Because Highmark Blue Cross Blue Shield (Highmark) loves keeping it simple

Apply in five steps for your new 2027 individual/family Affordable Care Act (ACA) health plan with this application.

HIGHMARK

To apply online, scan the QR code.

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association®.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

5 steps to apply.

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We're glad you're thinking of Highmark.

Let's make sure this is the application you need.

This application is for purchasing directly with Highmark, not if you're looking to purchase through the New York State of Health (NYSOH) Official Health Plan Marketplace. These plans don't apply federal premium tax credits or cost-sharing reductions. If you're not sure if you qualify for financial help, contact NYSOH at **nystateofhealth.ny.gov** or **1-855-355-5777**.

Other than that, you're eligible to enroll in these plans, regardless of your age, as long as you meet these requirements:

- ☐ You're not entitled to benefits under Medicare Part A, enrolled in benefits in Medicare Part B, or enrolled in the Essential Plan or Child Health Plus.

- ☐ You're currently living in the U.S.

- ☐ You live in one of the counties listed on page 15 of this application and select a plan available in the county where you live.

- ☐ You meet eligibility guidelines listed in Step 5 of this application.

In the right place? Great.

If you have any questions or want to enroll faster:

Call 1-800-888-5407.

Visit highmark.com.

Scan the QR code on the front to apply online

Talk to your insurance agent/producer if you're working with one.

Instructions:
We've made this application as easy as possible with just 5 steps.

It might look like a lot, but these tips will make this application easier and avoid any processing delays.

- **Follow all 5 steps and make sure you fill everything in.** Once you finish a section, tear it out to send back to us.

- **Print letters and numbers clearly with blue or black ink.** If you're applying during Open Enrollment, you can fill out an electronic version of this form on **highmark.com** and print it.

- **If there's a box for your name at the bottom of a page,** make sure you fill it in. That helps us keep track of your application.

- **Sign and date the application on page 20** — If you are applying for coverage for yourself and your spouse/domestic partner, you both must sign this application. If you are not married, under the age of 18, and applying for a policy that covers only you, a parent or guardian must sign this application.

- **Tear out your completed application pages and return them to Highmark.** We'll outline all the ways you can do that on page 21.

Highmark
Individual and Family Enrollment Application

Open Enrollment - Medical Plans
It might look like a lot, but these tips will make this application easier and avoid any processing delays.

During the annual Open Enrollment period, you may apply for coverage, or members can change plans.

- If Highmark receives the enrollment application on or before December 15th, coverage will begin on January 1st, as long as the applicable premium payment is received by then.

If you do not enroll during open enrollment, or during a special enrollment period, you must wait until the next annual open enrollment period to enroll.

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days prior to or after the occurrence of one of the following events:

1. You, Your Spouse or Child involuntarily loses minimum essential coverage including COBRA or state continuation coverage; including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if You have the option to renew the coverage;

2. You, Your Spouse or Child loses eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary and specialty care;

3. You, Your Spouse or Child become eligible for new eligible health plans because of a permanent move and You, Your Spouse or Child had minimum essential coverage for one (1) or more days during the 60 days before the move; or

4. You, Your Spouse or Child are no longer incarcerated.

5. You or anyone in your household will newly gain access to CHOICE Arrangement or will be newly provided with a qualified small employer health reimbursement arrangement (QSEHRA).

Please provide the date of the qualifying event: _____

Open Enrollment - Medical Plans (cont.)

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child can enroll for coverage within 60 days after the occurrence of one of the following events:

1. You, Your Spouse or Child's enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan or the NYSOH, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities;

2. You, Your Spouse or Child adequately demonstrate to Us that another health plan in which You were enrolled substantially violated a material provision of its contract;

3. You, Your Spouse, or Dependent Child became pregnant as certified by a Health Care Professional;

4. You gain a Dependent or become a Dependent through birth, adoption or placement for adoption or foster care, or through a child support order or other court order, however, foster Children are not covered under this Contract;

5. You gain a Dependent or become a Dependent through marriage, and You or Your Spouse had minimum essential coverage for one (1) or more days during the 60 days before the marriage;

6. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents; or

7. If You are an Indian, as defined in 25 U.S.C. 450b(d), You and Your Dependents may enroll in a health plan or change from one (1) health plan to another one (1) time per month;

8. You, Your Spouse or Child demonstrate to Us that You meet other exceptional circumstances as the NYSOH may provide;

9. You, Your Spouse or Child were not previously a citizen, national, or lawfully present individual and You gain such status;

10. You, Your Spouse or Child are determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for Cost-Sharing Reductions;

11. You are a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and You and Your Dependents seek to enroll in coverage separate from the perpetrator of the abuse or abandonment;

12. You, Your Spouse or Child apply for coverage during the annual open enrollment period or due to a qualifying event, are assessed by the NYSOH as potentially eligible for Medicaid or Child Health Plus, but are determined ineligible for Medicaid or Child Health Plus after open enrollment ended or more than 60 days after the qualifying event;

Please provide the date of the qualifying event: _____

Step 1: Tell us about you.

