Important eligibility information

Dear Member:

Thank you for your interest in the Keystone Health Plan East (Keystone) Guest Membership Program. Enclosed is an application for enrollment in the program as well as an "Other Insurance" questionnaire. Please complete the application and questionnaire and return both forms in the postage-paid envelope provided.

Once the completed application and other insurance information are reviewed and approved, the Guest Membership request will become effective – about 15 days after Keystone receives the completed forms. The Blue Cross® plan that will be hosting the Guest Membership will then forward member materials directly to the Guest Member. These may include an ID card, benefits descriptions, and information about providers in the service area.

SELECT A PCP

Be sure to select a primary care physician (PCP) with the host Blue Cross plan. The host PCP will coordinate care any time you or a covered family member is temporarily out of the Keystone Health Plan East service area.

Please note that the host Blue Cross plan will cover you for medical care only. If you require prescriptions, vision care, dental care, or behavioral health services (if covered by your employer through Keystone), contact Keystone at the number listed on your Keystone ID card.

EXPIRATION OF GUEST MEMBERSHIPS

Guest Memberships are approved for a specified amount of time depending on the type of Guest Membership and the employer's group renewal date. For coverage to remain effective, the subscriber must be an active employee within the employer group. If a Guest Member is a dependent, that individual must remain an eligible dependent of the subscriber for coverage to be effective.

Be sure to contact the Keystone Member Services Department to continue a Guest Membership after the termination date noted on the top right hand corner of the Guest Membership application. We recommend that you contact our office approximately 30 days prior to the termination date. Please note that not all Guest Membership types are eligible for renewal. A Member Services Representative can advise you whether you are eligible for renewal.

USING GUEST MEMBERSHIP SERVICES

While the Guest Member is within the host plan's service area, the Guest Member must present the identification card for that plan if he or she requires health care services. If the member travels outside of the host plan's service area, his or her Keystone Health Plan East card should be presented. Be sure to read the instructions on the back of the Keystone Health Plan East card for obtaining out-of-area care.

Keystone Health Plan East should be contacted if the Guest Member's address changes. We will notify the Host Plan of any changes.

Again, thank you for your interest in the Guest Membership Program. Please feel free to call us at the telephone number on your Keystone Health Plan East identification card with any questions.

Keystone Health Plan East

Away From Home Care Guest Membership Application

Please print clearly. Application must be completed and signed by the subscriber.

Today's date: _____ Guest membership termination date:

Subscriber information

Subscriber Subscriber's address: Street/Apt. # City State Zip code Telephone: _____	Group name: Group ID # Subscriber ID #
The applicant is not eligible for guest membership if the subscriber has moved outside of the Keystone service area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.	

Guest member information

Name: Social Security number Gender: ☐ Male ☐ Female Relationship to subscriber	Away from home address: Street Apt # City State Zipcode County Phone Cell phone

Other guest members

Name	Social Security No.	Gender	Relationship to subscriber
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

Provide full address to ensure receipt of ID cards and other information. If each guest member has a separate mailing address, provide address information for each member. Please include P.O. box, dorm room number, or mail stop number.

Guardian information

Guardian name

Guardian's relationship to guest member

When applying for guest membership for a minor under age 18, you must supply the name of guardian with whom that minor resides, and state the relationship.

Keystone Health Plan East

Away From Home Care Guest Membership Application

Guest membership details

Length of guest membership

How long will the member be out of the area? _____ (date range)

Members must be away for a *minimum* of 90 days to be eligible for a guest membership. The maximum time for a guest membership is:

- Long-term Traveler: 6 months (nonrenewable)
- Families Apart: 1 year (renewable)
- Students: 1 year (renewable while enrolled in an accredited program until the age limitation is met).

Reason for applying for guest membership

Please select the type of guest membership that you are seeking:

☐ **Long-term Traveler**. Available to qualified subscribers, their spouses, and dependents. This type of guest membership is typically used for long-term work assignments or for a retiree with a dual residence.

☐ **Families Apart.** Available to spouses or dependents only who do not reside with the subscriber; the subscriber is not eligible. This type of guest membership is typically used when divorced or separated families permanently reside outside the Keystone service area.

☐ **Student.** Available to qualified dependents who are temporarily residing outside of the Keystone service area while attending an accredited education institution. The dependent may not reside with the subscriber.

Name of the out-of-area host plan :
(Potential guest members must reside in the service area of another participating HMO plan in order to obtain guest membership).

