



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

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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 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.

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

Form with fields for 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) with checkboxes for 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)

Table with columns: NAME: First, M.I., Last, RELATION (spouse or child), SEX (M/F), HEIGHT (ft., in.), WEIGHT (lbs.), DATE OF BIRTH (mo/day/yr), SOCIAL SECURITY NUMBER, FULL-TIME STUDENT (Yes/No). Contains 5 rows for listing dependents.

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, _____ **YOU** Yes No
pipes, cigars, snuff or chewing tobacco – **in the last 12 months**? _____ **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 _____	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: _____	Agent's Phone Number: () _____
Agent's Code: _____	