

Health Insurance Solutions, Inc.

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

Health Insurance Solutions, Inc.

FAX# 623-933-8233

Dear Health Insurance Solutions, Inc.,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

I will contact Health Insurance Solutions, Inc. at 623-933-8569 to verify receipt of my application.

****I understand that Health Insurance Solutions, Inc. will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Health Insurance Solutions, Inc.. I will mail the original signed application to :

Health Insurance Solutions, Inc.

Attn: New Enrollment

9009 N. 103rd Ave #104

Sun City, AZ 85351

I will send the original application as soon as I have been contacted by Health Insurance Solutions, Inc. with confirmation that my application has been received by fax and reviewed for completeness.

Signature: _____

Date: _____

Do not staple or tear.



An Independent Licensee of the Blue Cross and Blue Shield Association



How to apply for Blue Cross Blue Shield of Arizona Individual Plans

IMPORTANT: Any applicant designated on this application must be under age 65 and must be a permanent resident of Arizona. Anyone receiving Medicare disability benefits is NOT ELIGIBLE for coverage.

You can apply for dependent coverage for your spouse and for your unmarried children who are under age 19 or, if full-time students, under age 25. If you only need insurance for your children, you can apply for child-only coverage for your children under age 19. Blue Cross Blue Shield (BCBSAZ) will review the medical history information of applicants to determine if they are eligible for coverage.

Please read the following directions carefully to ensure your application is processed as quickly as possible.

- Answer all questions, even if you currently have BCBSAZ coverage. If any part of any section is incomplete, it may result in processing delays.
- Fill in applicant name and social security number on every page.
- **Make sure you list all your health conditions.** We care about everything you know about your medical condition.
- All persons named on this application who are age 18 or older **MUST** sign and date the signature page located on page 10.
- Print your answers in **BLACK** ink. • Do not print in any shaded areas.
- Fill in boxes or ovals completely; do not just mark with an “x”.
- Do not use commas, dashes, hyphens or any other punctuation.
- Use only capital letters, print clearly and leave one blank space between words.

For example:

1 2 3 W H I L L S T

- Do not use highlighters.
- Do not mark in the margins or other areas where answers are not required.

Applications must be sent with a \$20.00 NON-REFUNDABLE fee.
(No fee is required for child-only applications or from current BCBSAZ members.)
Do not send the first month's premium.

NOTICE TO APPLICANTS THAT HAVE LOST GROUP OR COBRA HEALTH COVERAGE: If your group or COBRA health plan (employer provided health coverage) terminated within the past 63 days, you may be eligible for Individual Portability Coverage. This coverage does not require medical underwriting and there is no preexisting condition waiting period. To qualify for this coverage you must meet specific criteria. If you think you may qualify for this coverage, please call us at (602) 864-4899, or toll free at (877) 864-4899, and ask for the Individual Portability Coverage brochure and application. **NOTE: You will lose your eligibility for Individual Portability Coverage if you become insured under any non-group policy.**



An Independent Licensee of the Blue Cross and Blue Shield Association



BLUE CROSS BLUE SHIELD OF ARIZONA INDIVIDUAL APPLICATION

For new or existing customer, please complete entire application.

APPLICATION FOR: NEW CUSTOMER EXISTING CUSTOMER COVERAGE CHANGE ADD DEPENDENT LOWER DEDUCTIBLE

APPLICANT TO BE NAMED AS CONTRACT HOLDER -OR- IF APPLYING FOR CHILD-ONLY COVERAGE, NAME OF PARENT OR LEGAL GUARDIAN LIVING IN ARIZONA:

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER
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THIS LINE NOT APPLICABLE IF APPLYING FOR CHILD ONLY COVERAGE	DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="radio"/> MALE <input type="radio"/> FEMALE	MARITAL STATUS <input type="radio"/> MARRIED <input type="radio"/> SINGLE	HEIGHT ft. in.	WEIGHT lbs.
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MAILING ADDRESS (NUMBER AND STREET)	APARTMENT UNIT	WORK TELEPHONE (AREA CODE & NO.)	EXTENSION
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CITY	STATE	ZIP + FOUR
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COUNTY OF RESIDENCE	HOME TELEPHONE (AREA CODE & NO.)	FAX (AREA CODE & NO.)
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E-MAIL ADDRESS

