

# Application for Individual and Family Vision Coverage

Vision Coverage is underwritten by QCC Insurance Company

## Instructions:

1. This Application should be used if you wish to enroll in an individual Adult Vision plan purchased directly from Independence Blue Cross. The health plans available through this Application are not eligible for federal premium tax credits or cost sharing reductions available under the health care law.
2. Please complete all sections and print clearly in black ink.
3. Read carefully and sign the enclosed ***Declarations and Conditions of Enrollment***.
4. Provide information about your spouse, domestic partner, and dependents, if they are also applying for coverage. If you need additional space, attach a separate sheet with your signature and date.  
(Sections C and G)
5. Select one of the following payment options for your adult vision plan.

### First payment:

- Credit/debit and prepaid debit cards are accepted for the first month's premium. You can:
- Pay by phone by calling 1-888-879-4891 (TTY: 771)
- Or, visit [ibx4you.com/payment](http://ibx4you.com/payment) for instructions on how to pay online through e-Bill

If you would rather make your first payment by check, mail it along with this application to the address on the form.

### Ongoing payments:

For instructions on how to set up ongoing payments, visit [ibx4you.com/payment](http://ibx4you.com/payment) or call 1-866-346-2081 (TTY: 711).

**Important:** Receipt of your initial payment does not constitute enrollment in this program. Your coverage will not begin until this application has been processed, an effective date assigned, and your payment received. Failure to provide all information requested may result in a delay in the processing of your application. If we are unable to process your application, your check will be returned by mail.

6. Once your materials are complete, be sure to make a copy for your records. Mail your application to:

Independence Blue Cross  
P.O. Box 8240  
Philadelphia, PA 19101

All future premium payments should be remitted to the address on your monthly invoice.

The collection of Race, Ethnicity, and Language data is confidential and voluntary. We are collecting this information as part of our efforts to support equitable, whole-person coverage. This data may be analyzed by our data analysts to support equitable, whole-person health initiatives. For information regarding the Plan's policies and procedures for managing access to and use of race/ethnicity, and language data, including: controls for physical and electronic access to the data, permissible use of the data, as well as impermissible use of the data, please refer to the Notice of Privacy Practices at [ibx.com/privacy-policy](http://ibx.com/privacy-policy).

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-844-762-2140, Monday through Friday, between 8 a.m. and 6 p.m. You can also apply online by visiting us at [ibx4you.com/vision](http://ibx4you.com/vision).



For office use only

Application ID: \_\_\_\_\_

Account ID: \_\_\_\_\_

### Application for Vision Care Individual Coverage

The Adult Vision Individual Coverage is underwritten by QCC Insurance Company\*

In order to be eligible for coverage, the following must be true:

- The primary applicant must be 19 or older.
- Applicants are residents of Bucks, Chester, Delaware, Montgomery, or Philadelphia counties in Pennsylvania.
- Dependent children must be between 19 - 26 years old for Adult plans.

### SECTION A — Plan Selections

Type of coverage	Reason for application	Method of payment	For office use only
Individual only Individual and spouse or domestic partner Individual and child(ren) Family	New enrollment Add spouse/domestic partner Add dependent child(ren) Renewal (plan change)	Check enclosed Check Card / Debit Card / Pre-Paid Debit Card (first payment only) – call 1-888-879-4891 or visit <a href="http://ibx4you.com/payment">ibx4you.com/payment</a>	Effective date:  _____

Choice of Plan			
Standalone Vision Care			
Adult Vision Care 150	Family Vision Care 150	Adult Vision Care 200	Family Vision Care 200

### SECTION B — Primary Applicant Information (must be 19 or older)

Primary applicant name: Last, first, middle initial			
Social Security Number (required)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:
_____	____ / ____ / ____	_____	M      F      Intersex
Racial Identity (select all that apply) †			
American Indian or Alaska Native	Asian	Black or African American	
Native Hawaiian or Other Pacific Islander	White	Unknown	
Other	Prefer not to answer		
Ethnic Identity			
Hispanic/Latino	Non-Hispanic/Latino	Other	
Unknown	Prefer not to answer		

\*Available to eligible individuals only (see section G: Declarations and Conditions of Enrollment).

