

BlueCross BlueShield of Illinois Health Insurance Application Instructions

Download / Print the application form, then complete it by hand

Note the following items in completing the application form:

1. Use a dark ink pen. Don't use pencil. Don't type on the application form. Don't use correction fluid. If you make an error, cross out the incorrect information and write your initials next to the correct information.
2. Complete **Part 1 Section A** and **Section B** by providing basic information about the persons to be insured, and by specifying the BlueCross BlueShield of Illinois plan option you want.
3. **Part 1 Section C – Billing Information:** Specify how you want to pay for coverage. If you prefer to pay monthly, your payments are automatically transferred from a bank account you designate. You'll need to provide a voided check or deposit slip from your bank account and complete the **Automatic Payment Authorization** form on page 7.

If you prefer to mail premium payments, Blue Cross Blue Shield requires that you pay two months at a time.

4. **Part 2 – Health History:** Answer each **Section A** medical question “yes” or “no.” When your response is “yes,” provide a brief explanation in **Section B – Details of Health History**. Provide the name and address of the physician or hospital that provided the treatment. It's very important that you provide complete details regarding any “yes” responses. Incomplete health history details will delay processing of your application.
5. Provide information about prior and current health insurance in **Part 2 Section C**.
6. In **Part 3**, provide your signature/date where indicated. If your spouse or any dependent(s) age 18 or over is also applying for coverage, your spouse and/or dependent(s) must also provide a signature/date in Part 3 Section A.
7. If you're replacing other health insurance, be sure to sign and date the **Notice to Applicant Regarding Replacement of Health Insurance** form.
8. If you need more space to provide information, use an additional sheet of paper. Any additional pages must be signed and dated by the applicant, spouse (if applicable) and children age 18 or older (if applicable).
9. **A payment must accompany your application.** Provide a one-month payment if you choose the “Monthly Bank Draft” payment mode. Provide a two-month payment if you choose the “Two-Month Direct Bill” payment mode.

Return the completed application and check (payable to BlueCross BlueShield of Illinois) to the following address:

MedPlan Access
P.O. Box 2220
West Lafayette IN 47906

Applications can't be processed without payment (check payable to “Blue Cross Blue Shield of Illinois).

If you have questions about the plan or application, just call.

Approval of applications generally takes two to six weeks following submission to Blue Cross and Blue Shield of Illinois. The key factors in this process are 1) the completeness of your submitted application, 2) whether BlueCross BlueShield of Illinois requires copies of medical records and 3) how long it takes a physician or hospital to respond to BlueCross BlueShield of Illinois' request (should a request be made) for medical records.

MedPlan Access
1-877-MedPlan (1-877-633-7526)

Proceed to Application



APPLICATION FOR INDIVIDUAL COVERAGE



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.
- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid.

HOME OFFICE USE ONLY

CWA: _____

PART ONE Check one: New Policy Add Dependent Upgrade (increase of benefits)

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

In addition to having a permanent residence in Illinois, all persons applying for coverage who are not U.S. citizens must have resided in the U.S. for at least six months AND have had a complete physical by a physician in the U.S. within the past two years.

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 Phone # () (if applying) | | |
| Residence Street Address | | | City / State / ZIP | | | County | |
| Email (if available) | | | | | Best place and time to call (if necessary) <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon | | |

SPOUSE and DEPENDENT CHILDREN YOU WISH TO COVER (dependent children must be under age 19, or under age 25 if unmarried, full-time student)

| NAME: First | M.I. | Last | RELATION (spouse or child) | SEX | HEIGHT (ft., in.) | WEIGHT (lbs.) | DATE OF BIRTH (mo/day/yr) | SOCIAL SECURITY NUMBER | FULL-TIME STUDENT |
|-------------|------|------|-------------------------------|--|----------------------|------------------|------------------------------|------------------------|--|
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | / / | - - | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | / / | - - | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | / / | - - | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | / / | - - | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | / / | - - | <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

- | | |
|--|---|
| <input type="checkbox"/> SelectBlue® Deductible: <input type="checkbox"/> \$0 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80% Do You Want Maternity Coverage? <input type="checkbox"/> Yes | <input type="checkbox"/> BlueValue® Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80% Do You Want Maternity Coverage? <input type="checkbox"/> Yes |
| <input type="checkbox"/> SelectBlue Advantage® Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 Level of Coverage: <input type="checkbox"/> 80% Do You Want Maternity Coverage? <input type="checkbox"/> Yes | <input type="checkbox"/> BlueValue Advantage® Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 Level of Coverage: <input type="checkbox"/> 80% Do You Want Maternity Coverage? <input type="checkbox"/> Yes |
| <input type="checkbox"/> BlueChoice® Select Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 Level of Coverage: <input type="checkbox"/> 80% Do You Want Maternity Coverage? <input type="checkbox"/> Yes | <input type="checkbox"/> BlueChoice® Value Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 Level of Coverage: <input type="checkbox"/> 80% Do You Want Maternity Coverage? <input type="checkbox"/> Yes |
| <input type="checkbox"/> Traditional Blue® Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80% Do You Want Maternity Coverage? <input type="checkbox"/> Yes | <input type="checkbox"/> BasicBlue® Deductible: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 Level of Coverage: <input type="checkbox"/> 80% Maternity Option Not Available |
| | <input type="checkbox"/> High Deductible Deductible: <input type="checkbox"/> \$2,250 Level of Coverage: <input type="checkbox"/> 100% Do You Want Maternity Coverage? <input type="checkbox"/> Yes |

