

Applying for a BlueCross BlueShield Plan is Simple.

Just Follow 3 Easy Steps...

Step 1 Print this application and complete in black or blue ink.

Step 2 Call or fax in to pre-screen your application.

Step 3 Mail the application & check payable to BlueCross to the address below.

To assist you with completing the application here is a checklist:

All applicant(s) must sign and date the application.

All medical questions must be answered; please provide thorough details to all yes answers, attach an additional sheet if necessary. Please call with any questions.

First month's payment must be submitted with the application.

There is no coverage for Maternity, unless it is elected as an optional rider and additional premium is paid.

Please call with any questions; our office hours are 9am – 9pm Monday thru Friday

800-910-1507

404-575-1967 fax

Once the application is complete, please call us or fax in, so that we may pre-screen it for detail and completeness before you mail it. After our review is complete, please mail the application with the first month's payment to:

BlueCross BlueShield of Tennessee
Attn: Individual Sales
801 Pine Street
Chattanooga, TN 37402



801 Pine Street
Chattanooga, TN 37402-2555
www.bcbst.com

APPLICATION

Use Black Ink Only

Individual Health Coverage

Plan Use Only

Rec: _____

IHCA

- CONFIDENTIAL -

SECTION 1 - Primary applicant information and dependents to be covered under this policy

PRIMARY APPLICANT Male Female Any tobacco used during past 12 months YES NO

LAST NAME _____ JR, SR, etc. _____ FIRST NAME _____ MI _____ SOCIAL SECURITY NO. _____ DATE OF BIRTH (mmddyyyy) _____ HEIGHT (FT / IN) _____ WEIGHT (LBS) _____

ADDRESS (P.O. Box is not acceptable - Please provide place of residence)

CITY (Please do not abbreviate) _____ STATE _____ ZIP _____ DAYTIME PHONE _____

MAILING ADDRESS IF DIFFERENT (P.O. Box is acceptable)

CITY (Please do not abbreviate) _____ STATE _____ ZIP _____ EMAIL ADDRESS _____

SPOUSE Male Female Any tobacco used during past 12 months YES NO

LEGAL SPOUSE LAST NAME _____ JR, SR, etc. _____ FIRST NAME _____ MI _____ SOCIAL SECURITY NUMBER _____ DATE OF BIRTH (mmddyyyy) _____ [HEIGHT (FT/IN)] _____ [WEIGHT (LBS)] _____

DEPENDENT Male Female Natural Child/Stepchild Adopted/Legal Guardian Other (specify) _____

DEPENDENT LAST NAME _____ JR, SR, etc. _____ DEPENDENT FIRST NAME _____ MI _____ SOCIAL SECURITY NUMBER _____ DATE OF BIRTH (mmddyyyy) _____ [HEIGHT (FT/IN)] _____ [WEIGHT (LBS)] _____

DEPENDENT Male Female Natural Child/Stepchild Adopted/Legal Guardian Other (specify) _____

DEPENDENT LAST NAME _____ JR, SR, etc. _____ DEPENDENT FIRST NAME _____ MI _____ SOCIAL SECURITY NUMBER _____ DATE OF BIRTH (mmddyyyy) _____ [HEIGHT (FT/IN)] _____ [WEIGHT (LBS)] _____

DEPENDENT Male Female Natural Child/Stepchild Adopted/Legal Guardian Other (specify) _____

DEPENDENT LAST NAME _____ JR, SR, etc. _____ DEPENDENT FIRST NAME _____ MI _____ SOCIAL SECURITY NUMBER _____ DATE OF BIRTH (mmddyyyy) _____ [HEIGHT (FT/IN)] _____ [WEIGHT (LBS)] _____

TO INCLUDE ADDITIONAL DEPENDENTS, PLEASE RECORD INFORMATION FOR ADDITIONAL DEPENDENTS ON A SEPARATE SHEET OF PAPER AND ATTACH IT TO THIS APPLICATION.

