HIGHMARK®

APPLICATION FOR WHOLE HEALTH BALANCE PROGRAM*
MONTHLY PREMIUM RATE: $34.50

POLICY HOLDER INFORMATION

***IMPORTANT NOTE:**

If you are not currently enrolled in a Highmark Medigap Blue Medicare Supplement plan, you are not eligible to apply for the Whole Health Balance Program coverage. Do not complete this form.

First Name	Middle Initial (if applicable)	Last Name	Suffix

Home Address (No PO Boxes)	Apt. #	City	State	Zip	County

Mailing Address (PO Boxes allowed)	Apt. #	City	State	Zip	County

Home Phone (with area code)	Email Address

Medigap Blue Member ID (appears on current Medigap Blue ID card)	❑ Check box if you are currently applying for Highmark Medigap Blue coverage

READ AND SIGN BELOW

A. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

B. I hereby apply for coverage under a Highmark Blue Shield Whole Health Balance Subscription Agreement. I understand this application is subject to approval by Highmark Blue Shield and the provisions of the Subscription Agreement, including those that relate to the renewability of the coverage.

C. To the best of my knowledge and belief, the information provided on this application is true and correct.

I hereby acknowledge and agree that I have received an Outline of Coverage. My signature below verifies that I have read understand and agree to the terms and conditions for enrolling in this coverage and agree to pay the required monthly subscription fee.

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.

Signature	Date	Phone Number
POWER OF ATTORNEY		
Signature	Date	

Please return your completed Application to:
Highmark Blue Shield
P.O. Box 535049
Pittsburgh, PA 15253-9801

PRODUCER USE ONLY

A. List any other health insurance policies you have sold to this applicant which are still in force:

_____

_____

B. List any other health insurance policies you have sold to this applicant in the past five years which are no longer in force:

_____

_____

_____ _____

Signature of Agent or Broker Date

Print Name and I.D. Number:

_____

Agency Name and Number:

_____

Phone Number: _____

HIGHMARK®
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

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

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - 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
  - Information written in other languages

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

If you believe that the 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: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-679-6930.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-844-679-6930.

请注意：如果您说中文，可向您提供免费语言协助服务。

請致電 1-844-679-6930 。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-844-679-6930.

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ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-844-679-6930.

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-844-679-6930 uffrufe.

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-844-679-6930 로 전화.

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-844-679-6930 .

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-844-679-6930.

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-844-679-6930.

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-844-679-6930.

ધ્યાન આપશોઃ જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-844-679-6930 નંબર પર ફોન કરો .

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-844-679-6930.

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le 1-844-679-6930.

ប្រការចង់ចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ ការហៅ 1-844-679-6930 ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-844-679-6930.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-844-679-6930 .

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。1-844-679-6930 を呼び出します。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-844-679-6930. موجود است.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-844-679-6930.