Independence

AWAY FROM HOME CARE GUEST MEMBERSHIP APPLICATION

Please print clearly. Application must be completed and signed by the subscriber. All five pages must be completed and returned to: **Independence Blue Cross 1901 Market Street Attn: Print Room, Philadelphia, PA 19103.**

Today's date: _____

Guest membership effective date will be the 15th day following receipt of a completed form. (Retroactive effective dates are not allowed.) Guest membership termination date will be six months or one year following the effective start date. (Refer to selected category under Guest Membership Details below. Termination dates can be sooner per member request based on need.
Once enrolled, you will receive a Guest Membership ID card and program materials regarding your Primary Care Physician selection from the Host carrier based on the guest member's address. If the subscriber's HMO/POS coverage is cancelled at any time, the Guest membership coverage will be cancelled.

Please note: The below states **do not** participate in Away From Home Care.

Alabama
Alaska
Idaho
Iowa
Kansas
Mississippi
Montana
Michigan
Nebraska
North Carolina
North Dakota
Oregon
Puerto Rico
Rhode Island
South Carolina
South Dakota
Tennessee
Utah
Vermont
Virgin Islands
Washington
West Virginia
Wyoming

SUBSCRIBER INFORMATION

Subscriber:_____ Employer/Consumer: _____

Subscriber's address: _____ Suite/Apt. # _____

City _____ State _____ Zip code_____ Member ID # _____

Home telephone: _____ Alternative phone:_____

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

GUEST MEMBER INFORMATION

Guest member name:

_____

Social Security Number:

_____

Away from home address (**USPS verified**):

_____

Suite/Apt#_____

City _____ State _____ Zip code _____

County _____

Phone _____

KEYSTONE HEALTH PLAN EAST

Please send separate application for each member applying for Away From Home Care.

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.

GUEST MEMBERSHIP DETAILS

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 as follows:

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

REASON FOR APPLYING FOR GUEST MEMBERSHIP

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

☐ **Long-term Traveler** guest membership is 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** guest membership is available to spouses or dependents 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 of the KHPE service area. Please provide dates if you are planning to return to your home service area while on guest membership. _____

☐ **Student** guest membership is available to qualified dependents who are temporarily residing outside of the KHPE service area while attending an accredited education institute. The dependent may not reside with the subscriber. Please provide the dates that you will return home while on guest membership, i.e. breaks, holidays, in between semesters. _____

KEYSTONE HEALTH PLAN EAST

Important additional instructions

- **Prevent delays in your application.** Please complete and attach the Other Insurance Questionnaire (listed on page 4 and 5 of this application) to help prevent delays in processing your application.
- **Confirm when guest membership starts and ends.** (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; refer to your selected category above.
- **Guest Members Address.** Please ensure your address is a valid USPS mailing address.
- **Make 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.
- **Renew guest membership.** You must renew your guest membership for a spouse or dependent 30 days before the six months or one-year guest membership period ends; refer to your selected category above. **Notify us each time you move in or out of the area.** Call Customer Service, at the telephone number on the back of your Keystone Health Plan East ID card, each time guest members move in or out of the KHPE service area so that we may ensure proper assignment of the Primary Care Physician to enable access to care for the guest. You must notify us whenever the following happens:
  - Guest member comes home for break or a short period of time.
  - 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.

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 _____

KEYSTONE HEALTH PLAN EAST

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 _____

Dependent #1 _____

Dependent #2 _____

Dependent #3 _____

Subscriber #2 _____

Dependent #1 _____

Dependent #2 _____

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: _____

Employer address: _____

Employer phone number: _____

Employer information (subscriber #2)

Employer: _____

Employer address: _____

Employer phone number: _____

Please fill out the other insurance information for each applicable subscriber

Subscriber #1

Insurance company name _____

Policy number: _____

Effective date: _____

Type of benefits (check all that apply):

☐ Health/Medical
☐ Prescription drug
☐ Dental
☐ Vision

Subscriber #2

Insurance company name _____

Policy number: _____

Effective date: _____

Type of benefits (check all that apply):

☐ Health/Medical
☐ Prescription drug
☐ Dental
☐ Vision

KEYSTONE HEALTH PLAN EAST

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	**Medicare beneficiary #2**
Name _____	Name _____
ID number: _____	ID number: _____
What is the effective date of coverage for:	**What is the effective date of coverage for:**
Part A:_____ Part B:_____	Part A:_____ Part B:_____
Reason for Medicare eligibility (please check all that apply):	**Reason for Medicare eligibility (please check all that apply):**
☐ Age	☐ Age
☐ Disability	☐ Disability
☐ End-stage renal disease	☐ End-stage renal disease
Are you retired?	**Are you retired?**
☐ No	☐ No
☐ Yes, I retired on (date):_____	☐ 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