SPECIAL ENROLLMENT PERIOD FORM

A Special Enrollment Period is defined as a period during which you and your family have a right to sign up for new or make changes to existing health insurance coverage. Special Enrollment Period qualifying life events include, but are not limited to, certain permanent moves, certain changes in your income and changes in your family size (such as if you marry, birth or adoption) or lose coverage. If you are enrolled in a plan purchased outside of the Marketplace that counts as minimum essential coverage in most instances consumers have 60 days from the occurrence of the qualifying life event to sign up for or make changes to existing coverage; however there are some instances defined in the chart below that allows 60 days before and after a qualifying life event to sign up for or make changes to existing coverage.

This Special Enrollment Period Form CANNOT be used to make changes to coverage purchased from the Health Insurance Marketplace or to purchase new coverage from the Health Insurance Marketplace. To make such changes or purchases, you must contact the Health Insurance Marketplace directly.

If you would like to change plans due to a qualifying life event, you must complete this Special Enrollment Period Form and return it with a completed application and return them with any necessary supporting documents. Select the appropriate qualifying life event below and sign the form. The listing of qualifying life events is subject to change. If you do not see the qualifying event that describes your situation, please contact us at 1-877-959-2550.

ALL MATERIALS, INCLUDING SUPPORTING DOCUMENT(S), MUST BE PROVIDED BEFORE COVERAGE WILL BEGIN. FAILURE TO PROVIDE ALL MATERIALS, INCLUDING ANY SUPPORTING DOCUMENTS (LISTED BELOW) TO PROVE ELIGIBILITY, MAY DELAY YOUR ENROLLMENT OR CAUSE YOU TO BE DENIED COVERAGE.

POLICY HOLDER INFORMATION				
LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF EVENT
STREET ADDRESS	CITY		STATE	ZIP CODE
			PA	

QUALIFYING LIFE EVENT	COVERAGE EFFECTIVE DATE	SUPPORTING DOCUMENTS
❑ Birth ❑ Adoption ❑ Placed for Adoption ❑ Placed in Foster Care ❑ Court Order	Date of birth, adoption, placement for adoption or foster care OR the first day of the month following the event date. For court order, date the order is effective or if plan selection is between 1st and 15th of the month, your coverage will start on the 1st day of the following month. If the plan selection is between the 16th and end of the month, your coverage will start the 1st day of the second month. The coverage effective date cannot be prior to the occurrence of the event. Effective date requested:_____	❑ Birth Certificate ❑ Existing Highmark member with proof of claims for birth ❑ Legal papers for Adoption or Foster Care ❑ Court Order
❑ Marriage ❑ Domestic Partnership	First day of the month following plan selection. The coverage effective date cannot be prior to the occurrence of the event.	❑ Marriage certificate or ❑ Domestic partnership certification
❑ Loss of pregnancy related or medically needy coverage under Medicaid. ❑ Loss of Minimum Essential Coverage (includes but not limited to): - Loss of eligibility for employer sponsored coverage due to job loss or reduction in hours - Employer no longer offers benefits or closes - Legal separation/Divorce from policy holder	Notification can be 60 days prior to and 60 days after the loss of coverage. If plan selection is before or on the date of loss of coverage the effective date is the first day of the month following the loss of coverage. If plan selection is after the loss of coverage the effective date is the first day of the month following the plan selection. Coverage effective date cannot be prior to the occurrence of the event.	Documentation showing loss of medically needy coverage or Minimum Essential Coverage, including: • Termination Date • People covered by the plan ❑ Letter of termination from carrier/ insurance company (includes dependent age max reached) ❑ Notice of termination of government sponsored coverage