You + Highmark = one healthy 2027.

If you're applying for health insurance, you need to complete the next page.

- **Page 8** — Everyone fills this page out with their personal information, even if applying for someone else like a minor child.
- **Page 10** — Fill out this page if you're applying for yourself and anyone else, you're applying on behalf of your dependents and you'll be the policy holder, or you're applying on behalf of a child under 18 for the child's own individual policy.

If you have questions, we are only a phone call away. Keep these important phone numbers handy while you complete your application:

- If you have limited English proficiency or a disability call 1-833-521-1424 (TTY users can call 711) to get assistance with this application free of charge.
- If you have general questions or would like to enroll by telephone call 1-800-888-5407.

Step 1: Tell us about you.

Please fill everything in clearly and mark "N/A" if you need to. Otherwise, the processing of this form might be delayed.

Some basics:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

SEX

◯ Male ◯ Female ◯ Other

DATE OF BIRTH (MM/DD/YYYY)

◯ **Fill in this oval if you don't have a home address. You still need to give a mailing address where we can reach you.**

HOME ADDRESS

APARTMENT NUMBER

CITY, STATE, ZIP CODE

COUNTY

MAILING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)

APARTMENT NUMBER

CITY, STATE, ZIP CODE

COUNTY

HOME PHONE NUMBER (NON-MOBILE)

MOBILE PHONE NUMBER

PREFERRED CONTACT (SELECT ONLY ONE)

◯ Home ◯ Mobile

EMAIL ADDRESS

PREFERRED LANGUAGE SPOKEN (IF NOT ENGLISH)

PREFERRED LANGUAGE READ (IF NOT ENGLISH)

Who is this plan for?

Just fill in the oval that applies.

◯ Just for you.

◯ You and your family.

◯ You're applying on behalf of a child under 18 for his or her own coverage as an individual policy holder.

Donate Life Registry (Must be completed for members age 16 and above only)
Would you like to be added to Donate Life Registry? ◯ Yes ◯ Skip this question

Step 1: About you continued.

Communication preferences:

We can send you electronic communications consisting of email alerts and notifications, if you want. Those communications could include your agreement and outline of coverage, insurance plan notices, member newsletters, and health and wellness notices such as wellness, savings, and more. It'll be easier and faster to review. You can change your preference to paper or digital at any time, or request a print or digital copy by calling the Member Services phone number on the back of your identification (ID) card or visiting **MyHighmark.com**.

So, what do you think?

- ○ **Yes,** let's do this digitally.
- ○ **No,** let's stick to paper.

Go to **MyHighmark.com** to review the Contact Preferences Terms and Conditions for complete details regarding selecting or changing communication preferences.

To ensure that you receive your member materials by your preferred method, you must notify Highmark if your phone number or email address change.

SOCIAL SECURITY OR TAX ID NUMBER	APPLICANT'S LAST NAME	FIRST NAME

Step 1: Tell us about the rest of your family.

Just you? Go to page 13.

If you're applying for coverage for anyone else (let's call them dependents), fill their info in on this sheet. You can add more sheets if you need to.
Eligible dependents include:

- Your spouse or domestic partner
- Your children under the age of 30
- Your spouse or domestic partner's children under the age of 30
- Your unmarried child of any age who is medically certified as totally disabled and dependent upon you

The plan and deductible option you choose will apply to everyone covered by your plan.

Are any of the applicants included in this application that are an unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability (as defined in the New York Mental Hygiene Law), or physical disability and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon you for support and maintenance and will remain covered while your insurance remains in force and your child remains in such condition.

If yes, please state their name(s)

_____

_____

Highmark may require proof of such disability as deemed necessary.