†The information regarding demographic factors: (1) will be maintained as private; (2) may not be used by the insurer for eligibility determinations, underwriting, or rating purposes; and (3) the insurer will not deny an application based on the applicant's refusal to answer the questions related to demographic data.



## SECTION B — Primary Applicant Information (continued)

Preferred Language					
English	Spanish	Chinese			
Italian	Portuguese	Other			
Prefer not to answer					
Cultural Identity (Select up to 5)					
Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Cuban
Nanticoke Lenni-Lenape	Chinese	Haitian	Micronesian	German	Dominican (Dominican Republic)
Navajo	Filipino	Jamaican	Native Hawaiian	Irish	Guatemalan
Powhatan Renape Nation	Korean	Nigerian	Polynesian	Italian	Mexican
Ramapough Lenape Indian Nation	Vietnamese	West Indian	Samoan	Polish	Puerto Rican
Other	Prefer not to answer				

## SECTION C — Family Information (if applying)\*

Spouse/Domestic Partner name: Last, first, middle initial			
Social Security Number (required)	Birth date (mm/dd/yy)	Age	Sex assigned at birth:
_____	___ / ___ / ___	_____	M      F      Intersex
Racial Identity (select all that apply)			
American Indian or Alaska Native	Asian	Black or African American	
Native Hawaiian or Other Pacific Islander	White	Unknown	
Other	Prefer not to answer		
Ethnic Identity			
Hispanic/Latino	Non-Hispanic/Latino	Other	
Unknown	Prefer not to answer		
Preferred Language			
English	Spanish	Chinese	
Italian	Portuguese	Other	
Prefer not to answer			

\*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

**SECTION C — Family Information (continued)\***

Cultural Identity (Select up to 5)					
Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Cuban
Nanticoke Lenni-Lenape	Chinese	Haitian	Micronesian	German	Dominican (Dominican Republic)
Navajo	Filipino	Jamaican	Native Hawaiian	Irish	Guatemalan
Powhatan Renape Nation	Korean	Nigerian	Polynesian	Italian	Mexican
Ramapough Lenape Indian Nation	Vietnamese	West Indian	Samoan	Polish	Puerto Rican
Other	Prefer not to answer				

Dependent name: Last, first, middle initial				
Social Security Number (required)		Birth date (mm/dd/yy)	Age	Sex assigned at birth:
_____		____ / ____ / ____	_____	M      F      Intersex
Racial Identity (select all that apply)				
American Indian or Alaska Native		Asian	Black or African American	
Native Hawaiian or Other Pacific Islander		White	Unknown	
Other		Prefer not to answer		
Ethnic Identity				
Hispanic/Latino		Non-Hispanic/Latino		Other
Unknown		Prefer not to answer		
Preferred Language				
English		Spanish	Chinese	
Italian		Portuguese	Other	
Prefer not to answer				

\*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

**SECTION C — Family Information (continued)\***

Cultural Identity (Select up to 5)					
Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Cuban
Nanticoke Lenni-Lenape	Chinese	Haitian	Micronesian	German	Dominican (Dominican Republic)
Navajo	Filipino	Jamaican	Native Hawaiian	Irish	Guatemalan
Powhatan Renape Nation	Korean	Nigerian	Polynesian	Italian	Mexican
Ramapough Lenape Indian Nation	Vietnamese	West Indian	Samoan	Polish	Puerto Rican
Other	Prefer not to answer				

