



# Individual Application Instructions

Thank you for applying to Blue Cross of California  
or BC Life & Health Insurance Company.

## Please note:

### • Coverage is not available if:

1. Any family member is currently pregnant (whether or not listed on the application) or in the process of adoption.
  2. The applicant has not resided in the U.S. for the last three (3) consecutive months.
- Coverage is **not** guaranteed. Your application must be approved and accepted in writing by Blue Cross. Do not cancel existing coverage until you receive written notification of coverage by Blue Cross.

## Instructions

### Do not complete this application until you have read the current product brochure.

- **For your own protection, you, the applicant, must complete this application.** You are solely responsible for its accuracy and completeness.
- If you, the applicant, do not complete this application, the translator must complete the Statement of Accountability on page 8.
- All information must be stated accurately.
- All questions must be answered in full, or the application may be returned to you and may result in a delay in processing.
- For additional information or explanations, attach extra sheets if necessary. All attachments must be signed and dated.
- **This application must be signed in blue or black ink.**
- This application must be received by Blue Cross Medical Underwriting within 45 days from the signature date.
- Blue Cross plans are available only in areas where the Blue Cross network exists. Please see the appropriate Provider Directory for more details.
- Even if this application is approved, any misstatements or omissions may result in future claims being denied and the plan being voided from the beginning.
- Your insurance will become effective only if this application is approved as applied for, the appropriate premium is enclosed, and other specific conditions are met (see details under Section 8 – Conditions of Application).
- Please return this application and your check to your agent.

## FamilyElect

### Each family member can choose a different medical plan.

### All accepted family members choosing FamilyElect will be assigned the same effective date of coverage.

- First, indicate you are choosing to participate in the program by checking “Yes” for FamilyElect in Section 2.
- Next, go to Section 3. List the corresponding medical plan code number from Section 2 (i.e., code 07 for 40% Coinsurance plan) next to the family member’s name (i.e., John Smith).
- To figure your premium, choose the rate appropriate to your benefit choice, age and rating area.
- Add the monthly rates together for all plans, and submit one check.
- If you have any questions, please contact your agent.

## Billing information

### Carefully read the instructions accompanying each billing type on page 7. Please make sure that your check is attached where indicated on page 7 of this application.

- **Monthly billing** (available with Bank Draft Authorization only): Submit the one (1)-month premium, complete the Monthly Bank Draft Authorization and attach a blank check marked “VOID” to this form.
- **Optional bimonthly billing:** Submit the two (2)-month (bimonthly) premium.
- **Optional quarterly billing:** Submit the three (3)-month (quarterly) premium.
- **Initial premium payment by credit card:** Complete Section 9B authorizing initial payment for medical and/or dental premium.

**Applicant mailing address** – Please return this application to your agent.



# Individual Enrollment Application

Blue Cross Dental SelectHMO and all medical plans except Basic, Level II Deductible and PPO Dental are offered by Blue Cross of California. Basic, Level II Deductible, PPO Dental and Life products are offered by BC Life & Health Insurance Company. Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association.

1. This application must be signed in blue or black ink (cannot be completed with pencil).
2. This application must be completed by the applicant. If not, complete the Statement of Accountability on page 8.
3. If you have any questions or doubt about completing this application, please contact your agent.

## 1. Applicant Information (Please print)

Primary Applicant's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

## Reason for Application (Check one)

- New enrollment(s)
- Add dependent(s)
- Change existing Blue Cross plan –  
Certificate No: \_\_\_\_\_
- Summary bill (existing) –  
I.D. No: \_\_\_\_\_

Primary Applicant's Social Security No.	County Applicant Resides in (Required)	Home Phone No. ( )
Mailing Address (If different than above) or P.O. Box	Personal Mail Box (PMB) No.	Daytime Phone No. ( )
City / State / ZIP Code	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Spouse's Social Security No.
E-mail Address	Applicant / Spouse Maiden Name	
Occupation	Has any person listed on this application resided outside the U.S. for the past three (3) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	

## 2. Choice of Blue Cross Individual Coverage

I understand that I may decline coverage within 10 days from the date of delivery and receive a full refund on any subscription charges paid.