SECTION 2 - Benefit Section

BENEFIT OPTION CODE
Please indicate the letter and 2 character code of benefit plan.

Optional Products not available for all option codes
Dental YES NO
Maternity YES NO
(Maternity may only be purchased at initial enrollment or within 30 days of the qualifying event of 1) marriage; or 2) spouse's loss of group coverage.)

DESIRED EFFECTIVE DATE (CHOOSE ONE):

1. First of the month following approval
2. Day after approval
3. Day after my BCBST Short Term policy terminates (we will reduce the pre-existing waiting period by the length of the short term policy(s), for which there is not a gap between the term date and effective date of the policies).

4. Other Requested Effective Date:

_____ 2 0 _____

(If you request a specific effective date, this date cannot be changed once the policy is approved. If the requested date is prior to our receipt date, it will be changed to the day after receipt. In addition, you will be responsible for all premiums from this effective date.)

SECTION 3 - Payment Information - The first month's premium is required.

FIRST MONTH'S PREMIUM PAYMENT: CHECK/MONEY ORDER (ENCLOSED) VISA MASTERCARD

CREDIT CARD NUMBER _____ CARDHOLDER LAST NAME _____ CARDHOLDER FIRST NAME _____ EXPIRATION DATE (mmyy) _____ TOTAL \$ AMOUNT AUTHORIZED FOR CREDIT CARD _____

CHECK/MONEY ORDER NUMBER _____ CHECK/MONEY ORDER AMOUNT _____

\$ _____

Once approved you will receive an authorization form to enroll in an automated payment method. Until that request is processed you will be billed monthly via paper billing. We will notify you in writing when the automated payment will take effect. DO NOT ENCLOSE AN AUTHORIZATION REQUEST WITH THE APPLICATION, YOU MUST ENROLL AFTER YOU RECEIVE YOUR POLICY.

PRIMARY APPLICANT LAST NAME FIRST NAME MI SOCIAL SECURITY NO.

SECTION 4 – Explanation of Pre-existing Condition Waiting Period and Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Pre-Existing Condition Waiting Period – This coverage has a 12-month Pre-Existing Condition Waiting Period. This means that benefits will not be available until the coverage has been in effect for 12 months for any condition (either physical or mental) that was present during the 12-month period prior to the effective date of your coverage. **If you have experienced symptoms of a condition or if medical advice, diagnosis, care or treatment was recommended, received, or should reasonably have been received from a provider of health care services, the condition would be considered Pre-Existing.** If you are changing coverage from another BlueCross BlueShield of Tennessee individual product, you may be eligible to reduce your Pre-Existing Waiting Period. Information about this can be obtained through your BlueCross BlueShield of Tennessee sales personnel or your insurance representative.

Your Rights Under HIPAA - Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you or anyone for whom you are applying may be eligible for waivers of underwriting and our normal pre-existing waiting periods. The eligible individual must have had an aggregate of at least 18 months of creditable coverage without a significant break (63 days or more) in coverage. The most recent coverage must be from a group health plan (including COBRA), governmental plan or a church plan. It must also be no more than 63 days since that coverage terminated. COBRA and/or state continuation coverage must be exhausted to exercise your rights under HIPAA.

- Do you or any person for whom you are applying have creditable coverage as outlined in HIPAA? YES NO If "NO," initial in box below and go to Section 5.
- If you do have creditable coverage, check ONE of the following:
 - I (or any person for whom I am applying) have creditable coverage, but I would like to waive my HIPAA rights and apply for an underwritten plan with pre-existing condition waiting periods and medical underwriting. If you select this option, initial in box below and go to Section 5.
 - I (or any person for whom I am applying) have creditable coverage, but do not wish to waive my HIPAA rights. I would like to apply for a guaranteed issue policy with no pre-existing condition waiting period or medical underwriting. If you select this option, stop. See your agent for a different application for guaranteed issue coverage.