Dependent 1

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

◯ Male ◯ Female ◯ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 1 live with you? ◯ Yes ◯ No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed for members age 16 and above only)
Would you like to be added to Donate Life Registry? ◯ Yes ◯ Skip this question

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Family continued.

Dependent 2

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

◯ Male ◯ Female ◯ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 2 live with you? ◯ Yes ◯ No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed for members age 16 and above only)
Would you like to be added to Donate Life Registry? ◯ Yes ◯ Skip this question

Dependent 3

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

◯ Male ◯ Female ◯ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 3 live with you? ◯ Yes ◯ No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed for members age 16 and above only)
Would you like to be added to Donate Life Registry? ◯ Yes ◯ Skip this question

Dependent 4

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

◯ Male ◯ Female ◯ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 4 live with you? ◯ Yes ◯ No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed for members age 16 and above only)
Would you like to be added to Donate Life Registry? ◯ Yes ◯ Skip this question

Step 1: Family continued.

Dependent 5

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

◯ Male ◯ Female ◯ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 5 live with you? ◯ Yes ◯ No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed for members age 16 and above only)
Would you like to be added to Donate Life Registry? ◯ Yes ◯ Skip this question

Dependent 6

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

◯ Male ◯ Female ◯ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 6 live with you? ◯ Yes ◯ No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed for members age 16 and above only)
Would you like to be added to Donate Life Registry? ◯ Yes ◯ Skip this question

Dependent 7

Basic info:

FIRST NAME

MIDDLE NAME

LAST NAME

SUFFIX

SOCIAL SECURITY OR TAX ID NUMBER

RELATIONSHIP TO YOU

SEX

◯ Male ◯ Female ◯ Other

DATE OF BIRTH (MM/DD/YYYY)

Does dependent 7 live with you? ◯ Yes ◯ No

IF NO, LIST ADDRESS:

Donate Life Registry (Must be completed for members age 16 and above only)
Would you like to be added to Donate Life Registry? ◯ Yes ◯ Skip this question

Step 2: Find a plan.

Coverage that makes you smile.

In this next step, you're going to select your plan.

Step 2: Find a plan in Allegany, Chautauqua, Cattaraugus, Erie, Genesee, Niagara, Orleans, and Wyoming counties.

Choose one plan and deductible option. **Fill in the oval next to the plan you've selected.** Your selection will apply to everyone covered by your plan.

These plans are just for Allegany, Chautauqua, Cattaraugus, Erie, Genesee, Niagara, Orleans, and Wyoming counties.

my Blue Access EX		Annual Deductible	
		Individual	Family
	○ Standard Platinum	$0	$0
	○ Standard Gold	$1,200	$2,400
	○ Standard Silver	$3,750	$7,500
	○ Standard Bronze	$5,025	$10,050
	○ Platinum 0	$0	$0
	○ Platinum 0 + Adult Dental and Vision	$0	$0
	○ Gold 0	$0	$0
	○ Gold 0 + Adult Dental and Vision	$0	$0
	○ Silver 0	$0	$0
	○ Silver 0 + Adult Dental and Vision	$0	$0
	○ Bronze 0 HSA	$0	$0
	○ Bronze 0 HSA + Adult Dental and Vision	$0	$0

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Step 3: Your first payment.

The plan? Now, the check.

When you send this application in, you need to have your first premium payment included with it. We'll walk you through how to calculate that on the next page. If the first payment is not made with your application, your first premium payment will be due by the date printed on your first invoice.

Step 3: Your first payment.

Start by filling in this information:

POLICY HOLDER NAME (FIRST, MIDDLE, LAST)

SOCIAL SECURITY OR TAX ID NUMBER

Now locate your premium rate in your product brochure, or visit www.highmark.com to view it electronically.

Find the monthly premium for your plan based on the amount of people you listed in STEP 1 (that's you + any dependents you listed).

You'll need a check for that amount attached to this form, but fill the details of that check in below.

PAYMENT ENCLOSED

$

GROUP NUMBER

(Group number is the bold, blue eight-digit number; listed above plan selection.)

Once you receive your first invoice, you can head to **MyHighmark.com** to sign up for automatic payments. Auto payments are a more secure and convenient way to pay your bill that eases any stress about making on-time payments. Plus, you won't have to write more pesky checks like this one.

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Step 4: Current coverage.

The hard part is over.

Now we just need to know about any current health insurance you have (coverage you had for 2026).

Everyone fills this in:

1. **Are you or anyone else listed in Step 1** enrolled in a private or governmental group or individual health plan or program at the time of this application?

