



Individual Enrollment Application

Blue Cross Dental SelectHMO and all medical plans except the Basic PPO 1000, PPO Saver, BC Life Share 1000 and BC Life Share 500, are offered by Blue Cross of California. The Basic PPO 1000, PPO Saver, BC Life Share 1000, BC Life Share 500, PPO Dental and Term Life products are offered by BC Life & Health Insurance Company.

1. Application must be completed by the applicant in blue or black ink.
2. Any family member currently pregnant (whether or not listed on the application) or in the process of adoption is not eligible.

Applicant's Social Security No.

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) Child only
 Add dependent(s)
 Change existing Blue Cross plan –
 Certificate No: _____
 Summary bill (existing) –
 I.D. No: _____

Have Questions? Need Assistance? Call Us At: (877) 433-7868

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
E-mail Address	If possible, do you want e-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse's Social Security No.
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:	Language Choice (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese	Maiden Name of Applicant / Spouse
Ethnic Code (Optional)	5a <input type="checkbox"/> Native American Indian A <input type="checkbox"/> Amerasian J <input type="checkbox"/> Japanese N <input type="checkbox"/> Asian Indian T <input type="checkbox"/> Laotian	
1 <input type="checkbox"/> White 3 <input type="checkbox"/> Black/African American	5b <input type="checkbox"/> Alaskan Native C <input type="checkbox"/> Chinese K <input type="checkbox"/> Korean P <input type="checkbox"/> Hawaiian V <input type="checkbox"/> Vietnamese	
2 <input type="checkbox"/> Hispanic 4 <input type="checkbox"/> Asian	7 <input type="checkbox"/> Filipino H <input type="checkbox"/> Cambodian M <input type="checkbox"/> Samoan R <input type="checkbox"/> Guamanian Z <input type="checkbox"/> Other	

2. Choice of Blue Cross Individual Coverage

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

If yes, proceed to Section 3 on the following page. Refer to the 4-digit codes in parentheses below to indicate medical coverage choices in Section 3B for each family member. (NOTE: If choosing FamilyElectSM, 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.

MEDICAL COVERAGE	
PlanScape® Coverage	Low Option: <input type="checkbox"/> Basic PPO (7900) <input type="checkbox"/> PPO Saver (NM31) <input type="checkbox"/> PPO Share 2500 (7891) <input type="checkbox"/> EPO (MSA Compatible) (7892) Medium Option: <input type="checkbox"/> PPO Share 1500 (7889) <input type="checkbox"/> PPO Share 1000 (1393) <input type="checkbox"/> PPO Share 500 (7895) <input type="checkbox"/> BC Life Share 1000 (1930) <input type="checkbox"/> BC Life Share 500 (1929)
Alternative HMO Coverage	High Option: <input type="checkbox"/> HMO Saver* (Areas 1, 2, 3 only) (NM03) * If you have chosen Blue Cross Individual HMO or Blue Cross HMO Saver medical coverage, please complete Section 3A on the following page. <input type="checkbox"/> Individual HMO* (Areas 4, 5, 6 only) (NM02) If you do not qualify for an HMO plan, would you like to be enrolled in PlanScape® coverage with a 50% increase in premium? <input type="checkbox"/> No, DO NOT enroll me <input type="checkbox"/> Yes – Specify any PlanScape coverage you wish to be enrolled in except EPO (MSA Compatible): _____
HIPAA Enrollment	To determine eligibility for HIPAA guaranteed enrollment, please go to Section 5, questions E-E3. If eligible, please enroll me in: <input type="checkbox"/> HIPAA PPO Share 2500 (SMG2) <input type="checkbox"/> HIPAA PPO Share 1500 (SMG3)

LIFE INSURANCE COVERAGE	DENTAL COVERAGE											
<input type="checkbox"/> BC Life & Health Term Life Insurance The Term Life Insurance option is available with Level I and Level I+20 plan coverages ONLY. <i>Complete Section 4 on page 2.</i> DO NOT SUBMIT PREMIUM FOR LIFE INSURANCE.	<input type="checkbox"/> Blue Cross Dental PPO (7874) <input type="checkbox"/> Blue Cross Dental Saver SelectHMO* (ZE6N) <input type="checkbox"/> Blue Cross Dental SelectHMO* (ZE7N) <input type="checkbox"/> Blue Cross Dental Premier SelectHMO* (ZE8N) *For any of the Blue Cross Dental SelectHMO coverages, please indicate the Provider number below:	Please list applicants you wish to provide Dental coverage for:										
		<table border="1"> <thead> <tr> <th>NAME OF APPLICANT</th> <th>DATE OF BIRTH</th> </tr> </thead> <tbody> <tr> <td>SELF</td> <td></td> </tr> <tr> <td>SPOUSE</td> <td></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </tbody> </table>	NAME OF APPLICANT	DATE OF BIRTH	SELF		SPOUSE					
		NAME OF APPLICANT	DATE OF BIRTH									
		SELF										
		SPOUSE										

