

# REQUEST FOR UNDERWRITING OPINION



**BlueCross BlueShield of Illinois**

*Experience. Wellness. Everywhere.®*

This Underwriting Opinion Form should be used in those situations where there is a question about a proposed applicant's health history. Underwriting Opinions are based on the data provided below. **A fully completed application is required in order to determine an applicant's eligibility for coverage.**

Fax Underwriting Opinion Requests to: Individual/Family Plans 630-328-4505

Date: \_\_\_\_\_  
 Producer Name: \_\_\_\_\_  
 Producer ID Number: \_\_\_\_\_  
 Phone Number: ( ) \_\_\_\_\_  
 Fax Number: ( ) \_\_\_\_\_

Proposed Insured: \_\_\_\_\_  
 Sex: M \_\_\_\_\_ F \_\_\_\_\_  
 Current Age: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Mo. Day Year  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**CHOOSE ONE PLAN:** *Individual/Family Plans*

Please complete a separate form for each proposed insured.

<input type="checkbox"/> SelectBlue®	<input type="checkbox"/> BlueValue <sup>SM</sup>	<input type="checkbox"/> BlueEdge <sup>SM</sup>	<input type="checkbox"/> BlueEdge <sup>SM</sup>
<input type="checkbox"/> SelectBlue Advantage <sup>SM</sup>	<input type="checkbox"/> BlueValue Advantage <sup>SM</sup>	Individual HSA	Individual HSA 5000
<input type="checkbox"/> BlueChoice <sup>SM</sup> Select	<input type="checkbox"/> BlueChoice <sup>SM</sup> Value		
<input type="checkbox"/> Traditional Blue <sup>SM</sup>	<input type="checkbox"/> Basic Blue®		

**MEDICAL INFORMATION**

Date of last visit to Physician: \_\_\_\_\_ Reason: \_\_\_\_\_

Results of last visit: \_\_\_\_\_

Treatment?  YES  NO If yes, provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

1) Condition/Diagnosis	Date First Treated	Medication/Treatment	Degree and Date of Recovery
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

2) Has the proposed applicant ever been hospitalized or treated in an Emergency Room?  YES  NO

If yes, dates: \_\_\_\_\_ Reason for: \_\_\_\_\_

3) Has the proposed applicant ever had surgery?  YES  NO

If yes, dates: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

4) Is applicant taking any medications other than listed above?  YES  NO

If yes, details: \_\_\_\_\_

Additional comments: \_\_\_\_\_

**UNDERWRITER'S OPINION** (DO NOT WRITE IN THIS AREA: FOR UNDERWRITING SERVICES USE ONLY)

A final underwriting decision will be based on a formal application which can be submitted at any time for consideration. The final decision may be different from the opinion shown below.

Based solely on the information shown above; the proposed applicant may:

be eligible for coverage.  not be eligible for coverage.

Underwriter Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Underwriter: \_\_\_\_\_ Date: \_\_\_\_\_