PLAN FOR WHICH YOU ARE APPLYING

BluePreferred PPO <input type="radio"/> \$250 <input type="radio"/> \$500 <input type="radio"/> \$1,000 <input type="radio"/> \$2,500 <input type="radio"/> \$5,000	BluePreferred Basic PPO <input type="radio"/> \$5,000 <input type="radio"/> \$10,000	BluePreferred Saver PPO <input type="radio"/> \$2,600/80% <input type="radio"/> \$2,600/100% <input type="radio"/> \$5,000/100%	BlueSelect HMO <input type="radio"/> PLAN 1 <input type="radio"/> PLAN 2	BlueClassic Indemnity <input type="radio"/> \$250 <input type="radio"/> \$500 <input type="radio"/> \$750 <input type="radio"/> \$1,250 <input type="radio"/> \$2,500 <input type="radio"/> \$5,000
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TYPE OF COVERAGE <input type="radio"/> INDIVIDUAL <input type="radio"/> FAMILY <input type="radio"/> CHILD-ONLY	IF FAMILY OR CHILD-ONLY COVERAGE, CHECK ALL THAT APPLY <input type="radio"/> SPOUSE <input type="radio"/> ONE CHILD <input type="radio"/> TWO CHILDREN <input type="radio"/> THREE OR MORE CHILDREN
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IF MY APPLICATION IS APPROVED, PLEASE BILL ME AS FOLLOWS: <input type="radio"/> MONTHLY SURE PAY ELECTRONIC BANK DRAFT (PLEASE COMPLETE THE SURE PAY AUTHORIZATION) <input type="radio"/> MONTHLY PAPER BILL <input type="radio"/> QUARTERLY PAPER BILL (BILLED JAN./APRIL/JULY/OCT.)	THE EFFECTIVE DATE OF YOUR COVERAGE WILL DETERMINE THE DAY OF THE MONTH THAT YOUR PREMIUM WILL BE DUE. I PREFER MY COVERAGE TO BE EFFECTIVE: <input type="radio"/> ON THE FIRST OF THE MONTH <input type="radio"/> ON THE FIFTEENTH OF THE MONTH <input type="radio"/> EARLIEST DATE AVAILABLE (FIRST OR FIFTEENTH)
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IF YOU ARE APPLYING FOR CHILD-ONLY COVERAGE: PROVIDE INFORMATION ON CO-CUSTODIAL PARENT OR LEGAL GUARDIAN, IF APPLICABLE

LAST NAME	FIRST NAME	M.I.	HOME TELEPHONE (AREA CODE & NO.)
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SPOUSE AND/OR CHILDREN TO BE CONSIDERED FOR COVERAGE. WHEN ADDING A DEPENDENT TO EXISTING COVERAGE, LIST ONLY THOSE DEPENDENTS YOU ARE ADDING. IF YOU HAVE MORE THAN 3 CHILDREN, COMPLETE A SEPARATE SHEET AND CHECK BOX HERE.

SPOUSE	SPOUSE'S LAST NAME	FIRST NAME	M.I.
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DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT	DATE OF MARRIAGE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
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1 CHILDREN (DEPENDENT OR CHILD ONLY)	CHILD'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER
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DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT	RELATIONSHIP
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CHILD'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER
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2 CHILDREN (DEPENDENT OR CHILD ONLY)	DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT	RELATIONSHIP
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CHILD'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER
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3 CHILDREN (DEPENDENT OR CHILD ONLY)	DATE OF BIRTH (MM/DD/YYYY)	SEX <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT	RELATIONSHIP
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SPACE BELOW: FOR BROKER USE ONLY

ASSOCIATION NAME HEALTH INSURANCE SOLUTIONS, INC.	ASSN#	BROKER NAME, MAILING ADDRESS AND PHONE HEALTH INSURANCE SOLUTIONS, INC. 9009 N. 103rd AVE., SUITE 104, SUN CITY, AZ 85351 623-933-8569	BROKER #	05299
APPLICATION FEE RECEIVED				

APPLICANT'S NAME _____ APPLICANT'S SSN _____
(For child-only applications, enter the parent or legal guardian's name)

IF YOU WANT YOUR BILL MAILED TO A DIFFERENT ADDRESS, COMPLETE THIS SECTION

CARE OF (IF APPLICABLE)		ADDRESS (NUMBER & STREET)	
APARTMENT UNIT	CITY	STATE	ZIP + FOUR

SURE PAY AUTHORIZATION

SAVE THE HASSLE OF WRITING US A CHECK. With Sure Pay, there's no bill to keep track of. No check to write. And nothing to mail (or forget to mail). Instead, your premium is automatically withdrawn from your checking or savings account. Just complete and sign this authorization form. Include a voided blank check with your application, and we'll handle all the details with your bank.

Please note that your first monthly premium may be deducted after your normal payment due date. If the first deduction is delayed, it may be for more than one monthly premium.

Please debit my: Checking account Savings account

JOHN DOE 123
123 Any Lane Anytown, USA 12345 Date _____ 123
Pay to the ORDER OF _____ \$ _____
MEMO _____
:0101010101: ||.0101010101|| 123
Routing Number Account Number Check Number

ROUTING TRANSIT NUMBER	ACCOUNT NUMBER
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Important: Remember to sign the authorization below and attach a blank check marked "void."

I authorize Blue Cross Blue Shield of Arizona to start an automatic periodic charge to my checking or savings account as noted above. I also authorize my financial institution to reduce my account balance each period by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.

I want this charge to continue automatically until I write Blue Cross Blue Shield of Arizona telling them to discontinue my Sure Pay service. I agree to allow them reasonable time (usually 15 days) to do so.

I understand Blue Cross Blue Shield of Arizona and my financial institution have the right to discontinue this service if either elects to do so.

I further agree that if there are insufficient funds at the time my account is debited, the amount may be debited again that month or twice the amount the following month. My Blue Cross Blue Shield of Arizona coverage will be terminated if there are insufficient funds in two consecutive drafts.

I have read and agree to abide by the Sure Pay conditions as outlined on this authorization form.