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 By <input type="checkbox"/> AD	Date
					<input type="checkbox"/> AA <input type="checkbox"/> AD	

3. Applicants for Coverage

Please list ALL applicants (youngest to oldest) applying for coverage. If a family member's last name is different than yours, please explain.							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
Relation	Last Name	First Name	M.I.	Social Security No.	Date of Birth	Age	Height	Weight	PMG / IPA	Primary Care Physician (PCP)	Current Patient	
10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	Yourself				/ /						<input type="checkbox"/> Yes <input type="checkbox"/> No	
30 <input type="checkbox"/> Husband 40 <input type="checkbox"/> Wife	Spouse				/ /							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					/ /							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					/ /							
<input type="checkbox"/> Son <input type="checkbox"/> Daughter					/ /							

3C. 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						

* **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.

I have discussed Life Insurance with my agent and decline – Initial: _____

5. Prior Insurance History and HIPAA Eligibility – 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.** Has any applicant been a member of Blue Cross of California or any other health insurance plan within the last 5 years? Yes No
B. Has any applicant had coverage in the last 63 days? Yes No

If you answered "Yes" to A or B above, please provide the following information.

Name of applicant(s): _____ Certificate/Policyholder No: _____
 Plan name: _____ State: _____ Most recent coverage start date: ____ / ____ / ____ End date: ____ / ____ / ____
 I certify that my coverage terminated/will terminate on (date): _____

- C.** Has any applicant ever been eligible for or received benefits from Medicaid, Medi-Cal, Medicare, California State Disability Insurance, Workers' Compensation, or an employer-sponsored health plan? Yes No

If yes, start date (Mo/Day/Yr): _____ End date (Mo/Day/Yr): _____

- D.** 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

- E. HIPAA Coverage** – If I do not qualify for the Individual Plans, I would like to be considered for coverage under HIPAA. I understand that no underwriting is required and rates may be significantly higher than for the Individual Plans. If I qualify, please offer the HIPAA coverage and send complete details regarding my options and rates Yes No

If yes, name of applicant(s) applying for HIPAA coverage: _____

If yes, please answer the following questions.

- 1) Have you had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan, that ended within the last 63 days for a reason other than fraud or non-payment of premium? Yes No

If yes, you will be asked to provide the Certificate of Coverage from your former employer or carrier OR a letter from the employer giving us the Start date (Mo/Day/Yr): _____ End date (Mo/Day/Yr): _____ Name of applicant: _____
 Name of insurance carrier(s): _____ Phone no. (_____) _____

If no, you are not eligible for HIPAA coverage.

- 2) Were you eligible for COBRA or Cal-COBRA? Yes No

If yes, start date (Mo/Day/Yr): _____ End date (Mo/Day/Yr): _____
If no, please explain: _____

If COBRA or Cal-COBRA is not exhausted, you are not eligible for HIPAA coverage.

- 3) Are you currently covered by or eligible for Medicaid, Medicare or any other employer-sponsored health insurance benefits, or do you have other health coverage? Yes No

If yes, you are not eligible for HIPAA coverage.

6. Health History Include information on ALL family members you wish to enroll.

6A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.

Give COMPLETE details of any "Yes" answers in Section 6C on the following page.

Has any person listed on this application, in the last 10 years, had any signs or symptoms, seen a health care provider, had treatment recommended including prescription medications, received treatment, or been hospitalized for any of the following conditions as stated in questions 1 through 14?

