BlueCross BlueShield of Texas

P.O.Box 2034 Aurora, IL 60507-2034 888-697-0683

Application/Miscellaneous Change Form for Individual Coverage

Prem: _____ Fee: _____
For Home Office Use

To help us process your application promptly, please remember to:
- Print all answers in black ink. Pencil will not be accepted.
- Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line. Parent/guardian must sign if primary applicant is a minor.

PART ONE Check one: ☐ New Policy ☐ Add Dependent ☐ Cancel Dependent ☐ Upgrade (increase of benefits) ☐ Downgrade (decrease of benefits)

SECTION A — PERSON(S) APPLYING FOR COVERAGE (please print)

In addition to having a permanent residence in Texas, all persons applying for coverage must be a United States citizen, or if not a citizen, must be able to provide medical records from a licensed U. S. Physician, including but not limited to, a health evaluation conducted within the past two years. All others are ineligible for coverage.

PRIMARY APPLICANT

First Name, Middle Initial, Last Name		Social Security #	Sex (M/F)	Age	Date of Birth (mo/day/yr)	Height (ft., in.)	Weight (lbs.)
					/ /		
Home Phone # ( )	Business Phone # ( )	Fax # (if available) ( )	Occupation/Duties			Spouse's Business # (if applying)	
Residence Street Address		City/State/ZIP				County	
Email (if available)			Best place and time to call (if necessary) for a phone interview. ☐ Home ☐ Business ☐ Morning ☐ Afternoon				

Spouse and dependent CHILDREN you wish to cover (dependent children must be under age 25 and unmarried).
If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)? ☐ Yes ☐ No

Name: First Middle Initial Last	Relation (spouse or child)	Sex	Height (ft., in.)	Weight (lbs.)	Date of Birth (mo/day/yr)	Social Security Number	Court Ordered for Dependents
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No

Is any Dependent coverage required by court order? ☐ Yes ☐ No If "yes," was it effective within the last 30 days? ☐ Yes ☐ No
If "yes," to apply for court-mandated coverage for Dependent children, contact Blue Cross and Blue Shield of Texas for the appropriate form.

SECTION B – COVERAGE APPLIED FOR (please choose only one plan)

PPO Select Blue Advantage

Deductible Plan: I ☐ $250 II ☐ $500 III ☐ $1,000 IV ☐ $1,500
V ☐ $2,500 VI ☐ $3,500 VII ☐ $5,000 VIII ☐ $10,000

PPO Select Choice

Deductible Plan: I ☐ $250 II ☐ $500 III ☐ $1,000 IV ☐ $1,500
V ☐ $2,500 VI ☐ $3,500 VII ☐ $5,000 VIII ☐ $10,000

PPO Select Saver

Deductible Plan: I ☐ $500 II ☐ $1,000 III ☐ $1,500 IV ☐ $2,500
V ☐ $3,500 VI ☐ $5,000 VII ☐ $10,000

☐ **DENTAL INSURANCE COVERAGE** I (We) hereby apply for Dental coverage and understand that all Applicants and Dependents approved for health coverage will be covered under the Dental coverage. If any covered health individual is cancelled from the health coverage or if health coverage is cancelled in its entirety, I understand the same action will be applied to Dental coverage. **I understand this will be my only opportunity to purchase dental insurance.**

SECTION C – PAYOR AND BILLING INFORMATION

Requested Effective Date (mo./day/yr.) _____

Premium Mode: ☐ Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
☐ Monthly Direct Bill ☐ Two Month Direct Bill ☐ Quarterly Direct Bill
☐ List Bill Monthly (Available for two or more applicants billed at the same address)

Application Fee	**$30.00**
Premium (if enclosed)	**$_____**
TOTAL enclosed	**$_____**

A $30.00 NONREFUNDABLE Application Fee must be submitted with completed application.
Please make check payable to Blue Cross and Blue Shield of Texas.

Payor of premium (if different than applicant)
Will your employer be contributing towards the premium for this policy? ☐ Yes ☐ No

Name:	Address/City/State/ZIP:	DOB:	SSN:

Please complete all pages 1-4.

Applicant Name: _____ Social Security No. _____

PART TWO — EVIDENCE OF INSURABILITY

All health history/medical questions must be completed for all individuals (including dependents) applying for coverage.