I have read the Pre-existing and HIPAA sections above and understand these provisions. PRIMARY APPLICANT'S INITIALS:

SECTION 5 – Disclosure Information

It is understood and agreed as follows:

- I have read the statements and answers recorded on this application. They are true and complete and correctly recorded. They will become part of this application and any policy(ies) issued on it.
- I understand that BlueCross BlueShield of Tennessee is relying on the truthfulness and completion of the statements and answers on this application in making the decision to issue any policies of insurance on health coverage.
- No insurance agent or broker has authority to waive any of BlueCross BlueShield of Tennessee's rights or requirements, or to make or alter any contract or policy. I understand that if my answers on this application are incorrect or untrue, BlueCross BlueShield of Tennessee may have the right to deny benefits or rescind my coverage.
- This insurance coverage is not designed or marketed as employer-provided insurance. I certify that I understand that I am applying for personal health coverage.
- I understand that without my signature and the disclosure authorization, no policy can be issued.
- I understand that I do not have coverage with BlueCross BlueShield of Tennessee until my application has been approved, my initial premium payment has cleared my bank account and BlueCross BlueShield of Tennessee has issued a policy to me.
- I understand that a broker or agent may receive a portion of my premium as commission. For more information I will contact my broker or agent.
- It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.
- If I (we) have other health coverage, such coverage will be terminated upon the issue of the BlueCross BlueShield of Tennessee policy for which I (we) have applied.
- I understand that during the underwriting review of the application it may be determined that a Benefit Exclusion Rider is necessary to be placed on my Policy. If a Benefit Exclusion Rider is placed on a Policy issued for me or my dependents, then coverage for those specific conditions in the rider will not be available for benefit payment for the lifetime of the policy. I understand that I may request reconsideration after 1 year if there is a significant change in the health status of the person(s) named in the rider.
- By submitting this Application, I agree that BlueCross BlueShield of Tennessee's Grievance process will govern any dispute with the Application or any Policy issued.

PRIMARY APPLICANT'S SIGNATURE X DATE (mmddyyyy) 2 0 Relationship _____
(If signed by parent or guardian)

LEGAL SPOUSE'S SIGNATURE X DATE (mmddyyyy) 2 0

I certify that I have truly and accurately recorded on this application the information supplied by the applicant

Agent's Signature _____ Agent's ID 08594 DATE (mmddyyyy) 2 0 Agent's Name Joseph LePage
(Please print)
Referral Agent ID

Agent's EMAIL Address Joe@HealthPlanStore.com Referral Agent's Name _____
(Please print)

PRIMARY APPLICANT LAST NAME FIRST NAME MI SOCIAL SECURITY NO.

Section 6 – AUTHORIZATION / Consent for Release of Personal and Health Information

This form is to authorize the disclosure and use of protected health information to determine eligibility for enrollment in a health plan. If you do not sign this authorization, you will not be enrolled.

My dependents and I authorize any doctor, hospital, clinic, provider of health care, pharmacy or pharmacy benefit manager, health plan, insurance (or reinsuring) company, consumer reporting agency, my insurance agents, employers or any other person or firm having: (1) information as to cause, treatment, diagnosis, prognosis or advice of my physical or mental condition; or (2) any other information needed to determine my eligibility for insurance; to give BlueCross BlueShield of Tennessee, its affiliates, its employees and agents, my broker, or any consumer reporting agency, all such information. This may include (but is not limited to) medical records, prescription history, medications prescribed, information about driving records, mental illness and use of alcohol and drugs.

