

BlueIndividual
 APPLICATION FOR INDIVIDUAL COVERAGE
 (MEDICALLY UNDERWRITTEN)



1. Please **do not** remove the mailing label (if any).
2. Please print or type information.
3. **Sign** and return this application to the address shown above.
4. You must be a resident of the State of Delaware.
5. If anyone listed on this application is a "non-citizen resident" of the U.S. who has not resided in the U.S. for six (6) consecutive months, please provide the name(s) and explanation: _____

Incomplete applications will be returned. If additional information is needed from your physician(s), we will contact you. If this occurs, please allow 4-6 weeks to complete the application process.

I. APPLICANT INFORMATION. List all applicants. The oldest applicant accepted will be the policyholder. Use a separate sheet if more space is needed.

| Last Name | First Name | M.I. | Date of Birth | Relationship | Social Security Number | Height | Weight |
|-----------|------------|------|---------------|---|------------------------|--------|--------|
| | | | | Applicant: <input type="checkbox"/> Male <input type="checkbox"/> Female | | | |
| | | | | <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | |
| | | | | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | |
| | | | | <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | |

Address _____
 (Number) (Street) (City) (State) (Zip Code)

Home Phone () _____ Business Phone () _____ E-mail Address _____

Are you married? Yes No

Employment information **must** be completed for both applicant **and** spouse even if spouse is not applying for coverage.

Applicant's Employer _____ Self-Employed? Yes No Occupation _____ Full-time Part-time

Spouse's Employer _____ Self-Employed? Yes No Occupation _____ Full-time Part-time

II. PREMIUM SELECTION. Please check one option: Individual; Individual & Spouse; Individual & Child(ren); Family

III. COVERAGE LEVEL. Please check one option below.

BluePA Options: (Complete PCP information below.)

- \$10 Copay / \$500 Deductible \$20 Copay / \$1,000 Deductible
 \$30 Copay / \$1,000 Deductible

BluePPO Deductible Options:

- \$250 \$1,000 \$2,500
 \$500 \$1,500 \$5,000

Maternity Option? Yes No (There is an additional cost for this option, and benefits are subject to a 12-month waiting period.)

Choose Billing Cycle: Monthly Quarterly (January, April, July, October)

Please Note: Applicants with prior Blue Cross Blue Shield coverage should submit a *HIPAA Certificate* to possibly reduce the 12-month pre-existing waiting period.

| Name (to be completed by BluePA applicants only) | Primary Care Physician (PCP) Name | PCP's identification Number | Current PCP? |
|--|-----------------------------------|-----------------------------|--|
| (Applicant) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (Spouse) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (Dependent) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (Dependent) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | | | |
|------------------|-----------------------------|----------------|------------------------------|--------------------|
| BCBSD USE ONLY | Sub-Group No.: | Package No.: | Contract Type: | Effective Date: |
| AGENT'S USE ONLY | Agent Name: Kistler Tiffany | Agent No.: 176 | Producer Name: Barbara Kates | Producer No.: 5532 |

IV. OTHER INSURANCE INFORMATION

1. I am applying for new coverage.
 - I am applying for a change in coverage. Describe: _____
 - I am transferring from other **Blue Cross Blue Shield of Delaware** coverage. I.D. Number: _____
 - I am transferring from **another Blue Cross Blue Shield company**. Please submit your *HIPAA Certificate of Coverage* to possibly reduce the 12-month pre-existing waiting period.
 - Would this new Blue Cross Blue Shield of Delaware coverage replace an existing policy? Yes No. If yes, please provide the name of the carrier: _____
2. Is anyone listed on this application eligible for Medicare? Yes No. If yes, please provide the following:
 Name of family member(s) _____
 Medicare Number(s) _____ Effective Date(s) _____
3. Please list anyone on this application who:
 - is eligible for health insurance through an employer or association: _____
 - has **not** had any health insurance for the past 12 months: _____
 - previously applied for Individual Coverage in the past 3 years and was denied for medical reasons: _____

V. HEALTH STATEMENT

Give the name and address of your primary physician, with date and reason for last visit.