Date (MM/DD/YYYY)

Authorized Signature on Account X _____

HOW DID YOU LEARN ABOUT THE BCBSAZ PLAN FOR WHICH YOU ARE APPLYING? (check one)

PERSONAL RECOMMENDATION NEWSPAPER RADIO TV INTERNET BILLBOARD BROKER OTHER

OPTIONAL: INDICATE TERM LIFE INSURANCE FOR WHICH YOU ARE APPLYING. PLEASE COMPLETE THE ATTACHED DISCLOSURE AUTHORIZATION FORM, IF YOU ARE APPLYING FOR TERM LIFE INSURANCE.

IF INDIVIDUAL/FAMILY COVERAGE:

\$20,000 \$30,000 \$50,000 – THIS AMOUNT IS AVAILABLE ONLY IF APPLICANT IS 19 YEARS OR OLDER DO NOT WISH TO APPLY **DEPENDENT LIFE:** YES NO (AVAILABLE ONLY IF CONTRACTHOLDER HAS LIFE COVERAGE)

IF CHILD-ONLY COVERAGE:

\$10,000 \$20,000 \$30,000 DO NOT WISH TO APPLY ALL CHILDREN LISTED ON THIS APPLICATION WILL RECEIVE COVERAGE IF APPROVED, WITH PREMIUMS CALCULATED ON A PER CHILD BASIS. NOT AVAILABLE TO CHILDREN UNDER 1 YEAR OF AGE.

BENEFICIARY - LAST NAME	FIRST NAME	M.I.	RELATIONSHIP
CONTINGENT BENEFICIARY - LAST NAME	FIRST NAME	M.I.	RELATIONSHIP

IF APPLYING FOR TERM LIFE INSURANCE, WILL ALL OR PART OF THIS LIFE INSURANCE REPLACE EXISTING LIFE INSURANCE? YES NO

IF YES, NAME OF PRESENT CARRIER

EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)

BROKER STATEMENT

I ACKNOWLEDGE THAT THIS IS IS NOT A REPLACEMENT OF EXISTING LIFE INSURANCE.

BROKER SIGNATURE X _____

Life and disability plans are not underwritten by BCBSAZ. You can obtain information about products sold by CareAmerica Life Insurance Company by contacting your insurance broker.

EVIDENCE OF INSURABILITY

IMPORTANT: BCBSAZ will rely on the information provided to make a determination about coverage for all persons named on the application. **If information about any applicant's medical background is misstated or omitted, it could result in limitations on coverage or your contract could be rescinded/cancelled and considered never to have been in effect.** In that case, you would become responsible for all incurred medical expenses from the effective date of coverage.

Any change in the health status of any applicant that occurs between the date of this application and the effective date of coverage must be reported to Medical Risk Assessment at (602) 864-4040, or toll-free (800) 232-2345, ext. 4040.

Please consider the following questions carefully.

1 In the past ten (10) years, have you or any person on this application been aware of, been diagnosed, been treated (including maintenance therapy), been injured, experienced pain or other symptoms, had a history of, had tests or x-rays / CT scans / MRIs, taken medications, or been evaluated or advised by any type of health care professional regarding the following categories / conditions?

The categories on the following pages are only examples and do not limit the extent of the information requested. Fill in the "YES" or "NO" ovals for each category listed. Do not leave any items blank, do not write N/A (not applicable), and do not draw a line through the columns.