SECTION C — BILLING INFORMATION

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

REQUESTED EFFECTIVE DATE (mo./day/yr.) _____ PREMIUM AMOUNT ENCLOSED \$ _____

PREMIUM MODE: Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
 Two-Month Direct Bill

Billing Name and Address (if different than name and residence address given above)

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

If you answer "Yes" to ANY questions on this page, please give complete 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. Acquired Immune Deficiency Syndrome (AIDS); AIDS-Related Complex (ARC); HIV positive or other immune disorders? Yes No
- P. *Question 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
- Q. *Question 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

QUESTION CONTINUES AT RIGHT

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 medication due to any sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss **in the last 12 months**? Yes No
6. Have you or your spouse (if to be insured) smoked or used any tobacco products – such as cigarettes, _____ Yes No
pipes, cigars, snuff or chewing tobacco – **in the last 12 months**? _____ Yes No
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

PART THREE

SECTION A — REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I apply for coverage as indicated in PART ONE, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical coverage) which is herein called the Company. **I have read all the statements in PARTS ONE and TWO, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on PARTS ONE and TWO of this application may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of the Company.**

I have read and understand the Outline of Coverage that has been provided to me by my agent who sells Blue Cross and Blue Shield of Illinois insurance plans. My agent has informed me of the provisions of the Blue Cross and Blue Shield of Illinois health plan and the Medical Services Advisory (MSA[®]) Program (along with the provisions of the Mental Health Unit if applicable).

I understand that the insurance plan applied for is **not** an employer-sponsored group health plan and it **does not** comply with state or federal small employer laws.

Medical Authorization: I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, health plan, 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 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.

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: X _____ | Date Signed: _____ / _____ / _____ mo. day yr. |
| Spouse's Signature (ONLY if to be insured): X _____ | Date Signed: _____ / _____ / _____ mo. day yr. |
| Parent/Guardian Signature (If Primary Applicant is UNDER the age of 18): X _____ | Date Signed: _____ / _____ / _____ mo. day yr. |
| Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): X _____ | Date Signed: _____ / _____ / _____ mo. day yr. |
| Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): X _____ | Date Signed: _____ / _____ / _____ mo. day yr. |
| Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): X _____ | Date Signed: _____ / _____ / _____ mo. day yr. |

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 _____ | Date Signed: _____ / _____ / _____ mo. day yr. |
| Print Your Name as You Signed It: _____ | Date Signed: _____ / _____ / _____ mo. day yr. |

SECTION B — AGENT STATEMENT

I have personally, completely and accurately reaffirmed the information supplied by the applicant(s).

| | |
|-----------------------------------|---|
| Agent's Signature: X _____ | Date Signed: _____ / _____ / _____ mo. day yr. |
|-----------------------------------|---|

| | |
|---|---|
| Print Your Name as You Signed It: <u>Joseph Risse</u> | Agent's Phone Number: <u>1-877-633-7526</u> |
|---|---|

| |
|-----------------------------|
| Agent's Code: <u>605303</u> |
|-----------------------------|

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Health Care Service Corporation. 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 policy.

1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. 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 policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAS NEVER BEEN IN FORCE. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

- -

(Applicant's Social Security Number)



**BlueCross BlueShield
of Illinois**

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____ Check One: Checking Account Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

Applicant's Copy (if paying by automatic bank withdrawal)

▲ DETACH HERE ▲

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____ Check One: Checking Account Savings Account

| | | |
|---|---------------------|----------------------------|
| NAME OF BANK WHERE ACCOUNT IS AUTHORIZED | | |
| ADDRESS OF BANK | | |
| CITY | STATE | ZIP |
| NAME OF INSURED, APPLICANT (PRINT) | | |
| NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED | | RELATIONSHIP TO INSURED |
| SIGNATURE OF DEPOSITOR | | DATE |
| For Home Office Use Only: | BANK TRANSIT NUMBER | DEPOSITOR'S ACCOUNT NUMBER |

PLEASE ATTACH VOIDED CHECK OR DEPOSIT SLIP

Company's Copy (if applicant is paying by automatic bank withdrawal)