Do you wish to choose FamilyElect for medical coverage?  Yes  No

If yes, proceed to Section 3 on the following page. Refer to the 2-digit codes below to indicate medical coverage choices in Section 3B for each family member.

NOTE: If choosing FamilyElect, all family members will be assigned the same original effective date.

If no, select ONE medical plan choice below.

If you are choosing Dental coverage or Term Life Insurance, please complete the appropriate sections below.

Code	Medical Coverage (Choose one plan below if you are not selecting FamilyElect coverage.)	Code	Dental Coverage
14	<b>Low Option:</b> <input type="checkbox"/> Basic PPO \$1,000 Deductible (7900)	24	<input type="checkbox"/> Blue Cross Dental PPO (7874)
13	<input type="checkbox"/> High Deductible EPO \$2,350 (MSA Compatible) (7893)	40	<input type="checkbox"/> Blue Cross Dental Saver SelectHMO* (ZE6N)
26	<input type="checkbox"/> PPO \$2,250 Deductible (7891)	41	<input type="checkbox"/> Blue Cross Dental SelectHMO* (ZE7N)
12	<b>Medium Option:</b> <input type="checkbox"/> High Deductible EPO \$1,550 (MSA Compatible) (7892)	42	<input type="checkbox"/> Blue Cross Dental Premier SelectHMO* (ZE8N)
08	<input type="checkbox"/> Saver HMO (7896)	Please list names of applicants you wish to provide Dental coverage for: _____ Date of Birth _____	
25	<input type="checkbox"/> PPO \$1,500 Deductible (7890)	SELF _____	
07	<input type="checkbox"/> PPO 40% (7889)	SPOUSE _____	
06	<input type="checkbox"/> PPO 35% (7895)	_____	
10	<b>High Option:</b> <input type="checkbox"/> HMO (7898)	_____	
05	<input type="checkbox"/> PPO 30% (7888)	_____	
27	<input type="checkbox"/> Premier PPO 15% (7904)	_____	
15	<input type="checkbox"/> PPO \$500 Deductible (1501)	* For any of the Blue Cross Dental SelectHMO coverages, please indicate the Provider number below.	
17	<input type="checkbox"/> PPO \$1,000 Deductible (1503)	Blue Cross Dental SelectHMO Provider No. _____	
<b>Life Insurance Coverage</b>			
<input type="checkbox"/> <b>BC Life &amp; Health Term Life Insurance</b> The Term Life Insurance option is available with Level I and Level I+20 plan coverages ONLY. Complete Section 4 on page 3. <b>DO NOT SUBMIT PREMIUM FOR LIFE INSURANCE.</b>			

### FOR BLUE CROSS USE ONLY – DO NOT WRITE BELOW

Group No.	Certificate No.	Agent No.	Effective Date	X Ref. Cert. No.	<input type="checkbox"/> AA <input type="checkbox"/> AD	By	Date
					<input type="checkbox"/> AA <input type="checkbox"/> AD		
					<input type="checkbox"/> AA <input type="checkbox"/> AD		

### 3. Applicants for Coverage

**Please list ALL eligible family members applying for coverage.** If a listed family member's last name is different from your own, please explain on a separate sheet of paper.

Relation	Last Name	First Name	M.I.	Social Security No.	Date of Birth	Age	MUST BE ACCURATE		3A. For HMO Use Only Choose a physician for each family member from the Provider Directory.			3B. FamilyElect Medical Coverage Choose Medical Plan code number(s) from Section 2
							Height	Weight	PMG / IPA	Primary Care Physician (PCP)	Current Patient	
10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	Yourselves											<input type="checkbox"/> Yes <input type="checkbox"/> No
30 <input type="checkbox"/> Husband 40 <input type="checkbox"/> Wife	Spouse											<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter												<input type="checkbox"/> Yes <input type="checkbox"/> No

**Dependent Information:** Do you claim all children listed above who are between the ages of 19 through 22 as dependents on your Federal Income Tax?  Yes  No  
 If "NO", any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is NOT eligible as a dependent but may apply individually.