Applicant:

Physician's name _____ Telephone () _____

Address _____

Applicant's Name _____ Date of last visit _____

Symptom or condition _____

Other Family Member Applying (attach a separate sheet if necessary):

Physician's name _____ Telephone () _____

Address _____

Applicant's Name _____ Date of last visit _____

Symptom or condition _____

Has any person included on this application had any known indication, diagnosis or treatment **within the last 7 years** of any of the conditions listed below? Please check "Yes" or "No" for each condition. If "Yes," circle the appropriate condition. Answering yes will not necessarily result in rejection of your application.

| ALL QUESTIONS MUST BE CHECKED "YES" OR "NO." | Yes | No | Applicant or Name of Other Family Member Applying: |
|--|--------------------------|--------------------------|--|
| 1. Any cancer, cysts, tumors or unusual growths? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2. Any metabolic or endocrine conditions/disorders (examples: diabetes, adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, chronic fatigue syndrome, AIDS, or any immune disorder)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3. Any alcohol, drug, or substance dependency, abuse, or addiction? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 4. Any disorder of the circulatory system or heart (examples: aneurysm, chest pain, elevated cholesterol level, heart attack, heart murmur, high blood pressure, irregular heart beat, phlebitis, rheumatic fever, stroke, or varicose veins)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 5. Any emotional or psychological disorders (examples: adjustment disorder, anxiety, depression, obsessive-compulsive disorder, schizophrenia, or attempted suicide)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 6. Any disorder of the lungs or respiratory system (examples: allergy, asthma, chronic obstructive pulmonary disease, emphysema, or tuberculosis)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 7. Any disorder of the kidney or urinary system (examples: cystitis, renal failure, kidney stones, nephritis, prostatitis, or recurring bladder infections)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 8. Any disorder of the brain or nervous system (examples: epilepsy, seizures, head trauma, migraines, multiple sclerosis, or paralysis)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 9. Any disorder of the digestive system (examples: cirrhosis, chronic constipation, colitis, esophagitis, gall bladder/stones, hemorrhoids, chronic acid reflux, hepatitis, or ulcer)? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

ALL QUESTIONS MUST BE CHECKED "YES" OR "NO."

Yes No **Applicant or Name of Other Family Member Applying:**

- 10. Any disorder of the muscles or skeletal system (examples: arthritis, bursitis, carpal tunnel syndrome, gout, back or spine trouble, external deformity, osteomyelitis, osteoporosis, rheumatism, or scoliosis)? Yes No _____
- 11. Any disorder of the skin (examples: collagen disorder, eczema, or psoriasis)? Yes No _____
- 12. Any disorder of the blood (examples: anemia, hemophilia, leukemia, or sickle cell)? Yes No _____
- 13. Any breast or gynecological disorders (examples: endometriosis, infertility, irregular menstruation, or breast condition)? Yes No _____
- 14. Any venereal disease (examples: gonorrhea, herpes, or syphilis)? Yes No _____
- 15. Any disorders of the eye, ear, nose or throat (examples: allergy, deafness, or cataracts)? Yes No _____
- 16. Any of the following conditions or procedures: alzheimer's, cystic fibrosis, hodgkin's, muscular dystrophy, myasthenia gravis, palsy, parkinson's, polio, or transplants? Yes No _____
- 17. Any congenital conditions? Yes No _____
- 18. Any premature births, caesarean deliveries or miscarriages? Yes No _____
- 19. Is any person named on this application currently pregnant? Yes No _____

Expected delivery date: ____/____/____

- 20. Has any person included on this application had any health issue not previously mentioned on this application for which advice, diagnosis, care or treatment (including medical, surgical or hospital care) may or may not have been sought in the **past 7 years**? Yes No _____
- 21. Is any applicant scheduled for surgery or hospital admission within the next six months? Yes No _____

Please list the condition _____

Date of scheduled service ____/____/____

Attending physician _____

Telephone () _____

- 22. Has any applicant smoked, snuffed, or chewed tobacco at any time during the past 24 months? (Please name each applicant who has.) Yes No _____