Fill in YES or NO for each item	YES	NO	Fill in YES or NO for each item	YES	NO	Fill in YES or NO for each item	YES	NO
a Allergies (Sinusitis, Rhinitis, Allergy Shots)	<input type="radio"/>	<input type="radio"/>	o Eyes (Cataracts / Lens Implants, Glaucoma, Crossed / Lazy Eyes) State Site: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="radio"/>	<input type="radio"/>	cc Male Organs (Prostate, Testicles [Cysts, Nodules, Lump, Infection], Impotence)	<input type="radio"/>	<input type="radio"/>
b Back, Neck, Spine, Disc, Scoliosis	<input type="radio"/>	<input type="radio"/>	p Female Organs (Uterus, Cervix, Ovaries); Menstrual Disorder/Irregular Bleeding, Fibroids, Abnormal Pap, Infertility	<input type="radio"/>	<input type="radio"/>	dd Manic Depressive Disorder, Depression, Anxiety / Panic Attacks, Attention Deficit, Hyperactivity, Schizophrenia	<input type="radio"/>	<input type="radio"/>
c Birth / Congenital / Physical (Defect, Deformity, Disease, Disorder)	<input type="radio"/>	<input type="radio"/>	q Fractures (Bone: _____ <input type="checkbox"/> R <input type="checkbox"/> L) Surgery; Pins / Plates / Screws (Present/ Removed), Cast Only [Circle Answers]	<input type="radio"/>	<input type="radio"/>	ee Muscular System (Chronic Fatigue, Fibromyalgia, Muscular Dystrophy)	<input type="radio"/>	<input type="radio"/>
d Blood, Bleeding Disorders	<input type="radio"/>	<input type="radio"/>	r Gallbladder, Intestinal/Stomach (Colitis, Crohn's Disease, Irritable Bowel Syndrome, Hemorrhoids, Acid Reflux)	<input type="radio"/>	<input type="radio"/>	ff Nervous System (Parkinson's Disease, Tremors, Multiple Sclerosis, Paralysis, Numbness, Weakness)	<input type="radio"/>	<input type="radio"/>
e Blood Vessels / Circulation Disorders (Varicose / Spider Veins, Arteries, Lymph System, Edema / Swelling)	<input type="radio"/>	<input type="radio"/>	s Headaches (Migraines, Stress, Muscle Tension)	<input type="radio"/>	<input type="radio"/>	gg Prosthetic Implants or Devices (Breast, Joint, Eye, Tendon)	<input type="radio"/>	<input type="radio"/>
f Bone, Joint [Knee, Shoulder, etc.] (Arthritis, Bursitis, Tendonitis, TMJ, Carpal Tunnel Syndrome, Bunions)	<input type="radio"/>	<input type="radio"/>	t Heart Conditions of Any Kind, Chest Pain/Pressure, Pacemaker, Heart Murmur, Arrhythmia (Irregular Heart Beat)	<input type="radio"/>	<input type="radio"/>	hh Psychiatric or Psychological Treatment or Counseling	<input type="radio"/>	<input type="radio"/>
g Brain / Head (Concussion, Injury, Tumor)	<input type="radio"/>	<input type="radio"/>	u Hernia [Circle Type and State Site] (Hiatal, Umbilical, Inguinal, Ventral) Site: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="radio"/>	<input type="radio"/>	ii Reconstructive Surgery (Plastic, Cosmetic, Restorative)	<input type="radio"/>	<input type="radio"/>
h Breast [Male or Female] (Fibrocystic, Lumps, Nodules, Discharge, Abnormal Mammogram)	<input type="radio"/>	<input type="radio"/>	v High Blood Pressure	<input type="radio"/>	<input type="radio"/>	jj Sexually Transmitted Diseases (HPV / Genital Warts, Genital Herpes, Chlamydia, Gonorrhea)	<input type="radio"/>	<input type="radio"/>
i Elevated Cholesterol, Triglycerides	<input type="radio"/>	<input type="radio"/>	w Hormonal / Endocrine (Thyroid [Nodule /Goiter], Pituitary, Adrenal Gland)	<input type="radio"/>	<input type="radio"/>	kk Skin (Lesions, Discoloration, Lumps, Scleroderma, Psoriasis, Cancer [Melanoma, Basal Cell, Squamous])	<input type="radio"/>	<input type="radio"/>
j Convulsions (Epilepsy, Seizure Disorder, Febrile Seizure)	<input type="radio"/>	<input type="radio"/>	x Illicit Drug Use or Abuse / Other Drug Abuse	<input type="radio"/>	<input type="radio"/>	ll Steroid Use (Anabolic, Prednisone, Decadron, Cortisone Injection)	<input type="radio"/>	<input type="radio"/>
k Developmental / Cognitive / Motor / Speech Delay	<input type="radio"/>	<input type="radio"/>	y Immune System / Inflammatory Disorder (Lupus Erythematosus, Gamma Globulin Deficiency, Gout)	<input type="radio"/>	<input type="radio"/>	mm Stroke / Transient Ischemic Attacks (TIA)	<input type="radio"/>	<input type="radio"/>
l Diabetes, Abnormal Glucose (High or Low)	<input type="radio"/>	<input type="radio"/>	z Kidney / Urinary Tract / Bladder (Stones, Infection, Blood in Urine, Incontinence)	<input type="radio"/>	<input type="radio"/>	nn Benign Tumors, Cysts, Polyps, Growths, Plantar Warts	<input type="radio"/>	<input type="radio"/>
m Ear, Nose, Throat (Otitis / Infection, Tubes, Hearing Problems, Tonsillitis, Deviated Nasal Septum)	<input type="radio"/>	<input type="radio"/>	aa Liver (Cirrhosis, Hepatitis [State Type: _____], Elevated Liver Enzymes)	<input type="radio"/>	<input type="radio"/>	oo Ulcers (Skin, Stomach, Intestine, Eye)	<input type="radio"/>	<input type="radio"/>
n Eating Disorders (Anorexia, Bulimia)	<input type="radio"/>	<input type="radio"/>	bb Lungs (Asthma, Bronchitis, Emphysema/ COPD, Pneumonia, Reactive Airway Disease, Recurrent Cough / Wheeze, Sleep Apnea)	<input type="radio"/>	<input type="radio"/>	pp Weight Problems, Gastric Bypass, Recent Weight Loss or Gain	<input type="radio"/>	<input type="radio"/>