### 4. BC Life & Health Term Life Insurance

Applicants and/or any dependents that are approved for **Level I and Level I+20** coverage will also qualify for BC Life & Health Insurance Term Coverage at an additional charge. Applicants under the age of one year are not eligible for life insurance. **DO NOT SUBMIT PREMIUM FOR LIFE INSURANCE.**

Name of Family Member	✓ Amount of Coverage			Name of Beneficiary	Relationship	Beneficiary Address City / State / ZIP Code
	\$15,000 (30)	\$30,000 (31)	\$50,000* (32)			
Primary Applicant						
Spouse						
Dependent						
Dependent						

\* **NOTE:** The \$50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to \$30,000. **If beneficiary is not listed** and policy is issued, death benefits will be paid in accordance with the Beneficiary Provision on page 3 of the Policy.

### 5. Prior Insurance History – Please answer ALL of the following questions.

Blue Cross of California Companies credit prior coverage toward the preexisting period for those applicants who apply for coverage within 63 days after termination of qualifying prior coverage, as prescribed by law. To obtain credit toward the preexisting period, please complete the following.

- A. Do you, or anyone to be insured, currently have, or has anyone to be insured had coverage in the past 63 days? .....  Yes  No  
 If yes, provide Name of insured: \_\_\_\_\_ Insurance carrier: \_\_\_\_\_  
 Date coverage began: \_\_\_\_\_ Date coverage ended: \_\_\_\_\_  
 Do you agree to discontinue your current coverage if this application is accepted? .....  Yes  No  
 If no, please explain: \_\_\_\_\_
- B. Has anyone listed on this application been a Blue Cross of California member within the last 5 years? .....  Yes  No  
 If yes, name of Blue Cross of California member: \_\_\_\_\_ Certificate/Policyholder No: \_\_\_\_\_  
 Blue Cross Plan: \_\_\_\_\_ City / State: \_\_\_\_\_ Date cancelled: \_\_\_\_\_  
 I certify that my Blue Cross group coverage terminated/will terminate on (date): \_\_\_\_\_

### 6. Other Coverage – Please answer ALL of the following questions.

- A. Have any applicants identified above been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance or had such insurance rescinded? .....  Yes  No  
 If yes, provide name of applicant, company name, and a brief explanation: \_\_\_\_\_
- B. Are any persons applying for coverage on this application eligible for Medicare benefits? .....  Yes  No

# 7. Health History

Include information on ALL family members you wish to enroll.

## 7A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.

Give COMPLETE details of any "Yes" answers in Section 7E on the following page.

Has any person listed on this application ever had any signs or symptoms, seen a health care provider, had treatment recommended, received treatment, or been hospitalized for any of the following conditions?

