Because Highmark Blue Shield of Northeastern New York (Highmark BSNENY)  s keeping it simple.

Apply in five steps for your new 2023 individual/family Affordable Care Act (ACA) health plan with this application.

If you are applying because you have a Special Enrollment Period, please include this completed application along with the Special Enrollment Period form and all necessary supporting documentation.

If you're enrolling during open enrollment, you can do this digitally. Just scan or click here.

HIGHMARK. NORTHEASTERN NEW YORK

5 steps to apply.

We're glad you're thinking of Highmark BSNENY.

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

This application is for purchasing directly with Highmark BSNENY, 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 17** of this application and select a plan available in the county where you live.
- You meet eligibility guidelines listed in Step 5 on **page 23** of this application.

In the right place? Great.

If you have any questions or want to enroll faster:

Call 1-800-700-8482.

Visit highmark.com/blueshieldneny.

Scan the QR code on the front if you're applying during Open Enrollment. If you're applying during a special enrollment period, we'll need you to complete the paper application.

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/blueshieldneny** 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 23** — 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 BSNENY.** We'll outline all the ways you can do that on **page 24**.

Highmark Blue Shield of Northeastern New York

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 Blue Shield NENY receives the enrollment application on or before December 15, 2022, coverage will begin on January 1, 2023, 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 are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage;

3. 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;

4. 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

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

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 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;

4. 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;

5. 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

6. 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;

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

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

9. 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;

10. 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;

11. 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;

12. You, Your Spouse or Child apply for Medicaid or Child Health Plus coverage during the annual Open Enrollment period and are determined ineligible for Medicaid or Child Health Plus coverage after Open Enrollment has ended; or

13. You, Your Spouse or Child adequately demonstrate to the NYSOH that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a qualified health plan through the NYSOH.

Please provide the date of the qualifying event:

Step 1: Tell us about you.

You + Highmark BSNENY = one healthy 2023.

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

- **Page 10** — Everyone fills this page out with their personal information, even if applying for someone else like a minor child.
- **Page 12** — 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 his or her own individual policy.

If you have limited English proficiency or a disability, call 1-800-700-8482 (TTY users can call 711) to get assistance with this application free of charge.

62404

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.

62404

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 **1-800-700-8482** or visiting **highmark.com/blueshieldneny.**

So, what do you think?

○ **Yes,** let's do this digitally.

○ **No,** let's stick to paper.

Go to **highmark.com/blueshieldneny** to review the Contact Preferences Term 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 BSNENY 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 16.

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 26
- Your spouse or domestic partner's children under the age of 26

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

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:

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 1 live with you? ○ Yes ○ No

IF NO, LIST ADDRESS:

SOCIAL SECURITY OR TAX ID NUMBER

APPLICANT'S LAST NAME

FIRST NAME

Step 1: Family continued.

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 1 live with you? ○ Yes ○ No

IF NO, LIST ADDRESS:

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 1 live with you? ○ Yes ○ No

IF NO, LIST ADDRESS:

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 1 live with you? ○ Yes ○ No

IF NO, LIST ADDRESS:

Step 1: Family continued.

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 1 live with you? ○ Yes ○ No

IF NO, LIST ADDRESS:

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 1 live with you? ○ Yes ○ No

IF NO, LIST ADDRESS:

Dependent 8
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:

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

Step 1: Family continued.

Dependent 9
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:

Dependent 10
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:

Dependent 11
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:

Step 2: Find a plan.

Coverage that makes you  .

In this next step, you're going to select your plan. If you need any help with that, call **1-800-700-8482**.

Or, take a look through the plan brochure. All of the information you need is there.

If you have limited English proficiency or a disability, call 1-800-700-8482
(TTY users can call 711) to get assistance with this application free of charge.

Step 2: Find a plan in Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington 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 Albany, Clinton, Columbia, Essex, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington counties.

Highmark Blue Shield of Northeastern New York: 107075-56		Annual Deductible	
		Individual	Family
	○ Platinum Standard	$0	$0
	○ Gold Standard	$600	$1,200
	○ Gold Destination 65	$500	$1,000
	○ Silver Standard	$1,750	$3,500
	○ Silver Destination 65	$2,500	$5,000
	○ Bronze Standard HSAQ	$6,100	$12,200

Now, jump to page 18 to make your first payment.

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 grab your rate guide, or visit highmark.com/blueshieldneny.

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 highmark.com/blueshieldneny 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 2022).

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 BSNENY 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
- ○ 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):
- ○ An Individual Coverage Health Reimbursement Arrangement (ICHRA)

  EMPLOYER NAME:
- ○ A Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

  EMPLOYER NAME:

* 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 BSNENY 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 Shield of Northeastern New York. 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 BSNENY if any information I supplied on this Application changes. I must call 1-800-544-6679 to report any changes.

If your Application is accepted, you agree to resolve any and all disputes, claims, or controversies arising out of or relating in any way to the Agreement that is issued or any service for which benefits are provided thereunder through binding arbitration rather than litigation in court. Your agreement to arbitrate applies to disputes between you and Highmark BSNENY or any of Highmark BSNENY's parents, subsidiaries, affiliates, officers, directors, employees, or agents. Any such disputes, claims, or controversies may only be brought individually and not in concert with other individuals who are not covered under the Agreement, unless otherwise agreed to by Highmark BSNENY. Judgment may be entered on any arbitration award in any court having jurisdiction. The party filing arbitration may choose to file before JAMS, the American Arbitration Association, or any other organization or arbitrator mutually agreed to by the parties. New York law will apply.

Effective Date Of Coverage

Your plan is effective based on the type of enrollment.

- **If you apply between November 16 and December 15,** your plan will begin January 1, 2023. If you apply between December 16 and January 15, your plan will begin February 1, 2023. If you apply between January 16 and January 31, your plan will begin March 1, 2023.
- **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 MATERIAL THERETO, 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.

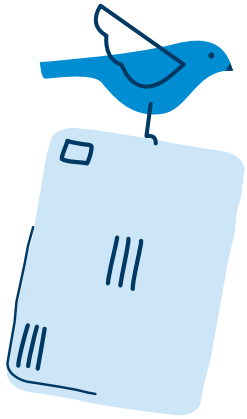
APPLICANT'S SIGNATURE

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 Shield of Northeastern New York
PO Box 640728
Pittsburgh, PA 15264-0728

That's it, you're done! We can't wait to spend 2023 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.

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

Producer's 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 his/her 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 product that he/she has selected, including satisfying his/her deductible(s)?

○ Yes ○ No

4. Is this applicant a current customer of Highmark BSNENY?

○ 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 any of Blue Shield of Northeastern New York's rights or requirements.

HIGHMARK NORTHEASTERN NEW YORK

Highmark Blue Shield of Northeastern New York
120 Fifth Avenue
Pittsburgh, PA 15222-3099

Highmark Blue Shield of Northeastern New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

Internal use only

NATIONAL PRODUCER NUMBER (NPN)

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)
- 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, please call the customer service number on the back of your member ID card or 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, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-24 75, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US 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 US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

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

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

.פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Diné k´ehjí yá´áti´bee shíká adoowot nohsingo naaltsoos nihaa halne´go nidaahtinígíí bine´déé´ Customer Service bibéésh bee hane´é biká'ígíí bich´j´dahodootnih.

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