IN THE PAST 10 YEARS:		YES	NO
2	Has surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) been performed on any applicant?	<input type="radio"/>	<input type="radio"/>
3	Has any applicant been advised to have surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) that has not yet been performed?	<input type="radio"/>	<input type="radio"/>
4	Has any applicant been aware of, evaluated, diagnosed, tested or x-rayed, treated or advised or experienced pain or other symptoms for any other conditions or injuries not listed, not yet diagnosed, or for which treatment has not been completed?	<input type="radio"/>	<input type="radio"/>
5	Has any applicant been diagnosed, treated, or evaluated for or experienced or been aware of symptoms related to alcoholism, use or abuse of alcohol, or conditions which may be related to alcohol use or abuse (cirrhosis, hepatitis, cardiac disease, DTs, blackouts)?	<input type="radio"/>	<input type="radio"/>
6	Has any applicant discussed his/her level of alcohol consumption with a health care professional and/or been advised to either decrease his/her intake of alcohol or stop drinking completely?	<input type="radio"/>	<input type="radio"/>

If the answer is "yes" to any item in questions **1** - **6**, indicate the question number or letter and provide full details below, including the onset and ending dates of injury/illness/symptoms and treatment. Providing **full details** may reduce the need for medical records and should include specifics concerning the type of disorder; conditions or symptoms; body location; tests or treatment advised, ordered or received; names and addresses of health care providers. **USE EXTRA PAPER IF NEEDED.**

THE COST OF OBTAINING MEDICAL RECORDS IS THE RESPONSIBILITY OF THE APPLICANT.

LAST NAME	FIRST	QUESTION # OR LETTER
<input type="text"/>	<input type="text"/>	<input type="text"/>
ONSET DATE (MM/YYYY) <input type="text"/>	Description, i.e. symptoms, diagnosis, condition, illness <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
END DATE (MM/YYYY) <input type="text"/>		
ONGOING SYMPTOMS/TREATMENTS? YES <input type="radio"/> NO <input type="radio"/>	Types of Treatment, Testing, Monitoring, Surgery, or Medication <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
	Name and Addresses of Past and Present Physicians, Hospitals, etc. <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

LAST NAME	FIRST	QUESTION # OR LETTER
<input type="text"/>	<input type="text"/>	<input type="text"/>
ONSET DATE (MM/YYYY) <input type="text"/>	Description, i.e. symptoms, diagnosis, condition, illness <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
END DATE (MM/YYYY) <input type="text"/>		
ONGOING SYMPTOMS/TREATMENTS? YES <input type="radio"/> NO <input type="radio"/>	Types of Treatment, Testing, Monitoring, Surgery, or Medication <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
	Name and Addresses of Past and Present Physicians, Hospitals, etc. <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

(ADDITIONAL BOX TO RECORD YOUR DETAILS IS LOCATED ON TOP OF NEXT PAGE.)

LAST NAME	FIRST	QUESTION # OR LETTER
ONSET DATE (MM/YYYY)	Description, i.e. symptoms, diagnosis, condition, illness	
END DATE (MM/YYYY)		
ONGOING SYMPTOMS/TREATMENTS? YES <input type="radio"/> NO <input type="radio"/>		Types of Treatment, Testing, Monitoring, Surgery, or Medication
	Name and Addresses of Past and Present Physicians, Hospitals, etc.	

IF ADDITIONAL DETAILS NEED TO BE ADDED, COMPLETE A SEPARATE SHEET AND CHECK HERE

7 In the past ten (10) years has any applicant been arrested or convicted for DUI / DWI? YES NO
 If "YES," please provide details below.

NAME	NO. TIMES?	STATE	DATE (MM/YYYY)	STATE	DATE (MM/YYYY)

8 Has any applicant **EVER** been aware of, evaluated, advised, tested (other than routine screenings), diagnosed or treated for cancer or malignant neoplasms (e.g. tumors, leukemia, Hodgkin's or melanoma)? YES NO

9 Has any applicant **EVER** been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions or tested positive for the presence of antibodies to the AIDS virus (HIV)? YES NO

If the answer is "YES" to questions **8** - **9**, please provide details below, including the onset and ending dates. Use extra paper if needed.

LAST NAME	FIRST	QUESTION # OR LETTER
ONSET DATE (MM/YYYY)	Description, i.e. symptoms, diagnosis, condition, illness	
END DATE (MM/YYYY)		
ONGOING SYMPTOMS/TREATMENTS? YES <input type="radio"/> NO <input type="radio"/>		Types of Treatment, Testing, Monitoring, Surgery, or Medication
	Name and Addresses of Past and Present Physicians, Hospitals, etc.	

10 Are any medications being taken by any applicant? **YES NO**

 List all medications being taken (regularly or as needed). Use extra paper if needed, and check here

NAME OF PERSON	NAME OF DRUG	REASON FOR TAKING	DATE OF LAST USE (MM/YYYY)

11 Is any male or female applicant applying for coverage currently an expectant parent? **YES NO**

 If yes, the applicant(s) expecting a child are not eligible for coverage *at this time*.

12 Females only: All females age 13 or older listed on this application must complete this section.

NAME	DO YOU MENSTRUATE? YES <input type="radio"/> NO <input type="radio"/>	PERIOD IN LAST 30 DAYS? YES <input type="radio"/> NO <input type="radio"/>
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If no, explain: _____

NAME	DO YOU MENSTRUATE? YES <input type="radio"/> NO <input type="radio"/>	PERIOD IN LAST 30 DAYS? YES <input type="radio"/> NO <input type="radio"/>
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If no, explain: _____

NAME	DO YOU MENSTRUATE? YES <input type="radio"/> NO <input type="radio"/>	PERIOD IN LAST 30 DAYS? YES <input type="radio"/> NO <input type="radio"/>
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If no, explain: _____

IMPORTANT: If any menstruating females listed on this application miss a menstrual period after this application has been submitted, it is considered to be a change in health status and must be reported to Medical Risk Assessment.