Yes No

If YES, have you used up all your benefits under that coverage?

Yes No

2. Is any person applying for this coverage entitled to benefits under Medicare Part A or enrolled in **Medicare Part B**?

Yes No

If anyone listed in Step 1 is entitled to benefits under Medicare Part A or enrolled in Medicare Part B, you need to remove them. Those entitled to or enrolled in Medicare can't apply for benefits through this application. Learn more at **ssa.gov** or visit the nearest Social Security Administration office.

3. Is the coverage you're applying for **intended to replace** any accident or health insurance you or anyone in Step 1 currently have? This includes a Highmark policy.

Yes No

SOCIAL SECURITY OR TAX ID NUMBER | APPLICANT'S LAST NAME | FIRST NAME

Step 4: Current coverage.

If you answered yes to 1, 2, or 3:

4. Tell us about any other coverage you and/or your family members have or have applied for:

NAME OF INSURANCE CARRIER

GROUP NUMBER

NAME OF POLICY HOLDER

EFFECTIVE DATE (MM/DD/YYYY)

POLICY NUMBER

RELATIONSHIP TO APPLICANT

POLICY HOLDER'S DATE OF BIRTH (MM/DD/YYYY)

POLICY HOLDER'S EMPLOYMENT STATUS

Everyone fills this in:

5. Will you or any of your family members who are applying for this coverage be receiving premium payment assistance or grants from a third party payer*?

◯ Yes ◯ No ◯ Not Sure

If you answered Yes or I'm Not Sure, please indicate the type of third-party making payments to you or to Highmark on your behalf:

◯ A family member

◯ An Indian Tribe, tribal organization, or urban Indian organization

◯ An employer (Non-CHOICE Arrangement and Non-QSEHRA)

◯ A local, State or Federal government program, including a grantee thereof

◯ A Ryan White HIV/AIDS program

◯ An IRS-recognized 501(c)(3) organization (nonprofit)

◯ A health care provider or supplier

◯ Other (please specify):

◯ CHOICE Arrangement

EMPLOYER NAME:

EMPLOYER IDENTIFICATION NUMBER (EIN)

◯ A Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

EMPLOYER NAME:

EMPLOYER IDENTIFICATION NUMBER (EIN)

*A third party payer would be any person, employer, organization or entity, that is paying all or some portion of your/your family's premium to Highmark, or directly to you/your family by means such as cash, check, money order, prepaid debit card, credit card or electronic fund transfers.

◯ I/we acknowledge that I/we have an ongoing obligation to report to Highmark any changes relating to premium payment assistance or grants made by a third-party payer.

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Step 5: Your signature.

One last thing.

This is going to be a lot of legal language to read. Take a deep breath, you can do this. Once you read it, sign at the bottom to let us know that you agree.

Ready? Let's finish this.

Step 5: Your signature.

My/our signature on this Application indicates that I/we have read and fully understand the following statements:

I/we hereby apply for health care plan coverage for myself and/or my eligible dependents listed on this Application. I/we understand and agree that the terms and conditions of our coverage will be controlled by the written Subscription Agreement and that they may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I/we recognize that our coverage will only apply to admissions that occur and services that are provided on or after the effective date of our coverage.

I/we understand that the Agreement is available only to residents of the geographic area in which the product for which this Application is completed is available and that this Application is subject to the provisions of this Agreement. This Agreement renews on an annual basis. **If the first payment is not made with this Application, the first premium payment is due by the due date printed on your first invoice.** Failure to pay before this due date will result in your Application being canceled. You can also pay your premium monthly in advance to Highmark Blue Cross Blue Shield. If it's convenient, you may pay more than your monthly amount. We will apply excess amounts on a monthly basis. These amounts will be subject to premium increases on the date the increase is effective.

I/we understand that the receipt of the benefits under this program is subject to the determination that the services were medically necessary and appropriate. Except for emergencies or delivery-related admissions, all inpatient admissions are subject to review prior to the proposed admission.

We must receive and process your full premium payment before we can pay claims for any eligible services you receive. If your ongoing monthly premium payments are not received in the full amount within the plan grace period, your plan will be terminated. The termination date will be the last month in which we received your required payment. Claims for eligible services will not be processed unless your current premium has been paid in full. I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

I know that I must tell Highmark Blue Cross Blue Shield if any information I supplied on this Application changes. I must call 1-855-344-3425 to report any changes.