<p><b>1. Brain/Nervous System</b> – frequent and/or severe headaches, migraines, seizures, epilepsy, dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, sleep apnea, narcolepsy, used a sleep monitoring device, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>9. Musculoskeletal System</b> – bone pain, injury or disorder of joint/tendon/ligament/disk, weakness of back/spine/joint, amputation, physical handicap, polio, arthritis, gout, sprain/strain, prosthesis, joint replacement, hardware, internal fixations (i.e., pins, plates, screws), fractures, TMJ, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>2. Heart/Circulatory System</b> – chest pain, angina, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, valve replacement, pacemaker, defibrillator; or blood clot, phlebitis, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, Raynaud's, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>10. a) Endocrine/Metabolic System</b> – diabetes, thyroid, anemia, adrenal disorders, pituitary disorders, lupus, AIDS/ARC, immune disorders, scleroderma, Epstein-Barr/chronic fatigue syndrome, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>3. Lungs/Respiratory System</b> – allergies, infections, sinusitis, asthma, bronchitis, emphysema, pneumonia, tuberculosis, difficulty breathing, shortness of breath, chronic cough, spitting/coughing up blood, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>b) Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant, or a candidate to donate an organ or bone marrow?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>4. Digestive System</b> – tonsillitis, infections of the mouth/throat, jaw/chewing problems, gastric reflux, ulcers, hernia, colitis, intestinal problems, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, gallbladder, pancreatitis, liver disease, cirrhosis, hepatitis, jaundice, unexplained weight loss, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>11. Has any proposed member ever had:</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>5. Urinary System</b> – kidney, bladder, urinary tract infections, stones, urinary incontinence, blood in urine, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><input type="checkbox"/> Cancer <input type="checkbox"/> Tumor/Growth <input type="checkbox"/> Leukemia <input type="checkbox"/> Cyst</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>6. Male Reproductive System</b> – prostate, infertility, low sperm count, impotence, sexual dysfunction, penile or scrotal implant, sexually transmitted disease, herpes, genital warts, undescended testes, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>12. Skin Disorder/Problems</b> – cancer, melanoma, pre-cancerous lesion psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, acne, fungal infections, eczema, dermatitis, herpes, scars/keloids, or revisions of cosmetic or reconstructive surgery, infections, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>7. Female Reproductive System</b> –</p>		<p><b>13. Sensory Organs</b> – diseases, infections, impairments, problems of the eyes (sight), blurred vision, cataracts, glaucoma, ears (hearing), nose (breathing), prosthesis, implants, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>a) breast disorder/cyst, lump, breast implants, fibroid tumors, endometriosis, pelvic pain, menstruation disorders, abnormal/absent menstrual bleeding, uterine fibroids, ovarian cysts, infertility, miscarriages, sexually transmitted disease, herpes, genital warts, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>14. Nervous, Mental, Emotional, Behavioral</b> – eating disorder, anorexia/bulimia, depression, anxiety, alcohol or substance abuse/dependency, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive or panic disorder, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>b) Does any proposed female member menstruate? If yes: <input type="checkbox"/> Applicant/Spouse <input type="checkbox"/> Dependent</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>15. Congenital Abnormalities, Birth Defects</b> – cleft lip/palate, foot, webbed fingers or toes, mental retardation, developmental delay, Down's syndrome, heart/lung problems, skull/facial deformities, birthmark, etc.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>c) Has it been more than 40 days since her/their last menstrual period? If yes, explain: _____</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>16. Has any proposed member ever been eligible for or received benefits from California State Disability Insurance, Workers' Compensation?</b> If yes, start date: _____ End date: _____</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>d) Date and result of last pelvic exam/Pap smear for each female over age 16.</p>		<p><b>17. Has any proposed member ever been a patient in a hospital, clinic, or medical facility?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p>		<p><b>18. Has any proposed member ever had an abnormal test, EKG, x-ray, or been advised to undergo further testing, surgery, or treatment; or been advised to see an oral surgeon or dentist?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p>		<p><b>19. Has anyone taken any prescribed medications in the last 12 months?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p>		<p><b>20. a) Has any proposed member had treatment in the last 10 years, contacted or seen a physician, dentist, oral surgeon, psychologist, chiropractor, counselor, therapist, or any other person providing health care services?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p><b>8. Reproduction – Must be completed by male and female applicants.</b></p>		<p>b) Has any proposed member ever seen or consulted any doctor, or any other person providing health care services for any other condition or symptom(s) not listed on this application?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>a) Is either the applicant, spouse, or any female dependent, whether or not listed on this application, currently pregnant, or in the process of adoption or surrogate pregnancy?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>b) Is any male listed on this application expecting a child with anyone, whether or not listed on this application?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>		

**IMPORTANT:** Applicant's medical conditions, which occur after the signature date and before the original effective date, are considered in the final underwriting decision.

