HIGHMARK

Former Employer Complete This Section	
Employer's Signature and Date:	Effective Date:

TO ENROLL IN FREEDOM BLUE PPO, PLEASE PROVIDE THE FOLLOWING INFORMATION:

First Name | Middle Initial (if applicable) | Last Name | Suffix | Sex ❑ Male ❑ Female

Home Address (No P.O. Boxes) | Apt# | City | State | Zip | County

Mailing Address (P.O. Boxes allowed) | Apt# | City | State | Zip | Date of Birth / /

Home Phone (with area code) ( )

Email Address (if applicable)

PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION:

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.

–AND–

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

Medicare Number: _____

IS ENTITLED TO Not applicable

EFFECTIVE DATE OF
HOSPITAL (Part A): _____

MEDICAL (Part B): _____

You must have Medicare Part A and Part B (or both) to join a Medicare Advantage plan.

YOU WANT TO ENROLL IN:

Please maintain a copy for your files and send a copy to:

Penn State Employee Benefits
Fax: (814) 863-6227
Email: benefits@psu.edu

☒ 0178428

The Penn State University

OTHER INSURANCE

1. Are you currently enrolled in a non-Medicare Highmark Blue Shield health plan? .....Yes ❑ No ❑
   If YES, name of plan: _____
2. Will either you or your spouse be employed once enrolled in Freedom Blue PPO? ..... Self: .....Yes ❑ No ❑ Spouse: ..... Yes ❑ No ❑
   Your Retirement Date (Month/Day/Year): _____ Spouse's Retirement Date (Month/Day/Year): _____
3. Will you have any Health Insurance and/or Prescription Drug Coverage other than Freedom Blue PPO or Medicare that will continue after your enrollment? ..... Yes ❑ No ❑

If YES, please complete the enclosed "Other Insurance Addendum" and return with your completed application.

READ AND ANSWER THESE IMPORTANT QUESTIONS

Please choose the name of a Primary Care Provider (PCP), clinic or health center.

Name of Provider (recommended)	PCP/NPI # (from Provider Directory)

The Freedom Blue PPO provider directory is available in a CD-ROM format for your computer. Please check here to receive your provider directory in CD-ROM. ❑

Are you currently enrolled in another Medicare Advantage plan? *(Confirmed enrollment in Freedom Blue PPO means you will be automatically disenrolled from your current Medicare Advantage plan.)* .... Yes ❑ No ❑

Are you enrolled in your State Medicaid program? .....Yes ❑ No ❑

If "YES," please provide your Medicaid Number: _____

Are you a resident in a long term care facility such as a nursing home? .....Yes ❑ No ❑

If "YES," please provide the following information:

Name of Institution: _____

Address and Phone Number of Institution (number and street): _____

STOP! If you belong to an employer group or trust fund health plan whose drug coverage is as good as or better than standard Medicare Prescription Drug Coverage (Part D). It is important that you consider your decision to enroll in our plan carefully. In order to finalize your request for enrollment in our plan, we need you to confirm that you want to be enrolled in this group sponsored plan by signing below.

READ AND SIGN BELOW

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Freedom Blue PPO, or by Medicare.

Signature	Today's Date

If you are the authorized representative, you must sign above and provide the following information:

Name: _____ Phone Number: _____

Address: _____ Relationship to Enrollee: _____

OPTIONAL INFORMATION

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a or Spanish origin
- ❑ **I choose not to answer.**
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ **I choose not to answer**
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Somoan

Please check one of the boxes below if you want us to contact you about receiving information in a language other than English or in an accessible format:

❑ I would like to receive my materials in a language other than English.

❑ I would like to receive my materials in an accessible format (Braille, Large Print, Etc.)

Please contact Freedom Blue PPO at **1-866-918-5285** (TTY users should call 711) to inquire about materials in an accessible format, a language other than English, or for telephone translation services. Our office hours are 8 AM - 8 PM, Monday to Sunday.