who is the subscriber of the other insurance? (Please list all)

Name (Subscriber #1): _____ Date of birth: _____

Name (Subscriber #2): _____ Date of birth: _____

Who else is covered by the other insurance? (Please list all)

Subscriber #1	**Subscriber #2**
Dependent #1 _____	Dependent #1 _____
Dependent #2 _____	Dependent #2 _____
Dependent #3 _____	Dependent #3 _____

Is the subscriber of the other insurance employed?

- ☐ No
- ☐ Yes. If *yes*, please complete the employer information for each applicable subscriber

Employer information (subscriber #1)	**Employer information (subscriber #2)**
_____	_____
Employer	Employer
_____	_____
Employer address	Employer address
Employer phone number: _____	Employer phone number: _____

Please fill out the other insurance information for each applicable subscriber

Subscriber #1	**Subscriber #2**
_____	_____
Insurance company name	Insurance company name
Policy number: _____	Policy number: _____
Effective date: _____	Effective date: _____
Type of benefits (check all that apply):	Type of benefits (check all that apply):
☐ Health/Medical	☐ Health/Medical
☐ Prescription drug	☐ Prescription drug
☐ Dental	☐ Dental
☐ Vision	☐ Vision

Other Insurance Questionnaire

Section 2

Are you or someone else in your household (spouse or dependent) covered by Medicare?

- ☐ No. If *no*, please proceed to the *Employee signature* section
- ☐ Yes. If *yes*, please complete Section 2.

Please supply the names, ID numbers, effective coverage dates, and reason for Medicare eligibility for each Medicare beneficiary.

Medicare beneficiary #1

Name

ID number: _____

What is the effective date of coverage for:

Part A: _____ Part B: _____

Reason for Medicare eligibility (please check all that apply):

- ☐ Age
- ☐ Disability
- ☐ End-stage renal disease

Are you retired?

- ☐ No
- ☐ Yes, I retired on (date): _____

Medicare beneficiary #2

Name

ID number: _____

What is the effective date of coverage for:

Part A: _____ Part B: _____

Reason for Medicare eligibility (please check all that apply)

- ☐ Age
- ☐ Disability
- ☐ End-stage renal disease

Are you retired?

- ☐ No
- ☐ Yes, I retired on (date): _____

Subscriber signature

I hereby certify that all information in this questionnaire is truthful and correct to the best of my knowledge.

Subscriber's signature _____ Date _____