I (We) UNDERSTAND:

- The information obtained with this authorization will be used by BlueCross BlueShield of Tennessee to determine eligibility for insurance. A copy of the authorization is as valid as the original. I (We) or my (our) authorized representative may request a copy of this authorization. This authorization will be in force for two years and six months from the date shown below.
- That I (we) may revoke this authorization at any time by writing BlueCross BlueShield of Tennessee. If I (we) revoke this authorization, any action taken by BlueCross BlueShield of Tennessee in reliance on this authorization prior to my (our) revocation will not be affected.
- My (our) signature(s) on this application will authorize any doctor, hospital or other provider of treatment to furnish to BlueCross BlueShield of Tennessee, any and all medical records pertaining to any person who is to be covered by this contract. I (we) am responsible for any fees for these records.
- If this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, this information may be re-disclosed by the recipient and no longer protected by federal privacy regulation.

PRIMARY APPLICANT'S SIGNATURE **X** _____ DATE (mmddyyyy) 2 0 Relationship _____
 (if signed by parent or guardian)

LEGAL SPOUSE'S SIGNATURE **X** _____ DATE (mmddyyyy) 2 0

DEPENDENT(S) AGE 18 AND OVER SIGNATURE **X** _____ DATE (mmddyyyy) 2 0

DEPENDENT(S) AGE 18 AND OVER SIGNATURE **X** _____ DATE (mmddyyyy) 2 0

DEPENDENT(S) AGE 18 AND OVER SIGNATURE **X** _____ DATE (mmddyyyy) 2 0

PRIMARY APPLICANT LAST NAME FIRST NAME MI SOCIAL SECURITY NO.

Section 7 - Individual Health Coverage Questionnaire

Have the primary applicant, spouse, or dependents applying for coverage been diagnosed, treated, or had a recommendation for treatment for any of the medical conditions listed below?

(Answer ALL questions, even if the answer is NO. Please **CIRCLE** any condition number(s) related to any questions answered YES and complete Section O below. This application will be returned for completion if numbers are not circled or section O is not completed.)