Effective Date Of Coverage

Your plan is effective based on the type of enrollment.

- **If you apply between November 1st and December 15th,** your plan will begin January 1st. If you apply between December 16th and January 15th, your plan will begin February 1st. If you apply between January 16th and January 31st, your plan will begin March 1st.
- **If you're applying during a Special Enrollment Period (SEP),** the effective plan date is based on the application laws for each eligible SEP.

To the best of my/our knowledge and belief, the information provided on this Application is true and correct. I also understand that any attempts to qualify for the program chosen through fraud or other intentional misrepresentation of a material fact will result in termination of my insurance contract.

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 MATERIALTHERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

APPLICANT'S SIGNATURE	DATE

SPOUSE/DOMESTIC PARTNER/PARENT'S SIGNATURE	DATE

NOTICE TO ALL APPLICANTS: If you are applying for coverage that includes your spouse or domestic partner, both you and your spouse/domestic partner must sign this Application form. If you are unmarried, under the age of 18, and applying for a policy that only covers yourself, your parent or guardian must sign. **This application is valid only when completed and signed by the applicant.**

Time to send this away.

Woohoo! You did it. You finished the application. Now, tear out the pages you completed and send them back to us.

Pack this completed, signed application into an envelope with a check for your first payment. Then send it to us here:

Highmark Blue Cross Blue Shield
PO Box 640728
Pittsburgh, PA 15264-0728

That's it, you're done! We can't wait to spend 2027 with you.

All done?

Double-check these items to make sure your application isn't delayed:

- ☐ Make sure you've provided your full Social Security number.
- ☐ If you have a group number, make sure it's filled in.
- ☐ Your check must be included with the application.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- 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 Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, 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 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
Phone: 1-800-368-1019, 800-537-7697 (TDD)

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

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call 1-833-521-1424 (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al 1-833-521-1424 (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die 1-833-521-1424 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nan 1-833-521-1424 (TTY: 711) pou jwenn èd.

U65_None_P_1Col_10pt_blk_1c_2025

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Если нужна помощь, позвоните по телефону 1-833-521-1424 (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero 1-833-521-1424 (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Appelez le 1-833-521-1424 (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìràànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìráàyè si wà pẹlu lọ́fẹ̀ẹ́. Pe 1-833-521-1424 (TTY: 711) fún ìràànlọ́wọ́.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט 1-833-521-1424 (TTY: 711) פאר הילף.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم 1-833-521-1424 (الهاتف النصي: 711) للحصول على المساعدة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打 1-833-521-1424（听障人士专用号码： 711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે 1-833-521-1424 (TTY: 711) પર કૉલ કરો.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Gọi số 1-833-521-1424 (TTY: 711) để được trợ giúp.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि 1-833-521-1424 (TTY: 711) मा कल गर्नुहोस्।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए 1-833-521-1424 (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 1-833-521-1424 (TTY: 711)로 전화하십시오.

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Only producers need to bother with this next section.
If you aren't a producer, you do not need to fill this page out.

If you have questions about completing this application, please call the Producer Line at 1-844-946-6305.

Producers Certificate

If this section is not fully completed, we will not pay a commission.

NATIONAL PRODUCER NUMBER (NPN)

PRODUCER'S NAME (LAST, FIRST, MIDDLE INITIAL)

AGENCY NAME

PRODUCER'S SIGNATURE

BUSINESS PHONE NUMBER

A PRODUCER must complete this section to act on the applicant's behalf.

1. Consider how the applicant answered your questions. Do you know of any factors impacting the applicant's eligibility? What about the applicant's dependents applying for this coverage?

◯ Yes ◯ No

PRODUCER SIGNATURE

DATE

AGENCY

2. Have you provided the applicant with all relevant marketing materials?

◯ Yes ◯ No

3. Have you advised the applicant of the features of the selected product, including satisfying the applicant's deductible(s)?

◯ Yes ◯ No

4. Is this applicant a current customer of Highmark?

◯ Yes ◯ No

5. Have you retained a signed copy of this application for your records?

◯ Yes ◯ No

Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the Application or policy; or
3. Waive any of Highmark Blue Cross Blue Shield's rights or requirements.

HIGHMARK

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120 Fifth Avenue
Pittsburgh, PA 15222-3099

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Internal use only

NATIONAL PRODUCER NUMBER (NPN)

2027

is looking pretty great.



To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to highmark.com or for a paper copy, call 1-855-873-4106.

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