IF ANY PART OF ANY SECTION IS NOT COMPLETE, IT MAY RESULT IN PROCESSING DELAYS.

13 During the last two (2) years, has anyone applying for coverage on this application been covered by or applied for BCBSAZ insurance? **YES NO**

LAST NAME	FIRST	DATE (YEAR TO YEAR)	TO
ID NUMBER	CITY	STATE	

14 Is any applicant currently receiving any type of physical or mental disability insurance benefits? **YES NO**

 If any applicant has been determined to be 100% disabled, that person is not eligible for coverage.

NAME	NATURE OF DISABILITY, SPECIFY BODY PART AFFECTED	% DISABILITY
NAME	NATURE OF DISABILITY, SPECIFY BODY PART AFFECTED	% DISABILITY

15 Has any application for a policy of life or health insurance on any applicant ever been declined, postponed, modified or required an extra premium?

YES	NO
<input type="radio"/>	<input type="radio"/>

NAME	TYPE OF INSURANCE	DATE (MM/YYYY)
INSURANCE COMPANY		REASON

NAME	TYPE OF INSURANCE	DATE (MM/YYYY)
INSURANCE COMPANY		REASON

16 Are any dependents listed on this application full time students age 19-25? If yes, list below. (Please note that children age 19 and over who are not students are not eligible for coverage under a parent's BCBSAZ policy. APPLICANTS age 19-25 who are not full-time students may apply for BCBSAZ coverage on their own.)

YES	NO
<input type="radio"/>	<input type="radio"/>

NAME	SCHOOL NAME	CITY	STATE	EXPECTED DATE OF GRADUATION (MM/YYYY)
NAME	SCHOOL NAME	CITY	STATE	EXPECTED DATE OF GRADUATION (MM/YYYY)

17 Is contract holder or any dependents listed on this application eligible for Medicare benefits? **If yes, that person is not eligible for this coverage.**

YES	NO
<input type="radio"/>	<input type="radio"/>

NAME OF PERSON (S) RECEIVING MEDICARE	NAME OF PERSON (S) RECEIVING MEDICARE

18 Will this coverage for which you are applying replace any other coverage you have?

NO **YES** - Temporary Coverage (E.G. Option One) **YES** - Other (Specify): _____

If this coverage will replace current BCBSAZ group or any current coverage from another Blue Cross Blue Shield plan, you may be eligible for conversion coverage. Conversion coverage does not require medical underwriting, but is has higher premiums and different benefits from your previous coverage. If you are interested in such coverage, please contact your current Plan or BCBSAZ for more details.

19 If your insurance is expiring, what is the expiration date?

(MM/DD/YYYY)

PLEASE NOTE: If you are applying for a BluePreferred or BlueClassic plan option, there is a waiting period for pre-existing conditions. Services for pre-existing conditions are not covered until 11 months after the contract effective date regardless of medical underwriting results.

If you are applying for BlueSelect, there is no pre-existing waiting period. BlueSelect does have a waiting period of 12 months from the effective date of the contract for normal maternity services.

More information on pre-existing condition waiting periods is in the BCBSAZ Health Plans for Individuals and Families brochure and the contract booklet. A contract booklet will be sent to you upon enrollment or upon request prior to enrollment.

IMPORTANT:

UNTIL THIS APPLICATION IS APPROVED, DO NOT CANCEL ANY INSURANCE YOU MAY HAVE. PLEASE MAKE SURE YOU SIGN THIS APPLICATION.

PLEASE READ CAREFULLY. UPON ACCEPTANCE, THIS APPLICATION BECOMES PART OF YOUR CONTRACT ACKNOWLEDGMENT

- A. I have carefully read all of this application and understand its terms and conditions. On behalf of myself and the persons listed on this application, I hereby apply for enrollment subject to all of its terms and conditions. I also understand that, if accepted for coverage, this application becomes part of my contract with Blue Cross Blue Shield of Arizona (BCBSAZ), and, if applicable, with CareAmerica Life Insurance Company (CareAmerica Life).
- B. I acknowledge and agree that coverage shall become effective only when a) this application has been accepted by BCBSAZ and/or CareAmerica Life, after its review of the health history I have furnished, and b) a contract has been issued by BCBSAZ and/or CareAmerica Life. Such contract, if issued, shall have an effective date assigned by the Corporation and its coverage shall be subject to its own waiting periods, limitations, medical waivers and other provisions, regardless of any prior coverage.
- C. I acknowledge that the information I have provided on this application is material to the medical underwriting process and that BCBSAZ will rely on the accuracy of such information to make a determination about each applicant's eligibility for coverage.

I represent that, to the best of my knowledge, the information provided on this application is complete and accurate. I understand that if I have misstated or omitted any information on this application, any contract issued covering me and my dependents may be rescinded, that is, declared null and void as of the effective date of coverage, and that such misstatement or omission may subject me to criminal or civil penalties. I also understand that failure to cooperate with an investigation concerning information disclosed or omitted on this application will result in rescission of the contract.