Additional instructions

- **Preventing delays in your application.** Please complete and attach the Other Insurance Questionnaire to help prevent delays in processing your application.
- **Confirming when guest membership starts and ends.** Call Customer Services at the phone number on your member ID card to confirm the effective and termination dates of the guest membership. (The effective date of the guest membership coverage is 15 days after a correctly completed and signed application is received and processed by the Away From Home Care Department.) Guest memberships are approved for a specified period of time that depends on the type of guest membership and the employer's group renewal date.
- **Making sure your guest membership coverage is active.** For coverage to remain effective, the subscriber's coverage must remain active with the employer group. In addition:
  - If the guest member is a dependent, he or she must remain an eligible dependent of the subscriber for coverage to be effective.
  - For student guest membership, remember to keep up with the student verification requirements of your plan.
- **Renewing guest membership.** You must renew your guest membership for a spouse or dependent 30 days before the one-year guest membership period ends or before your group's open enrollment (renewal) date, whichever is sooner.
- **Notifying us each time you move in or out of the area.** Call Customer Service each time guest members move in or out of the Keystone service area so that we may ensure the guest member may receive services and is assigned the proper primary care physician. You must notify us whenever the following happens:
  - When a guest member comes home for break or a short period of time.
  - When a guest member returns to the away-from-home area.

If you have questions and need help, call Customer Service at the number on the back of your ID card.

Away From Home Care Guest Membership Application

Subscriber signature

I hereby certify that all information in the guest membership application is truthful and correct to the best of my knowledge. I acknowledge that the benefits program providing coverage to me or eligible dependents as guest members of the host HMO may vary from the benefits program at my home HMO. I understand that as a guest member, the host HMO benefits program's scope and levels of coverage apply.

Subscriber's signature _____ Date _____

AFHC coordinator's use only

Date received _____ Effective date _____ Approved by _____

Keystone Health Plan East

Other Insurance Questionnaire

Please complete the following questionnaire for all members of your household. Completion of this questionnaire, which concerns other insurance coverage, is required to process your request for guest membership.

Section 1

Do you or someone else in your household have other insurance?

☐ No. If *no*, please proceed to Section 2.
☐ Yes. If *yes*, please complete Section 1 before going to Section 2.

Who is the subscriber of the other insurance? (Please list all)

Name (Subscriber #1): _____ Date of birth: _____

Name (Subscriber #2): _____ Date of birth: _____

Who else is covered by the other insurance? (Please list all)

Subscriber #1	**Subscriber #2**
Dependent #1 _____	Dependent #1 _____
Dependent #2 _____	Dependent #2 _____
Dependent #3 _____	Dependent #3 _____

Is the subscriber of the other insurance employed?

☐ No
☐ Yes. If *yes*, please complete the employer information for each applicable subscriber

Employer information (subscriber #1)	**Employer information (subscriber #2)**
_____ Employer	_____ Employer
_____ Employer address	_____ Employer address
Employer phone number: _____	Employer phone number: _____

Please fill out the other insurance information for each applicable subscriber

Subscriber #1	**Subscriber #2**
_____ Insurance company name	_____ Insurance company name
Policy number: _____	Policy number: _____
Effective date: _____	Effective date: _____
Type of benefits (check all that apply):	Type of benefits (check all that apply):
☐ Health/Medical	☐ Health/Medical
☐ Prescription drug	☐ Prescription drug
☐ Dental	☐ Dental
☐ Vision	☐ Vision

Section 2

Are you or someone else in your household (spouse or dependent) covered by Medicare?
- ☐ No. If *no*, please proceed to the *Employee signature* section
- ☐ Yes. If *yes*, please complete Section 2.

Please supply the names, ID numbers, effective coverage dates, and reason for Medicare eligibility for each Medicare beneficiary.

Medicare beneficiary #1	**Medicare beneficiary #2**
_____	_____
Name	Name
ID number: _____	ID number: _____
What is the effective date of coverage for:	What is the effective date of coverage for:
Part A: _____ Part B: _____	Part A: _____ Part B: _____
Reason for Medicare eligibility (please check all that apply): ☐ Age ☐ Disability ☐ End-stage renal disease	Reason for Medicare eligibility (please check all that apply) ☐ Age ☐ Disability ☐ End-stage renal disease
Are you retired? ☐ No ☐ Yes, I retired on (date): _____	Are you retired? ☐ No ☐ Yes, I retired on (date): _____

Subscriber signature

I hereby certify that all information in this questionnaire is truthful and correct to the best of my knowledge.

_____ _____
Subscriber's signature Date