HIGHMARK
Blue Cross Blue Shield

SUPPLEMENT VISION COVERAGE APPLICATION

PLEASE PRINT ALL ENTRIES

SOCIAL SECURITY NUMBER

GROUP NO.

REQUESTED START DATE

MR.
MRS.
MISS

LAST NAME | FIRST NAME | MIDDLE NAME

HOME PHONE NO.

CUSTOMER NUMBER

STREET ADDRESS

HIRE DATE

CITY | STATE | ZIP CODE

YOUR BIRTHDATE
MO. | DAY | YR.

NAME OF EMPLOYING COMPANY

PRINT SPOUSE'S FIRST NAME AND INITIAL

HUSBAND 02
WIFE 05

SPOUSE'S BIRTHDATE
MO. | DAY | YR.

CHECK THE COVERAGE EMPLOYEE IS ELIGIBLE FOR

INDIVIDUAL | FAMILY

LIST ADDITIONAL DEPENDENTS ON REVERSE SIDE

I hereby apply to be enrolled for the coverage which my employer has indicated in the box to the right hereof. If enrolled, I hereby authorize a provider of any covered service to furnish Highmark Blue Cross Blue Shield the medical information and records necessary to process claims.

SIGNATURE: _____ DATE: _____

- Fashion Advantage Option I ☐
- Fashion Advantage Option V ☐
- Fashion Advantage Gold Option I ☐
- Fashion Advantage Gold Option V ☐

'100% firm participation required.

(Not all options may be available to your group.)

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