

# 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

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## PART 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"/> <b>SelectBlue®</b> 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"/> <b>BlueValue®</b> 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"/> <b>SelectBlue Advantage®</b> 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:    80% Do You Want Maternity Coverage? <input type="checkbox"/> Yes	<input type="checkbox"/> <b>BlueValue Advantage®</b> 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:    80% 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)
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# 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, 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<sup>®</sup>) 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: <b>X</b> _____	Date Signed: _____
	mo. / day / yr.
Spouse's Signature (ONLY if to be insured): <b>X</b> _____	Date Signed: _____
	mo. / day / yr.
Parent/Guardian Signature (If Primary Applicant is UNDER the age of 18): <b>X</b> _____	Date Signed: _____
	mo. / day / yr.
Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): <b>X</b> _____	Date Signed: _____
	mo. / day / yr.
Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): <b>X</b> _____	Date Signed: _____
	mo. / day / yr.
Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): <b>X</b> _____	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: <b>X</b> _____	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: <b>X</b> _____	Date Signed: _____
	mo. / day / yr.
Print Your Name as You Signed It: _____	Agent's Phone Number: ( ) _____
Agent's Code: _____	

## 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 HAD 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.

OB1935

Rev. 7/94

**NOTE TO PRODUCER:** An applicant who is replacing existing health insurance with Blue Cross and Blue Shield coverage must read, sign, and date the blue replacement form at right. You must then submit that replacement form along with the application. This form must remain with the applicant.

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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.

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

\_\_\_\_\_ Date

-----  
\_\_\_\_\_  
Applicant's Signature

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Rev. 7/94

**This form must be signed  
and dated by  
the applicant and returned  
with the application.**

**This form stays  
with the applicant.**

# CONDITIONAL RECEIPT FOR



**BlueCross BlueShield  
of Illinois**

CONSUMER MARKETS

Proposed Insured: \_\_\_\_\_

Date of Application: \_\_\_\_\_ Amount Received: \_\_\_\_\_ Date of Receipt: \_\_\_\_\_

**NO INSURANCE WILL BECOME EFFECTIVE UNLESS EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO PRODUCER IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.**

Subject to the limitations shown below, insurance will become effective under the receipt if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Health Care Service Corporation, a Mutual Legal Reserve Company (Blue Cross and Blue Shield of Illinois) hereafter "HCSC," at its Home Office (or the office of the designated administrator).
2. The first full premium, according to the mode of premium payment chosen, has been paid and the check is honored on first presentation for payment.  
"An effective date in compliance with HCSC guidelines" means the later of:
  - a. The requested coverage date, if any, shown on the application; or
  - b. The date upon which the application is approved by HCSC at its Home Office (or office of the designated administrator).
3. The policy is issued by HCSC exactly as applied for within 60 days from date of application, delivered, and accepted by the proposed insured.

Applicant's Copy (if paying by check or money order)

(over, please)

## 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

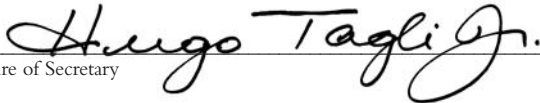
PLEASE ATTACH VOIDED CHECK OR DEPOSIT SLIP

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

✂ DETACH HERE ✂

Limitation:

This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided herein. In the event HCSC declines to issue a policy as applied for, the amount received by HCSC will be refunded.



Signature of Secretary

Signature of Producer

Producer's Code: \_\_\_\_\_

Blue Cross and Blue Shield of Illinois  
Administrator: Hallmark Services Corp.  
PO Box 2038  
Aurora, Illinois 60507-2038

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF ILLINOIS.  
DO NOT PAY CASH OR MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.**

If you do not hear from HCSC regarding the proposed insurance within 30 days, please call 1-800-538-8833.

**THIS FORM LIMITS OUR LIABILITY.**

**BE SURE TO READ AND SIGN THE APPLICATION AND, IF DESIRED, THE AUTOMATIC PAYMENT REQUEST FORM. KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.**