SECTION A — HEALTH HISTORY/MEDICAL QUESTIONS

Please Complete the Following Health Questions: For this insurance to be in force, you must answer the following health questions fully and truthfully and provide all of the health information asked for, including routine physical examinations, and Blue Cross and Blue Shield of Texas must approve this application. No one may change this requirement for you in any way. If you commit fraud or intentionally misrepresent any information required on any enrollment form, your coverage may later be rescinded. Rescission voids your coverage from the effective date, and any premiums already paid (less any benefits paid) will be refunded. **Please do not mark over or strike out any signature, date or health question information. Important! Do not cancel any existing health coverage until notified of your acceptance.**

If you answer "Yes" to ANY questions on this page, please give details on the next page. Please note the timeframe reference for each question.

1. Has any person applying for coverage been advised to seek treatment for alcohol use or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism within the last **10 years**? . . . . . □ Yes □ No

2. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use or dependency within the last **10 years**? . . . . . □ Yes □ No

3. Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last **10 years** for the following: Please check ☑ Yes or ☑ No. If any boxes are checked "Yes" (☑Yes), also circle the condition, e.g. (**migraines,**) and give details on the next page.

   A. Migraines; headaches; carpal tunnel syndrome; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? . . . . . □ Yes □ No

   B. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? . . . . . □ Yes □ No

   C. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? . . . . . □ Yes □ No

      If "Yes" to HBP, provide 3 readings and their dates w/in the last year _____and_____and_____

   D. Varicose veins/spider veins/varicosities; elevated cholesterol or lipids; anemia; blood clot or any other blood disorder? . . . . . □ Yes □ No

   E. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; or any breathing difficulty, lung or respiratory disease, disorder or condition? . . . . . □ Yes □ No

   F. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach or duodenum, or any other digestive disorder or condition? . . . . . □ Yes □ No

   G. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? (indicate type of hepatitis_____). . . . . □ Yes □ No

   H. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? (indicate diagnosis and location_____) . . . . □ Yes □ No

   I. Acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other skin disorder? . . . . . □ Yes □ No

   J. Kidney stones; reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? . . . . . □ Yes □ No

   K. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? . . . . . □ Yes □ No

   L. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; bunions; joint replacement; or manipulation therapy? . . . . . □ Yes □ No

   M. Thyroid disorder; goiter; Graves disease; diabetes; lupus; pituitary or adrenal disorder? . . . . . □ Yes □ No

   N. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? . . . . . □ Yes □ No

   O. Has anyone applying for coverage ever been diagnosed as having or told by a medical doctor that you have AIDS, HIV, or ARC disorders? . . □ Yes □ No

   P. Have you or any person applying for coverage ever been tested positive for antibodies for the AIDS virus? . . . . . □ Yes □ No

   Q. Has any person applying been diagnosed by a member of the medical profession as having AIDS and/or has any proposed insured received treatment from a member of the medical profession for AIDS? . . . . . □ Yes □ No

   R. **Questions for Male Applicants and Dependents Only** Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? . . . . . □ Yes □ No

   S. **Questions for Female Applicants and Dependents Only** Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? . . . . . □ Yes □ No

4. During the last **5 years**, has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist? . . . . . □ Yes □ No

5. Has any person applying for coverage been prescribed or taken any medications due to sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss in the last **12 months**? . . . . . □ Yes □ No

6. Have you, your spouse (if to be insured), or any child (if to be insured) smoked or used any tobacco products – such as cigarettes, pipes, cigars, snuff or chewing tobacco – in the last **12 months**? YOU □ Yes □ No YOUR SPOUSE □ Yes □ No YOUR CHILD □ Yes □ No. If Yes, ... Name(s) _____

7. A. **Question for Female Applicants and Dependents Only:** Is any female applying for coverage now pregnant? . . . . . □ Yes □ No
   B. **Question for Male Applicants and Dependents Only:** Is any male applying for coverage now an expectant parent? . . . . . □ Yes □ No
   If "Yes" to either question, coverage cannot be offered.

8. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin or penile implant), internal fixation (e.g. pins, plates or screws), prosthesis, pacemaker, valve replacement, shunt or monitoring device? . . . . . □ Yes □ No

9. Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery which has not yet been performed? . . . . . □ Yes □ No

10. Has any person applying for coverage **ever** been hospitalized or been treated in the emergency room or had any physical impairment, deformity, congenital anomaly, sickness, operation, injury or hospitalization other than admitted to on this page? . . . . . □ Yes □ No

11. Is each person applying for coverage a permanent resident of Texas, except for court-ordered Dependents? . . . . . □ Yes □ No

Applicant Name: _____ Social Security No. _____

PART TWO – CONTINUED

SECTION B – DETAILS OF HEALTH HISTORY

If you answered "Yes" to ANY questions on the previous page, please provide further information using the chart below. Be sure to use the "correct" example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

	Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment, Advice Given, and Medications Prescribed	Name, Address and Phone Number of Doctors and Hospitals
			What is it?	Date that is Started	Date of Recovery (if applicable)			
Correct Example:	3C	Joe Smith	high blood pressure	6/95	none	no, ongoing	40mg Atenolol once	Dr. Jones St. Mary's Peoria, IL (309) 555-1212

Previous Coverage Information In order to receive credit for pre-existing condition waiting periods, you must provide coverage information for the last 18 months for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this application. (If more than one plan was in effect, attach additional pages.)