## 7B. Lifestyle

<p><b>1. Within the last 5 years, has any applicant smoked or used any tobacco products – such as: cigarettes, pipe, cigar, snuff, or chewing tobacco?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p><b>3. Has any applicant consumed any alcoholic beverages in the last 6 months?</b> (Amount: A drink is 12 oz. of beer, or 6 oz. of wine, or 1 oz. of liquor.)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Name: _____ Type: _____ Date discontinued: _____</p>		<p>Name: _____ Type: _____</p>	
<p>Name: _____ Type: _____ Date discontinued: _____</p>		<p>Amount: _____ per: <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month</p>	
<p>Name: _____ Type: _____ Date discontinued: _____</p>		<p>Name: _____ Type: _____</p>	
		<p>Amount: _____ per: <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month</p>	
<p><b>2. Has any applicant used marijuana, cocaine, heroin, methamphetamines, LSD, or any other illegal or controlled drugs, or substances in the last 10 years, or been diagnosed as chemically or alcohol dependent?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Name: _____ Type: _____</p>	
<p>Name: _____ Substance: _____ Date discontinued: _____</p>		<p>Amount: _____ per: <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month</p>	
<p>Name: _____ Substance: _____ Date discontinued: _____</p>			
<p>Name: _____ Substance: _____ Date discontinued: _____</p>		<p><b>4. Has any applicant been advised to reduce alcohol intake within the past 10 years?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
		<p>Name: _____ Date discontinued: _____</p>	
		<p>Name: _____ Date discontinued: _____</p>	
		<p>Name: _____ Date discontinued: _____</p>	

**7C. Last Doctor Visit (for any reason including check-up) – Provide information for ALL family members you wish to cover.**

Family Member	Date of Visit	Reason for Visit	Results		Name, Phone No. & Fax No. of Physician or Hospital Complete Address / City / State / ZIP Code
			Normal	Abnormal (Explain)	
					Name: _____ Phone: _____ Fax: _____ Address: _____
					Name: _____ Phone: _____ Fax: _____ Address: _____
					Name: _____ Phone: _____ Fax: _____ Address: _____

**7D. Prescription Medications – List all medications taken within the last 12 months by any family member listed on this application.**

Family Member	Medication / Dosage / Frequency (i.e., Zantac/50mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. & Fax No. of Physician or Hospital Complete Address / City / State / ZIP Code
					Name: _____ Phone: _____ Fax: _____ Address: _____
					Name: _____ Phone: _____ Fax: _____ Address: _____
					Name: _____ Phone: _____ Fax: _____ Address: _____

**7E. Medical Services – Give COMPLETE details below of any “Yes” answers to the questions in Section 7A.**

<b>Question #</b>	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care			Phone No. ( )
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Cardiac	
Name of Condition/Illness			<input type="checkbox"/> Internal medicine	<input type="checkbox"/> Family	<input type="checkbox"/> Other: _____	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / <b>Results</b>			Address			Suite No.
			City / State / ZIP Code			Fax No. ( )
<b>Question #</b>	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care			Phone No. ( )
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Cardiac	
Name of Condition/Illness			<input type="checkbox"/> Internal medicine	<input type="checkbox"/> Family	<input type="checkbox"/> Other: _____	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / <b>Results</b>			Address			Suite No.
			City / State / ZIP Code			Fax No. ( )
<b>Question #</b>	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care			Phone No. ( )
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Cardiac	
Name of Condition/Illness			<input type="checkbox"/> Internal medicine	<input type="checkbox"/> Family	<input type="checkbox"/> Other: _____	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / <b>Results</b>			Address			Suite No.
			City / State / ZIP Code			Fax No. ( )
<b>Question #</b>	Name of Family Member (As identified on Physician's Record)		Name of Hospital, Clinic and/or Person Providing Care			Phone No. ( )
Date of Onset/Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment	Physician Specialty	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Cardiac	
Name of Condition/Illness			<input type="checkbox"/> Internal medicine	<input type="checkbox"/> Family	<input type="checkbox"/> Other: _____	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / <b>Results</b>			Address			Suite No.
			City / State / ZIP Code			Fax No. ( )

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

No. of sheets attached

## 8. Conditions of Application

**IMPORTANT: It is important that you carefully read and fully understand the following.**

### Authorization

**Authorization to Obtain or Release Medical Information:** I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give Blue Cross of California, its affiliates ("Blue Cross"), their respective agents, employees, designees, or representatives, including my Blue Cross agent, or broker, any and all information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related Complex), of me or any of my dependents applying for or having Blue Cross coverage. I understand that this information may be collected in connection with the review, investigation or evaluation of an enrollment form or of any claim for benefits.

**HIV TESTING PROHIBITED:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance. I also authorize Blue Cross to disclose all such medical or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purpose of investigating or evaluating any claim for benefits.