I understand and acknowledge that I alone am responsible for any information stated or omitted on this application, regardless of whether any other person advised me or assisted me in filling out this application, or if they filled out some or all of the application for me.

I further understand that, in the event of rescission, BCBSAZ will seek reimbursement for claims or expenses paid on my behalf and/or on behalf of my dependents. The amount of the paid claims or expenses will be deducted from the premium refund due to me, if any. If the amount of paid claims or expenses exceed the premiums paid, BCBSAZ will seek payment from me for the difference. I understand I may be responsible to pay reasonable attorney's fees and court costs BCBSAZ may incur in collecting amounts due under this contract.

- D. BCBSAZ, CareAmerica Life, its reinsurers, and their authorized representatives may obtain medical information in order to evaluate this application. Any cost for obtaining medical records is the responsibility of the applicant. Personal information may be collected from someone other than myself, or one of the proposed covered persons.

If you are applying for child-only coverage:

- E. On behalf of the named child(ren), I hereby apply for enrollment subject to all of the contract terms and conditions. I understand that if this application is accepted by BCBSAZ and/or CareAmerica Life, I will be the contract holder on behalf of the child(ren) named on this application. I also understand that this application becomes part of any contract issued by BCBSAZ and/or CareAmerica Life on behalf of the named child(ren). I further understand that, in the event of rescission, BCBSAZ will seek reimbursement from the contract holder for claims paid on behalf of the child(ren).
- F. BCBSAZ will not disclose confidential information from the child's file without the contract holder's specific written consent, or when applicable, the consent of the child(ren), except as permitted by applicable law. **I understand that both parents are entitled to have equal access to medical and other records of a child directly from the custodian of the records, unless otherwise provided by court order or law, and a copy of such court order or law has been provided to BCBSAZ (A.R.S. § 25-403, 25-408).**

FOR QUESTIONS ABOUT THIS APPLICATION, Call your broker or BCBSAZ at (602) 864-4899 or toll-free at (877) 864-4899.

FOR QUESTIONS CONCERNING STATUS OF MEDICAL REVIEW OF YOUR APPLICATION OR RECEIPT OF MEDICAL INFORMATION, Please call (602) 864-4040 or (800) 232-2345, ext. 4040.

FOR QUESTIONS CONCERNING THE GENERAL STATUS OF YOUR APPLICATION OR ENROLLMENT, Please call (602) 864-4115 or (800) 232-2345, ext. 4115.

TO AUTHORIZE ANOTHER TO HAVE ACCESS TO YOUR PERSONAL INFORMATION, the Confidential Information Request form included at the end of this application must be completed.

ADDITIONAL FORMS are available from your broker, the BCBSAZ website at www.azblue.com in the Forms section, or by calling (602) 864-4899 or toll-free at (877) 864-4899.

SIGNATURES

All persons named on this application age 18 and older **MUST** sign and date this form, acknowledging their understanding of and their agreement to the conditions listed above. A copy of the Acknowledgment and Authorization to Obtain and Disclose Information is available to you or your authorized representative upon request.

Individual/Family Coverage Signatures(s)

Date (MM/DD/YYYY)

Contract holder X _____
X _____
X _____
X _____
X _____

Child-only Coverage Signature(s)

Date (MM/DD/YYYY)

X _____
(Parent or legal guardian designated as contract holder)

Relationship _____

Date (MM/DD/YYYY)

X _____
(Co-parent or legal guardian*)

Relationship _____

If you are the legal guardian, please attach a copy of the guardianship papers.

* Co-parents or legal guardians who want authority to make changes to the child's contract must sign the application.

Note: This application must be received by BCBSAZ within 15 days from the date of applicant's signature(s) and will become VOID 90 days from that date, requiring submission of a new, updated application.

Before you mail this application, please check the following:

- Did all persons named on this application (age 18 and older) sign and date application above? (If applying for child only coverage, did the parent(s) or legal guardian(s) sign and date application above?)
- Important:** Have all questions been answered? If not, it may result in processing delays.
- If you indicated you would like to make your monthly payment with **Sure Pay (electronic bank draft)**, then be sure to fill out the separate Sure Pay authorization on page 3. Don't forget to attach a voided check.
- If you are applying for the optional life term life insurance, be sure to complete the attached Disclosure Authorization form.
- Did you attach the \$20.00 application fee payable to Blue Cross Blue Shield of Arizona?**
(Please note: If you are applying for child-only coverage, or if you are a current BCBSAZ customer and you are applying for coverage change, adding a dependent or lowering your deductible, the \$20 application fee is not necessary.)
- Please return all pages of this application to: **ATTN: Cash Control • Blue Cross Blue Shield of Arizona
PO Box 81049 • Phoenix, AZ 85069-1049**



An Independent Licensee of the Blue Cross and Blue Shield Association

Instructions for Completing Confidential Information Release Form

Please complete the Confidential Information Release Form if you would like Blue Cross Blue Shield of Arizona (BCBSAZ) to share your personal information with the individual or organization you specify on the form. Each individual 18 and over should complete a separate form.