<p>1. Brain/Nervous – 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. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>2. Heart/Circulatory – 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. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>3. Lungs/Respiratory – allergies, infections, sinusitis, asthma, bronchitis, emphysema, pneumonia, tuberculosis, difficulty breathing, shortness of breath, chronic cough, spitting/coughing up blood, etc. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>4. Digestive – 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. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Urinary – kidney, bladder, urinary tract infections, stones, urinary incontinence, blood in urine, etc. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Male Reproductive System –</p> <p>a) Prostate, infertility, low sperm count, impotence, sexual dysfunction, penile or scrotal implant, sexually transmitted disease, herpes, genital warts, undescended testes, etc. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not listed on this application? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Female Reproductive – Yes No <input type="checkbox"/> <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. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>b) Does any proposed female member menstruate? Yes No <input type="checkbox"/> <input type="checkbox"/> If yes, indicate if: <input type="checkbox"/> Applicant/spouse <input type="checkbox"/> Dependent(s) Dependent name(s): _____</p> <p>c) Has it been more than 40 days since her/their last menstrual period? Yes No <input type="checkbox"/> <input type="checkbox"/> If yes, explain: _____</p> <p>d) Has any female applicant had a pelvic exam/Pap smear? Yes No <input type="checkbox"/> <input type="checkbox"/> <i>If yes, complete 7e below.</i></p> <p>e) Date and result of last pelvic exam/Pap smear for each female over age 16.</p> <p>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>Name: _____ Mo/Day/Yr: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>f) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy? Yes No <input type="checkbox"/> <input type="checkbox"/></p>	<p>8. Musculoskeletal – bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, 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. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>9. Endocrine/Metabolic –</p> <p>a) Diabetes, thyroid, anemia, adrenal disorders, pituitary disorders, lupus, AIDS/ARC, immune disorders, scleroderma, Epstein-Barr/chronic fatigue syndrome, etc. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>b) Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>c) Is any applicant on the waiting list to donate an organ or bone marrow (excluding DMV donor card)? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Has any applicant ever had cancer, tumor/growth, leukemia, cyst? Yes No <input type="checkbox"/> <input type="checkbox"/> If yes, specify: <input type="checkbox"/> Cancer <input type="checkbox"/> Tumor/growth <input type="checkbox"/> Leukemia <input type="checkbox"/> Cyst</p> <p>11. Skin Disorder/Problems – 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. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>12. Eyes, Ears, Nose and Throat – diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing – such as: any infections, crossed eyes, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, problems with tonsils or adenoids, sleep apnea, etc.? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Nervous, Mental, Emotional, Behavioral – 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. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Congenital Abnormalities, Birth Defects – cleft lip/palate, club foot, webbed fingers or toes, mental retardation, developmental delay, Down's syndrome, heart/lung problems, skull/facial deformities, birthmark, etc. Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Has any applicant taken any prescribed medications in the last 12 months? Yes No <input type="checkbox"/> <input type="checkbox"/> <i>If yes, complete 6E on page 4.</i></p> <p>16. Has any applicant consulted a provider for any condition or symptom(s) in the last 12 months, for which a diagnosis has not been established? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Has any applicant been advised to see a dentist or oral surgeon the last 12 months? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>18. Has any applicant ever been a patient in a hospital, clinic, surgicenter, sanatorium, or other medical facility as an inpatient or outpatient (excluding childbirth)? Yes No <input type="checkbox"/> <input type="checkbox"/> <i>If yes, complete 6C on page 4.</i></p> <p>19. Has any applicant ever had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing, surgery or treatment? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>20. Has any applicant ever seen, received treatment from or consulted any doctor, or any other person providing health care services for any other condition or symptom(s) not listed on this application? Yes No <input type="checkbox"/> <input type="checkbox"/> <i>If yes, complete 6C on page 4.</i></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.

6B. Other Health Questions

<p>1. During the past 12 months, has any applicant smoked cigarettes, cigars, pipes, or used chewing tobacco? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Name: _____ Date discontinued: _____</p> <p>Name: _____ Date discontinued: _____</p> <p>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? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Name: _____ Substance: _____ Date discontinued: _____</p> <p>Name: _____ Substance: _____ Date discontinued: _____</p>	<p>3. Has any applicant consumed any alcoholic beverages in the last 6 months? Yes No <input type="checkbox"/> <input type="checkbox"/> <i>(Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.)</i></p> <p>Name: _____ Type: _____</p> <p>Amount: _____ per: <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month</p> <p>Name: _____ Type: _____</p> <p>Amount: _____ per: <input type="checkbox"/> Day <input type="checkbox"/> Week <input type="checkbox"/> Month</p> <p>4. Has any applicant been advised to reduce alcohol intake within the past 10 years? Yes No <input type="checkbox"/> <input type="checkbox"/></p> <p>Name: _____ Date discontinued: _____</p> <p>Name: _____ Date discontinued: _____</p>
---	---

6C. Professional Services

Applicant's Social Security No.

Give COMPLETE details below of any "Yes" answers to the questions in Section 6A.

Question #	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 <input type="checkbox"/> Internal medicine <input type="checkbox"/> Family <input type="checkbox"/> Other: _____	
Name of Condition/Illness		Address	Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / Results		City / State / ZIP Code	Fax No. ()
Question #	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 <input type="checkbox"/> Internal medicine <input type="checkbox"/> Family <input type="checkbox"/> Other: _____	
Name of Condition/Illness		Address	Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / Results		City / State / ZIP Code	Fax No. ()
Question #	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 <input type="checkbox"/> Internal medicine <input type="checkbox"/> Family <input type="checkbox"/> Other: _____	
Name of Condition/Illness		Address	Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / Results		City / State / ZIP Code	Fax No. ()

6D. 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: _____

6E. 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., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name and Phone No. of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____

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
--	------------------------

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 "Application Conditions and Agreement."

X

Signature of Translator (Required)

Today's Date (Required)

7. Application Conditions and Agreement

Applicant's Social Security No.

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

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 4).

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.

Effective Date (PPO Applicants only) REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED.

- 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.

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.

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 applicants over age 18 must sign and date.

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

Agreement (all applicants)

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

- Blue Cross may decline my application. No coverage comes into effect until Blue Cross approves this application and informs 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 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.
- I understand Blue Cross of California may use any information 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. Blue Cross and the Member also agree to give up any right to pursue on a class basis any claim or controversy against the other.

Signatures (Required) – IMPORTANT: All applicants over age 18 must sign and date.

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