This authorization is effective immediately and shall remain in effect for a period of thirty (30) months, except that it shall remain effective for use in connection with any claim for benefits for as long as any Blue Cross coverage may be in effect. A photocopy of this authorization is as valid as the original, and I and my Blue Cross agent or broker, am entitled to receive a copy of this form.

### Signatures (Required) – IMPORTANT: All signatures MUST include today's date.

Applicant / Parent or Legal Guardian	Today's Date	Applicant's Spouse	Today's Date
X		X	
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
X		X	

**If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 60 to 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.**

### PPO Plan Applicants only

I, the undersigned, understand that under the Blue Cross plan in which I am enrolling, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use a network hospital or physician.

**All Applicants age 18 and over must personally read, agree to and sign the following. If an Applicant does not read English, the translator must sign and submit a Statement of Accountability for translating this entire application (see page 8).**

#### Effective Date (PPO Applicants only)

I request that Blue Cross assign my effective date if my application is approved. My effective date will be assigned as either the 1st or the 15th of the month following the approval date of my application.

**Please note:** If you are adding a dependent or changing coverage, your effective date will always be the first of the **month following approval**.

If Blue Cross approves my application, please assign an effective date of the  1st *or*  15th of \_\_\_\_\_.  
This date must be after the signature date but not greater than 75 days from the signature date on this application.

**REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED.**

### HMO Applicants only

I understand I will only receive benefits for services by or authorized by the HMO facility I selected on this application.

If Blue Cross approves my application, please assign an effective date of the  1st *or*  15th of the **month following approval**.

### High Deductible EPO for MSA Applicants only

I understand that the High Deductible Plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an MSA. To do so, I must contact a qualified financial institution. Also, I understand that I should contact my tax advisor.

### Eligible/Ineligible Applicants

Blue Cross will enroll all eligible family members unless otherwise instructed.

I, the Applicant, request that Blue Cross not enroll any eligible applicants unless ALL family members qualify.

### Agreement (all applicants)

**By applying for coverage, I, the undersigned, agree to the following:**

- Blue Cross may decline my application, and if so, neither I nor any dependents for whom coverage is applied for will have any coverage. No coverage comes into effect unless and until Blue Cross approves this application and tells me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Blue Cross at its discretion.
- Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Blue Cross nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Blue Cross.
- The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or the terms of any Blue Cross coverage.
- Any of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if any information is false or incomplete and that Blue Cross may revoke coverage if it discovers that any information on this application is incomplete or false.
- If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
- In no event shall Blue Cross or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the

**Agreement** (Continued)

money submitted with this application if this application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Blue Cross of California.

7. I understand Blue Cross of California may use any information Blue Cross of California obtains prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.

**I have personally read and completed this application.** If I am accepted, this application will become part of the contract between Blue Cross and me. I and any enrolled family members agree to abide by the terms of that contract.

**Arbitration:** I agree that any dispute between me or any enrolled family member, and Blue Cross of California and/or its affiliates must be resolved by binding arbitration if the amount in dispute exceeds the jurisdictional limits of the Small Claims Court. Any such dispute will be resolved not by lawsuit or resort to court process, except as California law provides for judicial review or arbitration proceedings. Under this coverage, both I and my enrolled family, and Blue Cross of California and its affiliates, are giving up the right to have any dispute decided in a court of law before a jury.

**Signatures** (Required) – **IMPORTANT: All signatures MUST include today's date.**

Applicant / Parent or Legal Guardian	Today's Date	Applicant's Spouse	Today's Date
<b>X</b>		<b>X</b>	
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
<b>X</b>		<b>X</b>	

**9. Billing Information** **Payment required.****9A. Billing Type** **Monthly Billing**

Available with Monthly Checking Account Deduction Authorization only.

- Submit the one (1)-month premium and a voided check.
- Complete Section 9C. Monthly Checking Account Deduction Authorization below. Attach a blank check marked "Void."**
- If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account on the first of the month.

 **Optional Bimonthly (Two-month) Billing**

Submit the two (2)-month premium.

 **Optional Quarterly (Three-month) Billing**

Submit the three (3)-month premium.