- A. YES NO
BONE / SKELETAL / MUSCLE
 001 Abdominal / Inguinal Hernia
 002 Back Injury or Impairment
 003 Bulging Disc / Herniated Disc
 004 **Fibromyalgia ***
 005 Knee Injury or Impairment
 006 Osteoarthritis
 007 Pituitary Dwarfism / Growth Hormones
 008 **Rheumatoid Arthritis ***
 009 Scoliosis
 010 **Spina Bifida ***
 011 **Osteoporosis * (include DEXA scan results)**
 012 Other Bone / Skeletal / Muscular Disorder
- B. YES NO
INTESTINAL / ENDOCRINE
 013 Adult / Juvenile Diabetes (non-gestational)
 014 **Bleeding Ulcer ***
 015 Chronic Pancreatitis
 016 Cirrhosis of the Liver
 017 Crohn's Disease
 018 Diverticulosis / Diverticulitis
 019 Gastroesophageal Reflux Disease (GERD)
 020 Hiatal Hernia
 021 **Hepatitis B ***
 022 Hepatitis C
 023 Irritable Bowel Syndrome (IBS)
 024 Colon Polyps
 025 Ulcerative Colitis / Ulcerative Proctitis
 026 Thyroid Disease
 027 Other Intestinal / Endocrine Disorder
- C. YES NO
URINARY / KIDNEY
 028 Chronic Prostatitis
 029 Dialysis
 030 **Enlarged Prostate ***
 031 Kidney Stones
 032 Neurogenic Bladder
 033 Polycystic Kidney Disease
 034 Renal Failure
 035 Other Urinary / Kidney Disorder
- D. YES NO
LUNG / RESPIRATORY
 036 Asthma
 037 Allergies
 038 Cystic Fibrosis
 039 Emphysema
 040 Pneumonia
 041 RSV Shots
 042 Sleep Apnea
 043 **Tuberculosis ***
 044 Chronic Bronchitis
 045 Other Lung or Respiratory Disorder
- E. YES NO
HEART / CIRCULATORY
 046 Anemia
 047 Aneurysm
 048 Angina
 049 Angioplasty
 050 Bypass Surgery
 051 Congestive Heart Failure
 052 Heart Attack
 053 Heart Murmur
 054 Hemophilia
 055 **High Blood Pressure / Hypertention ***
 056 **High Cholesterol / Lipid Disorders * (include current fasting lipid panel)**
 057 Mitral Valve Prolapse
 058 Stroke
 059 Transient Ischemic Attacks (TIA's)
 060 Other Heart or Circulatory Disorder
- F. YES NO
BRAIN / NERVOUS
 061 Alzheimer's or Dementia
 062 Cerebral Palsy
 063 **Epilepsy / Seizures ***
 064 Migraine
 065 Multiple Sclerosis
 066 Muscular Dystrophy
 067 Paralysis
 068 Parkinson's Disease
 069 **Developmental Disorders ***
 070 Other Brain / Nervous Disorder
- G. YES NO
CANCER
 071 Breast Cancer
 072 Chemotherapy / Radiation
 073 Colon Cancer
 074 Hodgkin's / Lymphoma
 075 Leukemia
 076 Liver Cancer
 077 Lung Cancer
 078 Melanoma
 079 Other Cancer
- H. YES NO
IMMUNE SYSTEM
 080 AIDS / HIV Infection
 081 Connective Tissue Disease
 082 **Discoid (subcutaneous) Lupus ***
 083 Systemic Lupus Erythematosus
 084 Other Immune System Disorder
- I. YES NO
TRANSPLANTS
 085 Bone Marrow Transplant
 086 Organ Transplant
 087 Discussed Possible Transplant
- J. YES NO
EYES / EARS / NOSE / THROAT / SKIN
 088 Acoustic Neuroma
 089 Adenoiditis
 090 Cataracts
 091 Chronic Ear Infections / Ear Tubes
 092 Chronic Sinusitis
 093 Chronic Tonsillitis
 094 Cleft Lip / Cleft Palate
 095 Eczema or Psoriasis
 096 Glaucoma
 097 **Retinopathy ***
 098 TMJ Syndrome
 099 Other Eye / Ear / Nose / Throat / Skin
- K. YES NO
BEHAVIORAL HEALTH / CHEMICAL DEPENDENCY
 100 ADD / ADHD
 101 Alcoholism
 102 Anorexia / Bulimia or Other Eating Disorder
 103 **Anxiety / Depression ***
 104 Bipolar Disorder / Manic Depressive Disorder
 105 **Counseling ***
 106 Drug Abuse or Illegal Drug Use
 107 Other Behavioral Health Disorder
- L. YES NO
REPRODUCTIVE
 108 Anyone Currently Pregnant/Expectant Parent (including Father)
 109 Born Premature (<37 weeks)
 110 Breast or Other Fluid-Filled Implants
 111 Endometriosis
 112 History of Pregnancy Complications
 113 Polycystic Ovarian Disease
 114 Sexually Transmitted Disease
 115 Uterine Fibroids
 116 Other Reproductive System Disorder
- M. YES NO
MISCELLANEOUS
 117 **Advised to have Surgery and / or Testing ***
 118 Inpatient or Outpatient Surgery
 119 **Abnormal Lab Results / Abnormal Pap Smear ***
 120 **Physical Exam with Abnormal Results ***
 121 Anyone currently taking or has taken any medications within the last 12 months
 122 Anyone seen any physicians and / or practitioners within the last 12 months
- N. YES NO
CONSUME ALCOHOL
 123 If "Yes," please indicate the family members' name and number of drinks consumed per day in Section O below.

* Medical Records including office visit notes, must be provided for these conditions. Medical Records may also be required for conditions other than those indicated with an (*).

Section O - Answer all of the specific information below for any condition with a "YES" above

Condition #	Family Member Name	Diagnosis, Treatment including Medications, or Reason for Visit	Date of Onset	Date of Last Treatment	Physician/Provider Name	Was Recovery Complete?

If more room is needed, please record information on a separate sheet of paper and attach it to this application.