QUALIFYING LIFE EVENT	COVERAGE EFFECTIVE DATE	SUPPORTING DOCUMENTS
- Employee/policy holder becomes Medicare entitled - Death of policy holder - Child loses dependent status - Loss of eligibility for Medicaid or CHIP - Expiration of COBRA or non-calendar year policy *NOTE: Voluntarily quitting other health insurance coverage or being terminated for not paying premiums are not considered losses of minimum essential coverage. Losing health insurance coverage that is not minimum essential coverage is also not considered a loss of minimum essential coverage.*		❑ Letter/notice of termination of benefits from the employer (includes divorce from policy holder, death of policy holder or policy holder becomes Medicare entitled) ❑ COBRA eligibility notice or documentation showing that COBRA coverage or non-calendar year policy is ending *NOTE: Documentation of prior coverage ending is not required if a Highmark plan is being replaced and is indicated on the application for individual/family plan health insurance.*
❑ A permanent move to a new area that offers different health plan options. Includes: • Release from incarceration • Return from active military service	If the plan selection is between the 1st and 15th of the month, your coverage will start as soon as the 1st day of the following month. If the plan selection is between the 16th and end of the month, your coverage will start the 1st day of the second month. The coverage effective date cannot be prior to the occurrence of the event.	❑ Notice from carrier no longer providing health insurance coverage ❑ Proof of new residence such as dated rental/lease agreement, deed, purchase agreement, new driver's license or state photo ID card ❑ A utility bill in the applicant's name and containing the new address ❑ Prison release form ❑ Supporting paperwork confirming departure date from active military service
❑ A change in income, household or other status that affects eligibility for Advance Premium Tax Credits (APTC) or Cost-sharing Reductions (CSR). Must currently be enrolled in a Qualified Health Plan.	If the plan selection is between the 1st and 15th of the month, your coverage will start as soon as the 1st day of the following month. If the plan selection is between the 16th and end of the month, your coverage will start the 1st day of the second month. The coverage effective date cannot be prior to the occurrence of the event.	❑ Copy of Health Insurance Marketplace eligibility notice
❑ Determine to be newly eligible for Advance Premium Tax Credit (APTC) due to not being eligible for coverage by an eligible employer sponsored plan	Notification can be 60 days prior to and 60 days after the loss of coverage. If plan selection is before or on the date of loss of coverage the effective date is the first day of the month following the loss of coverage. If plan selection is after the loss of coverage the effective date is the first day of the month following the plan selection. Coverage effective date cannot be prior to the occurrence of the event.	❑ Copy of Health Insurance Marketplace eligibility notice

QUALIFYING LIFE EVENT	COVERAGE EFFECTIVE DATE	SUPPORTING DOCUMENTS
❑ The Health Insurance Marketplace determined that an unintentional enrollment error is the result of an action or omission by an agent of the Health Insurance Marketplace or Non-Health Insurance Marketplace entry.	Coverage effective date will be determined by the Health Insurance Marketplace. You must send in the necessary supporting documentation from the Health Insurance Marketplace along with this form and a completed application.	❑ Copy of Health Insurance Marketplace eligibility notice
❑ The Health Insurance Marketplace determines that there has been a violation of a material provision of the health insurance plan in which you or a dependent are enrolled. Must currently be enrolled in a Qualified Health Plan.	Coverage effective date will be determined by the Health Insurance Marketplace. You must send in the necessary supporting documentation from the Health Insurance Marketplace along with this form and a completed application.	❑ Copy of Health Insurance Marketplace eligibility notice

To the best of my/our knowledge and belief, the information provided on this Special Enrollment Period Form is true and correct.

I also understand that any attempts to make a change to current enrollment through fraud or other intentional misrepresentation of a material fact will result in termination of such 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 subjects such person to criminal and civil penalties.

POLICYHOLDER'S SIGNATURE	DATE

Notice to All Applicants: If you are applying for coverage due to a Special Enrollment Period, you must sign this Special Enrollment Period Form. If you are unmarried, under age 18 and applying for a policy that only covers yourself, your parent or guardian must sign. Note: The deductible amount and out-of-pocket maximum for your new individual coverage will reset on January 1st.