**Please note:** Your check will not be cashed until your application is approved.

**9B. Initial Premium Payment by Credit Card**

New members only. Not available to make a coverage change.

**Initial premium is for Medical and Dental fees only.**

Number of months premium:  1 month  2 months  3 months

Amount of initial premium: \$ \_\_\_\_\_

Credit card: (VISA or MasterCard only)  VISA  MasterCard

Card No.: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Cardholder's name: \_\_\_\_\_

Relationship to applicant: \_\_\_\_\_

Signature of cardholder: **X** \_\_\_\_\_

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

**ATTACH PREMIUM CHECK HERE. DO NOT TAPE.**

**ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION, IF APPLICABLE, HERE.  
DO NOT TAPE.**

**9C. Monthly Checking Account Deduction Authorization**

Complete this section and attach a blank check marked "VOID" to this form (**DEPOSIT SLIPS NOT ACCEPTABLE**). Attach a check for one (1) month's premium above where indicated. If the account listed below is a joint account, both account holder's signatures are required.

**AUTHORIZATION** – As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California dues. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Applicant's Name	
Applicant's Social Security No.	Group No.
Name on Checking Account (If different than above)	
Checking Account No.	

Name of Bank
Address
City / State / ZIP Code

**NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option. **You may incur a \$25 service charge for any withdrawal not honored.**

Authorized Signature (As it appears in the financial institution's records)	Date	Authorized Signature (As it appears in the financial institution's records)	Date
<b>X</b>		<b>X</b>	

**To be completed by the Blue Cross-Appointed Agent**

- Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk? .....  Yes  No
- Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? .....  Yes  No  
If no, please explain: \_\_\_\_\_

3. **Breakdown of funds collected:**

Total Medical funds	\$ _____
Total Dental funds	\$ _____
<b>Total funds collected</b>	<b>\$ _____</b>

- Was the Term Life Insurance option selected? (If yes, first Term Life Insurance payment will be billed.) .....  Yes  No
- Was the Summary-Bill application cover sheet completed? (Only if applicable) .....  Yes  No
- Was the Monthly Checking Account Deduction Authorization form completed? (Only if applicable) .....  Yes  No

Name of Agent (Print name)		Agent's Street Address		Suite No. / Personal Mail Box (PMB) No.	
Agent No.	Sub-Agent Tax I.D. No.	City / State / ZIP Code		Location No.	
Phone No. (     )	Fax No. (     )	E-mail Address			
Signature of Agent (Required)				Date (Required)	
<b>X</b>					

**Mail Service Agreement to:**       Broker/Agent       Subscriber

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the subscriber.

**Mailing address:**

**Agent:** Please mail this application to the following address: **Blue Cross of California • P.O. Box 9041 • Oxnard, CA 93031-9041**

**Agent/Applicant checklist – Most common causes for delay in underwriting**

**Missing, inaccurate or incomplete information such as:**

- Spouse's Social Security number (whether the spouse is listed on the application or not)
- Dependent's Social Security number
- Height and weight
- Age and date of birth
- Dates of last pelvic examination
- Results of last pelvic examination
- Incomplete or illegible information such as the mailing address does not include city, state, and ZIP code.
- Incomplete Health History (Section 7). If it does not apply to the applicant, the answer should be "No."  
DO NOT leave any answers blank. Explain "Yes" answers to health questions fully in Section 7E.
- The application is not signed and dated by the applicant and/or all listed dependents over age 18.
- The agent portion of the application is not completed, signed or dated.
- Primary Medical Group (PMG) (Section 3A) is not specified for HMO coverage or dental office provider number is not indicated for Blue Cross Dental SelectHMO (Section 2).

**STATEMENT OF ACCOUNTABILITY – To be completed when the applicant cannot complete the application.**

I, \_\_\_\_\_, personally read and completed this Individual Enrollment Application for the applicant named below because:

- Applicant does not read English       Applicant does not speak English       Applicant does not write English  
 Other (explain): \_\_\_\_\_

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by:

\_\_\_\_\_

I also translated and fully explained the "Conditions of Application."

**X**

Signature of Translator (Required)

Today's Date (Required)