BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

DIRECT MARKETS

APPLICATION TO ADD DEPENDENT AND/OR OPTIONAL MATERNITY COVERAGE

For Comprehensive Major Medical Plus, Preferred Major Medical, High Deductible $2250 or The Alternative Plans

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 anydependent(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.

PART ONE

Check one: ☐ Add Spouse or Dependent Child(ren)
☐ Add Optional Maternity Coverage (not available with The Alternative)

PERSON(S) APPLYING FOR COVERAGE (please print)

In addition to having a permanent residence in Illinois, all persons applying for coverage must be either a United States citizen or hold Permanent Resident Alien status. All others are ineligible for coverage. (NOTE: For each applicant with Permanent Resident Alien status, a copy of both the front and the back of the Permanent Resident Alien ID card must be submitted with the application.)

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*)
	☐ Home ☐ Business ☐ Morning ☐ 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
		☐ M ☐ F			/ /	– –	☐ Yes ☐ No
		☐ M ☐ F			/ /	– –	☐ Yes ☐ No
		☐ M ☐ F			/ /	– –	☐ Yes ☐ No
		☐ M ☐ F			/ /	– –	☐ Yes ☐ No
		☐ M ☐ F			/ /	– –	☐ Yes ☐ 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 it Started	Date of Recovery (if applicable)			
Incorrect Example:	~~C~~	~~Mr. Smith~~	~~blood pressure~~	~~1995~~	~~N/A~~	~~N/A~~	~~prescription~~	~~Dr. Jones St. Mary's Hospital~~
Correct Example:	3C	Joe Smith	high blood pressure	6/95	none	no, ongoing	40mg Atenolol once a day 140/80 - 7/8/01 138/78 - 10/12/01 139/77 - 2/9/02	Dr. Jones St. Mary's Peoria, IL (309) 555-1212

If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)?..... ☐ Yes ☐ No

SECTION C — OTHER INSURANCE INFORMATION

1. Does any person applying for coverage currently have, or did they previously have, Blue Cross and Blue Shield of Illinois coverage, either as a primary insured or as a dependent? ☐ **Yes** ☐ **No** *If "Yes", please complete the following:*

   Member Name _____ Member No. _____ Group No. _____

2. Does any person to be covered have any Major Medical, HMO, or PPO Medical Insurance with any other Insurer? ☐ **Yes** ☐ **No**
3. Will the issuance of this coverage cause you to discontinue your existing coverage? ☐ **Yes** ☐ **No**

   If "Yes", when is coverage to be discontinued (mo./day/yr.)? _____ (Note: A Notice of Replacement Form must also be submitted with your application, even if replacing Blue Cross and Blue Shield of Illinois coverage.)

   If "No", please explain _____
4. Has any person applying for coverage ever been declined, postponed, charged an extra premium for or had a rider applied to life, health, or disability insurance, or had any such insurance rescinded? ☐ **Yes** ☐ **No**

   If "Yes", please explain _____

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

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**

QUESTION CONTINUES AT RIGHT

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**

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, pipes, cigars, snuff or chewing tobacco – **in the last 12 months?**
YOU ☐ **Yes** ☐ **No**
YOUR SPOUSE ☐ **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 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.

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.)

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 _____

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: _____ **Agent's Phone Number:** (____) _____

Agent's Code: _____