- If you have checked "yes" to any of the questions ABOVE, enter details below. (If more space is required, use a separate sheet.)
- All questions must be checked "yes" or "no," or your application will be returned.
- Failure to disclose conditions may result in voiding of coverage and denial of benefits.

| Name of Family Member Applying | Ques. No. | Illness or Condition | Last Treatment Month Day Year / / | Operation? <input type="checkbox"/> Yes <input type="checkbox"/> No | Attending Physician Name and Address |
|--------------------------------|-----------|----------------------|---|---|--------------------------------------|
| | | | Month Day Year / / | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | Month Day Year / / | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | | Month Day Year / / | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

If any person included in this application is presently taking prescription drugs, please provide the following information:

| Name of Family Member Applying | Drug and Daily Dosage | Illness or Condition |
|--------------------------------|-----------------------|----------------------|
| | | |
| | | |
| | | |

VI. TERMS OF AGREEMENT

I hereby apply on behalf of myself, my spouse and my dependent children (if listed on this application) for a Blue Cross Blue Shield of Delaware (BCBSD) health insurance contract.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I have the authority to act for myself, my spouse and all of my dependent children including those who have reached the age of 18.
2. The contract will be effective only for those applicants approved by BCBSD.
3. If BCBSD accepts this application, I will receive a copy of the contract and an identification card. The contract will state plan benefits for insureds and define the conditions under which the benefits will be available. If I am a new member, the carrier holding my ID card will specify the effective date of my coverage.
4. A pre-existing condition is any condition anyone covered under this contract had before the contract's effective date.
BCBSD has a 12-month waiting period before pre-existing conditions will be covered under this contract. BCBSD will apply this waiting period to any condition (*whether physical or mental*), for which medical advice, diagnosis, care, or treatment was recommended or received from a health care provider by anyone covered by my contract within a six (6) month period ending on the day this contract is effective.
5. The contract, application and any attached amendments shall constitute the entire agreement and shall supersede any previous agreements.
6. I will pay the premiums to BCBSD when due.
7. In the event there is an error made in any payment of benefits, I agree to refund to BCBSD the amount of any overpayment of benefits to which I am not entitled.
8. I will notify BCBSD in writing if there have been any changes to the health of any person listed on this application, that occur prior to acceptance of this application by BCBSD.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly stated. They are representations that are made to induce the issuance of and form part of the consideration for a BCBSD contract. I also understand that failure to enter accurate, complete, and updated medical information in writing, prior to acceptance of this application by BCBSD, may result in the denial of benefits, cancellation or voiding of my contract, or attachment of an exclusionary amendment to my contract denying coverage for the affected individual or condition that was not disclosed.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any physician, hospital or other health care provider who is provided a signed copy of this authorization to furnish to BCBSD any medical information, reports or copies of records which may be requested by BCBSD or any of its agents or representatives, in order to determine eligibility for coverage under the health insurance contract for which application has been made. **I will be directly responsible to the provider for any charge for this service.**

I understand that I have the right to revoke this authorization at any time by giving written notice of my revocation to BCBSD who will promptly implement it. Revocation of this authorization will not affect any action that BCBSD or any health care provider took before I provide written notice of revocation. I understand that failure to execute this authorization may result in a denial of my application for coverage. This authorization shall continue until BCBSD notifies me of its decision to accept or reject this application.

I have carefully read this Application and Authorization to Release Medical Information and agree to the terms and conditions specified.

All applicants have signed below, except for dependent children under the age of 18.

Signature of Applicant (DO NOT PRINT)

Printed Name of Applicant

____/____/____
Date

Signature of Spouse or Child Age 18 or Older (DO NOT PRINT)

Printed Name of Spouse or Child Age 18 or Older

____/____/____
Date

Signature of Child Age 18 or Older (DO NOT PRINT)

Printed Name of Child Age 18 or Older

____/____/____
Date

Before mailing this application, please remember to:

- answer all 22 health questions.
- enter current information in the height and weight columns.

Note: If you have prior Blue Cross Blue Shield coverage, please submit a HIPAA Certificate of Coverage.

Premiums are not required at the time of application, but coverage will not be in effect until payment is received.