This authorization is voluntary. We will not condition our claim payment activities, your enrollment in our health plan or your eligibility for benefits on you giving us this authorization.

Examples of Use

Here are a few examples for which the form may be used. Complete the form if you would like BCBSAZ to share certain or all of your personal information with:

- Another adult such as a spouse, parent, child or personal representative so they can discuss your claims or billing questions with us.
- Your broker during or after the enrollment process for the level of service he or she is to provide (enrollment, claims and/or billing questions, etc.).
- Your attorney for a specific legal issue that arises, such as a personal injury case.

Specific Instructions

Information to be Disclosed: Indicate the specific information you want us to share (application, enrollment, eligibility, EOBs, claims, medical records, etc.)

Person About Whom the Above Information Relates: Enter the name of whose information should be disclosed. This will normally be your name.

Entities Receiving Information: Tell us with whom you want us to share your information.

Purpose of Use/Disclosure: Include a brief reason why you want us to share your information such as "To assist with claims or billing questions".

Expiration Date: This authorization will automatically expire 90 days after your last coverage date. You have the right to revoke this authorization earlier by contacting the Privacy Office.

Identification Number and Group Number: Enter your BCBSAZ ID number if you've received one; otherwise enter your social security number.

Signature: Print and sign your name and date the form.

Group Name and Number: If applicable, enter the name and number of the employer or other insured group under which you are covered.

Personal Representative: A personal representative is a legal designation and generally refers to parent of an unemancipated minor, Legal Guardian, or Holder of Power of Attorney. If you are the Personal Representative and are completing this form for someone else, please complete the last two rows and attach copies of relevant legal documents.



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Confidential Information Release Form

(To authorize BCBSAZ to disclose your information)

You must use a separate form for the release of HIV-related information. Return this completed form with your application. Current BCBSAZ customers should mail this completed form to Blue Cross Blue Shield of Arizona, Attention: Enrollment Services, P.O. Box 13466, Phoenix, Arizona 85002. Blue Cross Blue Shield of Arizona (BCBSAZ) will not condition its payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits in our health plan on you giving this authorization.

Information to be Disclosed: I authorize BCBSAZ to disclose the following information, including information about communicable diseases, alcohol and drug abuse treatment and genetic testing:

(Please check all that apply.)

- Application, Enrollment, Eligibility Information
- Billing/Payment Information
- Claims/EOB Information
- Medical Records
- Precertification Information
- Account Information
- Other (please describe): _____

Person About Whom the Above Information Relates: _____

Entities Receiving Information: I authorize BCBSAZ to disclose the above information to:

Name: _____

Company Name: _____

Address: _____

City, State, Zip code _____

Purpose of Use/Disclosure: I authorize BCBSAZ to use and/or disclose the above information for the following purpose:

Unless you revoke this authorization earlier, it will expire 90 days after the expiration or termination of your coverage with BCBSAZ. It is possible for the protected health information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal health information privacy laws. You may revoke this authorization by giving written notice to the BCBSAZ Privacy Office, C105, BCBSAZ, P.O. Box 13466, Phoenix, AZ 85002-3466. Revocation of this authorization will not affect any action BCBSAZ took in reliance on this authorization before it received your written notice of revocation.

Printed Name

Identification Number

Signature

Date

Group Name (if applicable)

Group Number (if applicable)

Personal Representative's Name*

Relationship to Individual

Personal Representative's Signature

Date

*Please attach a copy of the relevant legal document(s).

**You are entitled to a copy of this authorization after you sign it.
You may refuse to sign this authorization.**



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Disclosure Authorization Form

(To authorize BCBSAZ to disclose your information to CSA Marketing Resources, Inc. in connection with your life insurance application)

Blue Cross Blue Shield of Arizona (BCBSAZ) will not condition its payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits in our health plan on you giving this authorization.

By signing this form, you authorize BCBSAZ to disclose the information contained in your BCBSAZ Individual Application and your BCBSAZ subscriber identification number, if any, to CSA Marketing Resources, Inc., an entity which performs administration on behalf of life insurance carriers. The purpose of the disclosure is to allow both CSA Marketing Resources, Inc. and BCBSAZ to perform administrative services in connection with any life insurance you may receive as a result of completing and submitting the Individual Application.

This authorization will expire upon the termination of your policy with BCBSAZ or, if you do not obtain a policy with BCBSAZ, within six (6) months from the date set forth below. It is possible for the protected health information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal health information privacy laws.

You may revoke this authorization by giving written notice to the BCBSAZ Privacy Office, C105, BCBSAZ, P.O. Box 13466, Phoenix, AZ 85002-3466. Your revocation will not affect any action BCBSAZ took in reliance on this authorization before it received your written notice of revocation.

Those individuals 18 years or older should sign and complete the information below.

Printed Name

Social Security Number

Signature

Date

Printed Name

Social Security Number

Signature

Date

Printed Name

Social Security Number

Signature

Date

Printed Name

Social Security Number

Signature

Date

Personal Representative's (PR) Name

PR's Relationship to Individual

Signature

Date

**You are entitled to a copy of this authorization after you sign it.
You may refuse to sign this authorization.**