Name of Policyholder	Date of Birth / /	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Group or Policy Number	ID Number
Employer's Name Name and address of other insurance company, TPA, HMO	Employment Date ___/___/___ Effective Date ___/___/___ Will coverage be continued? ☐ Yes ☐ No If "No," Expected Cancel Date ___/___/___		Type of Coverage ☐ Health ☐ Dental ☐ Employer-Sponsored OR ☐ Individual Purchase		Type of Policy ☐ Self ☐ Family ☐ Employee/Spouse ☐ Employee/Child

Replacement of Coverage Will this insurance replace any health insurance currently in force? ☐ Yes ☐ No

If "Yes," read the statement below and complete the following:

List all coverage that will be replaced

Insured	Name of Company	Policy Number	Termination Date

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Blue Cross and Blue Shield of Texas. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

1. Health conditions which you may presently have may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning the medical/health history of any person applying for coverage. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Blue Cross and Blue Shield of Texas.

Applicant Name: _____ Social Security No. _____

Acknowledgements: The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows: 1. This application does not provide coverage of any kind unless approval is provided by Blue Cross and Blue Shield of Texas (the Company); and the application, if not previously approved or declined, will be considered withdrawn on the 60th day after its date. **2.** Medical expense coverage will not be available until the effective date of the health contract and payment, in full, of the first month's premium. **3.** The medical expense benefits applied for and if issued, shall not cover any illness, accident, or physical impairment which existed or occurred prior to the effective date of the Applicant's coverage until the Applicant shall have held coverage under the contract for a period of 12 months if PPO Select Saver or PPO Select Choice is selected, or 18 months if PPO Select Blue Advantage is selected. **4.** No agent can accept risks or modify policies or requirement of the Company. **5.** The Company is not bound by any statement not written in this application. **6.** If a spouse is included for medical expense coverage, the premium will be calculated based on the age of each adult. **7.** Fraud or any intentional misrepresentation of a material fact may result in rescission of coverage or denial of a claim under the terms of the policy.

The undersigned Applicant further acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an Individual Policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by the Company in connection with the issuance of the Individual Policy, they should contact the agent.

Agreement: I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following underwriting approval and payment in full of the first months premium and receipt and acceptance by the Company of any required Amendatory Endorsement and/or Coverage Exclusion Rider, if applicable. The undersigned Applicant and agent acknowledge that the Applicant has read the completed application and that he/she realizes that any false statement material to the risk or misrepresentations therein may result in loss of coverage under the policy.

Medical Authorization: I authorize any medical professional,hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Signatures: I acknowledge receipt of the Required Outline of Coverage and I certify that:
1. Premiums are being paid by me as a personal expense. **2.** My employer is not contributing to any part of the premium, either directly or through reimbursement. **3.** Since my employer does not sponsor an employee health plan, neither my employer nor I deduct any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code.

The Patient Protection Act Disclosure Statement will be provided upon request. (Also available at www.bcbstx.com)

Important: Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant's* Signature: _____ Date Signed: _____

Spouse's signature (ONLY if to be insured): _____ Date Signed: _____

*Parent/Guardian Signature (if Primary Applicant is a Minor): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the Required Outline of Coverage, and if requested, Patient Protection Act Disclosure Statement.

Policy(ies) should be mailed to ☐ **Agent** ☐ **Applicant**

☐ **Agent** ☐ **Agency** # _____ _____ % _____
BCBSTX Assigned Agent # percent Tax I.D.

Please PRINT Name _____

Address _____

City, State, Zip _____

Phone (___) _____ Fax (___) _____

Signature _____ Date _____

☐ **Agent** ☐ **Agency** # _____ _____ % _____
BCBSTX Assigned Agent # percent Tax I.D.

Please PRINT Name _____

Address _____

City, State, Zip _____

Phone (___) _____ Fax (___) _____

Signature _____ Date _____

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Primary Applicant's Signature: **X** _____

Print Your Name as You Signed It: _____ Date Signed: ____ / ____ / ____

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