Dependent name: Last, first, middle initial				
Social Security Number (required)		Birth date (mm/dd/yy)	Age	Sex assigned at birth:
_____		____ / ____ / ____	_____	M      F      Intersex
Racial Identity (select all that apply)				
American Indian or Alaska Native		Asian	Black or African American	
Native Hawaiian or Other Pacific Islander		White	Unknown	
Other		Prefer not to answer		
Ethnic Identity				
Hispanic/Latino		Non-Hispanic/Latino		Other
Unknown		Prefer not to answer		
Preferred Language				
English		Spanish	Chinese	
Italian		Portuguese	Other	
Prefer not to answer				

\*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

**SECTION C — Family Information (continued)\***

Cultural Identity (Select up to 5)					
Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Cuban
Nanticoke Lenni-Lenape	Chinese	Haitian	Micronesian	German	Dominican (Dominican Republic)
Navajo	Filipino	Jamaican	Native Hawaiian	Irish	Guatemalan
Powhatan Renape Nation	Korean	Nigerian	Polynesian	Italian	Mexican
Ramapough Lenape Indian Nation	Vietnamese	West Indian	Samoan	Polish	Puerto Rican
Other	Prefer not to answer				

Dependent name: Last, first, middle initial				
Social Security Number (required)		Birth date (mm/dd/yy)	Age	Sex assigned at birth:
_____		____ / ____ / ____	_____	M      F      Intersex
Racial Identity (select all that apply)				
American Indian or Alaska Native		Asian	Black or African American	
Native Hawaiian or Other Pacific Islander		White	Unknown	
Other		Prefer not to answer		
Ethnic Identity				
Hispanic/Latino		Non-Hispanic/Latino		Other
Unknown		Prefer not to answer		
Preferred Language				
English		Spanish	Chinese	
Italian		Portuguese	Other	
Prefer not to answer				

\*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

## SECTION C — Family Information (continued)\*

Cultural Identity (Select up to 5)					
Cherokee	Asian Indian	African	Guamanian or Chamorro	English	Cuban
Nanticoke Lenni-Lenape	Chinese	Haitian	Micronesian	German	Dominican (Dominican Republic)
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Powhatan Renape Nation	Korean	Nigerian	Polynesian	Italian	Mexican
Ramapough Lenape Indian Nation	Vietnamese	West Indian	Samoan	Polish	Puerto Rican
Other	Prefer not to answer				

## SECTION D — Personal Information

Residence address			Mailing address (if different from residence address)		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			County		

## SECTION E — Contact Information

Home phone number (     )	Mobile phone number (     )	Email address
Best time to call: Morning      Afternoon	Best location to call: Home      Business      Mobile	

## SECTION F — Household Information

A. Do all applicants reside in the same household?		Yes	No
If no, provide reason:		Address:	
_____		_____	
_____		_____	
_____		_____	
B. Do all applicants reside in one of the following counties: Bucks, Chester, Delaware, Montgomery, or Philadelphia?		Yes	No
If no, provide reason:		Address:	
_____		_____	
_____		_____	
_____		_____	

\*If you need to apply for additional dependents, please complete another application and mail it along with your primary application.

**SECTION G — Declarations and Conditions of Enrollment**

*Please read carefully before signing below.*

By applying to QCC Insurance Company (“the company”) for coverage for myself and the dependents listed in Section C, I understand and agree to the following:

1. a) For your effective coverage date, please see the information in the Premium Rate Letter.  
 b) Coverage does not begin until this application is processed by the company with an effective date of coverage assigned and payment has been received.  
 c) Credit card/debit card payments and pre-paid debit card payments are acceptable for the first month’s premium payment only.  
 d) Receipt of the initial payment does not constitute enrollment under any program.  
 e) This coverage is provided only to residents of the geographical area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, Pennsylvania, served by the company. The company reserves the right to investigate and confirm your residence.
2. The company may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by intentionally supplying a material misrepresentation of fact, except in the case of fraud, for which there is no time limit for voiding the policy.
3. The terms and conditions of the coverage will be controlled by the written agreement with the company, and the company may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.
4. **By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-group policy, the company will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.**
5. 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.
6. I can confirm that no one applying for health insurance on this Application is incarcerated (detained or jailed).