You MUST send in a completed Special Enrollment Period form along with a completed application and any supporting documentation or we will not be able to process your new coverage.

To submit you can:

- Mail to: Highmark Blue Cross Blue Shield
  P.O. Box 382555
  Pittsburgh, PA 15250-8555
- Fax to Highmark at 1-866-224-5403
- Call a Highmark licensed representative at 1-877-959-2550
- Visit your insurance agent
- Visit a Highmark Direct store

FOR PRODUCER USE ONLY	
PRINT PRODUCER NAME	
PRODUCER SIGNATURE	DATE

By signing this Special Enrollment Period Form I do hereby attest, acknowledge and agree to the following:

- The Policyholder has designated me as their authorized representative in compliance with all applicable state and federal laws, rules, regulations and guidelines;
- I have read this Special Enrollment Period Form to the Policyholder required to sign this Form and such Policyholder ACCEPTS the terms and conditions set forth in this Form;
- I will immediately send a copy of this completed and submitted Special Enrollment Period Form to the Policyholder in a secure manner in compliance with all applicable state and federal laws, rules, regulations and guidelines; and
- I have retained a copy this completed and submitted Special Enrollment Period Form for my records.

Blue Cross Blue Shield Agency No.							Producer No.							

Insurance may be provided by Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Choice Company. Highmark Blue Cross Blue Shield, Highmark Health Insurance Company and Highmark Choice Company are independent licensees of the Blue Cross and Blue Shield Association. Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association. Highmark is a registered mark of Highmark Inc. Information regarding the Patient Protection and Affordable Care Act of 2010 (a.k.a. "PPACA", "Affordable Care Act", "ACA", and/or "Health Care Reform"), as amended, and/or any other law, does not constitute legal or tax advice and is subject to change based upon the issuance of new guidance and/or change in laws. State laws may be applicable. Any review of materials, request for information, or application does not obligate you to enroll for coverage. Please request the Outline of Coverage for details on benefits, conditions and exclusions. Providing your information is voluntary. We are committed to providing outstanding services for our applicants and members. Highmark does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations. To find more information about Highmark's benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4106.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call us at 1-877-959-2550 to request these free services. (TTY/TDD: 711)

Estamos comprometidos a ofrecer servicios excepcionales a nuestros solicitantes y miembros. Si usted necesita ayuda especial, incluyendo acomodaciones para discapacidades o dominio limitado del inglés, por favor llámenos al 1-877-959-2550 para solicitar estos servicios gratuitos. (TTY/TDD: 711)

我們致力於為我們的申請人和會員們提供卓越的服務。如果您需要特殊協助，包括殘障或英語能力有限，請致電1-877-959-2550來要求這些免費服務。(TTY/TDD: 711)

May pananagutan kaming magbigay ng bukod-tanging mga serbisyo para sa aming mga aplikante at mga miyembro. Kung kailangan mo ng espesyal na tulong, kabilang ang mga akomodasyon para sa mga kapansanan o limitadong kahusayan sa wikang Ingles, mangyaring tawagan kami sa 1-877-959-2550 para hilingin ang mga libreng serbisyong ito. (TTY/TDD: 711)

Nihinaanish niizhónígo bee nihiká' adiilwołígíí binahji' ts'ídá yéego bidiilkaal, nihí naaltsoos nidahoníłígíí dóó Bee Atah ídlínígíí nihił hada'dít'éhígíí nihá. Bilagáana bizaad doo hazhó'ó bik'i'diitiihgó, áká'a'ayeed nínízingo, béésh bee hane'é bikáá', éí éí 1-877-959-2550, t'áá jíík'eh níká' idoowołgo át'é. T'ááyó nijéékałgo éí TTY chodayooł'ínígíí 711 nídíígis dóó bich'į' hólne' dooleeł, díí éí t'áá jíík'eh níká' idoowoł.