# AWAY FROM HOME CARE GUEST MEMBERSHIP APPLICATION

Please print clearly. Application must be completed and signed by the subscriber. All five pages must be completed and returned.

Today's date: _____ Guest membership termination date**:** _____

## SUBSCRIBER INFORMATION

Subscriber:_____ Group name (Employer): _____

Subscriber's address: _____Street/Apt. # _____ Group ID # _____

City _____ State _____ Zip code_____ Subscriber ID # _____

Home telephone: _____ Alternative phone:_____

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

Guest member name:
_____

Social Security number:
_____

Gender: ☐ Male ☐ Female

Relationship to subscriber
_____

Away from home address:
_____

Street/Apt #_____

City _____ State _____ Zip code _____

County _____

Phone _____ Cell phone _____

### Other members applying for a Guest Membership

| Name | Social Security No. | Gender (M/F) | Away from Home Address |
|---|---|---|---|
| | | | |
| | | | |

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 for each guest member.

## 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

**GUEST MEMBERSHIP DETAILS:**

**Length of Guest Membership**_____

**How long will the member be out of the area?** _____

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 as follows:

- Long Term Traveler: 6 months (non-renewable)
- Families Apart: 1 year (renewable)
- Students: 1 year (renewable while enrolled in an accredited program until age imitation is met.)

**Reason for applying for guest membership**

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

 **Long-term Traveler** guest membership is 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** guest membership is available to spouses or dependents 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 of the Keystone service area.

**Student** guest membership is available to qualified dependents who are temporarily residing outside of the Keystone service area while attending an accredited education institute. The dependent may not reside with the subscriber.

**Important 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 Service 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.**



**SUBSCRIBER SIGNATURE**

# KEYSTONE HEALTH PLAN EAST

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**

Effective Date _____ Approved By_____

# KEYSTONE HEALTH PLAN EAST

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** _____

Dependent #1 _____

Dependent #2 _____

Dependent #3 _____

**Subscriber #2** _____

Dependent #1 _____

Dependent #2 _____

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 : _____

Employer address: _____

_____

Employer phone number: _____

**Employer information (subscriber #2)**

Employer:_____

Employer address: _____

_____

Employer phone number: _____

**Please fill out the other insurance information for each applicable subscriber**

**Subscriber #1**

Insurance company name _____

Policy number: _____

Effective date: _____

Type of benefits (check all that apply):

- Health/Medical
- Prescription drug

**Subscriber #2**

Insurance company name _____

Policy number: _____

Effective date: _____

Type of benefits (check all that apply):

- Health/Medical

- Dental
- Vision

- Prescription drug
- Dental
- 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):** | **Reason for Medicare eligibility (please check all that apply):** |
| ☐Age | ☐Age |
| ☐Disability | ☐Disability |
| ☐End-stage renal disease | ☐End-stage renal disease |
| **Are you retired?** | **Are you retired?** |
| ☐ No | ☐ No |
| ☐ Yes, I retired on (date):_____ | ☐ 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