**Signature(s) Required**

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; padding: 2px; margin-right: 5px; writing-mode: vertical-rl; transform: rotate(180deg); font-size: 8px;">SIGN HERE</div> <div style="margin-left: 5px;">X _____</div> </div> <p style="margin-left: 20px;">Applicant/Parent or legal guardian signature</p>	/ /	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; border-radius: 50%; padding: 2px; margin-right: 5px; writing-mode: vertical-rl; transform: rotate(180deg); font-size: 8px;">SIGN HERE</div> <div style="margin-left: 5px;">X _____</div> </div> <p style="margin-left: 20px;">Applicant/Spouse or domestic partner signature (if applying for coverage)</p>	/ /
Date		Date	



**SECTION H – Statement of Accountability (if applicable)**

To be completed if the applicant cannot complete or has not completed the application:

I, \_\_\_\_\_, have read and completed the application form for the primary applicant for the following reason(s):

Applicant does not speak English	Applicant does not read English
Applicant does not write in English	Other (please explain)

I translated and fully explained the “Declarations and Conditions of Enrollment.” I also translated the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by:

_____	_____
Name	Signature of translator (required)
_____/_____/_____	_____
Date (required)	Relationship to applicant

**SECTION I – Broker Information (if applicable)**

Agent National Producer Number (NPN)	
Primary broker code	Producer broker code
Primary broker name	Producer name
Telephone number	Telephone number

**Independence Sales Representative (if applicable)**

National Producer Number (NPN)	Name of sales representative
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## SECTION J — Assistance with Completing this Application (if applicable)

You can choose an authorized representative. You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact Independence Blue Cross. If you're a legally appointed representative for someone on this application, submit proof with the application.

Name of authorized representative (First name, Middle name, Last name)		
Address		Apartment or Suite number
City	State	ZIP code
Phone number		
Organization name (if applicable)		ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with Independence Blue Cross.

X \_\_\_\_\_  
Your signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date (mm/dd/yy)

Mail your application to:

**Independence Blue Cross  
P.O. Box 8240  
Philadelphia, PA 19101**

All future premium payments should be remitted to the address on your current invoice.

If you have any questions, contact Independence Blue Cross at  
1-844-762-2140 between 8 a.m. and 6 p.m.

By voluntarily giving Independence Blue Cross my mobile phone number and/or e-mail address, I authorize Independence Blue Cross and its subsidiaries (collectively "Independence") to send me information/data about Independence, including, but not limited to, information about my account and other insurance products and services. Independence may contact me via e-mail, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from Independence Blue Cross. Text STOP to stop and HELP for help. Terms and conditions at [www.myhelpsite.net/ibx](http://www.myhelpsite.net/ibx). Any information provided by me to Independence is subject to Independence's Privacy Policy



Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.

## Language Assistance Services

**Spanish:** ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

**Chinese:** 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

**Korean:** 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

**Portuguese:** ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

**Gujarati:** સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

**Vietnamese:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

**Russian:** ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

**Italian:** ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

**Arabic:** ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

**French Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

**Telugu:** క్షణ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషాసహాయక సేవలు ఉచితంగా లభిస్తాయి. 1-800-275-2583 (TTY: 711) కు కాల్ చేయండి.

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

**Pennsylvania Dutch:** BASS UFF: Wann du Pennsylvania Deitsch schwetzsch, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

**Japanese:** 備考: 母国語が日本語の方は、言語アシスタンスサービス (無料) をご利用いただけます。1-800-275-2583へお電話ください。

### Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

**Navajo:** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódíílnih kojí' 1-800-275-2583.

### Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

### Mon-Khmer, Cambodian:

សូមមេត្តាចាំបំរើអារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរស័ព្ទទៅលេខ 1-800-275-2583។

Taglines as of 12/31/2022

## Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and 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 and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This 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 our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: [civilrightscordinator@1901market.com](mailto:civilrightscordinator@1901market.com). If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. 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: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Taglines as of 12/31/2022