



FOR AGENT USE ONLY (Please print legibly)			
Agency Code	K	7	
Agent Number	1	3	4 8
Agent Name	McAlpin, Steven J.		

# Personal Blue<sup>SM</sup> or Options Blue<sup>SM</sup> 80/100 Individual Health Contract Application

## **A Reason for Application**

- I am a new applicant, not currently a Blue Cross and Blue Shield of Minnesota (Blue Cross) member, and I am applying for Personal Blue or Options Blue 80/100
- I have a Personal Blue or Options Blue 80/100 contract and I am:
  - applying for a lower deductible;  adding a dependent Blue Cross ID # \_\_\_\_\_
- I have other Blue Cross coverage and I am applying for Personal Blue or Options Blue 80/100 Blue Cross ID # \_\_\_\_\_

## **Application instructions**

1. Please complete this entire application including all explanations as requested. Print clearly using black or blue ink. Incomplete applications will be returned to you to be completed. This may affect the date your coverage starts.
2. Sign and date this application. This application must be received at the home office of Blue Cross within 15 days of your signature date.
3. Submit this application with a minimum of one month's premium to Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, MN 55164. If paying by check, make your check payable to Blue Cross and Blue Shield of Minnesota. Your payment will be refunded if this application is not approved.

## **General application information**

- You must be a resident of Minnesota.
- Infants must be at least 90 days of age on the date the application is signed to be considered for coverage.
- Maternity-related services are not covered for the first 18 months the contract is in effect.
- Your premium may be different than quoted if: there is a change to the effective date; there is a change in the ages or number of individuals approved for coverage; you agree to a plan modification; rates change.
- If approved, coverage will be provided under an individual contract. Blue Cross does not issue individual coverage through any arrangement with an employer.

## **After you submit your application**

- You may be contacted from Blue Cross for additional information. For example, Blue Cross may ask you to complete an authorization to release medical records from your clinic/hospital or call you for additional information.
- The application process generally takes 2 – 4 weeks unless there is a delay in receiving your medical records.
- You will be notified by mail if your application is approved or denied.

## **How to contact us**

- Please contact your agent for assistance or call 651-662-5050 or toll-free at 1-800-262-0823 and one of our Blue Cross representatives will be happy to assist you.

# Individual Application

## **B Applicant information**

Applicant Name \_\_\_\_\_ Legal Marital Status \_\_\_\_ Single \_\_\_\_ Married  
FIRST LAST

Applicant Social Security Number \_\_\_\_\_ Spouse/Same Sex Domestic Partner Social Security Number \_\_\_\_\_

Applicant address \_\_\_\_\_ Email address \_\_\_\_\_  
Street including Apt#

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred telephone number ( ) \_\_\_\_\_ Alternate telephone number ( ) \_\_\_\_\_

Applicant occupation \_\_\_\_\_ Spouse/Same sex domestic partner occupation \_\_\_\_\_

Starting with Applicant, list each family member applying for coverage:

First	Name	Last	Social Security Number	Relationship to Applicant	Birth Date mm/dd/yyyy	Sex M/F	Height	Present Weight	Weight one year ago
				Applicant			ft. in.	lbs.	lbs.
							ft. in.	lbs.	lbs.
							ft. in.	lbs.	lbs.
							ft. in.	lbs.	lbs.
							ft. in.	lbs.	lbs.
							ft. in.	lbs.	lbs.

Additional family members on attached page

### Tobacco use:

I (applicant/contractholder) have used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application. Yes No

My spouse/same sex domestic partner (if included or being added on this application) has used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application.

**NOTE:** Tobacco-free rates are available only to persons who have not used tobacco and/or smokeless tobacco in the preceding 24 months.

## **C Payment selection**

Choose your preferred payment option:  Monthly automatic withdrawal (Pay-O-Matic); or Bill me:  Quarterly  Semiannually  Annually

A minimum of one month's premium must accompany this application. Amount paid with this application \$ \_\_\_\_\_. If paying by check, please make your check payable to Blue Cross and Blue Shield of Minnesota.

## **D Coordination of Benefits**

Will you or any family member on this application have other health or medical coverage, including Medicare, once this policy is in force?  Yes  No

If the response is Yes, you may be contacted for more information.

**E Plan selection - I am applying for one of the following calendar year deductible plans and one network option:**

<p><b>Personal Blue 80</b></p> <p><input type="checkbox"/> \$1,500 deductible    <input type="checkbox"/> \$2,500 deductible</p> <p><input type="checkbox"/> \$3,500 deductible    <input type="checkbox"/> \$4,500 deductible</p>	<p><b>Options Blue 80</b></p> <p><input type="checkbox"/> \$1,300 single deductible or \$2,600 family deductible</p> <p><input type="checkbox"/> \$2,000 single deductible or \$4,000 family deductible</p>
<p><b>Personal Blue 80 with Copay</b></p> <p><input type="checkbox"/> \$1,000 deductible</p> <p><input type="checkbox"/> \$3,000 deductible</p>	<p><b>Options Blue 100</b></p> <p><input type="checkbox"/> \$2,500 single deductible or \$5,000 family deductible</p> <p><input type="checkbox"/> \$3,500 single deductible or \$7,000 family deductible</p> <p><input type="checkbox"/> \$4,500 single deductible or \$9,000 family deductible</p> <p><input type="checkbox"/> \$5,800 single deductible or \$11,600 family deductible</p>
<p><b>Personal Blue 100</b></p> <p><input type="checkbox"/> \$4,000 deductible    <input type="checkbox"/> \$7,500 deductible</p> <p><input type="checkbox"/> \$10,000 deductible    <input type="checkbox"/> \$15,000 deductible</p>	
<p>The deductibles, copays and out-of-pocket maximums are subject to annual adjustments on the annual renewal date. These adjustments are based on the medical care component of the Consumer Price Index (CPI) published by the U.S. Department of Labor.</p>	

**PROVIDER NETWORK SELECTION. Select one Network:**  Accord Network  Aware Network

Your premium will be higher if you select the Aware Network. More information about Provider Networks can be found at [www.bluecrossmn.com](http://www.bluecrossmn.com). Health history underwriting will be required if you request to move (with the same deductible and plan) to the Aware Network at a later date.

**COVERAGE FOR SUBSTANCE ABUSE IS INCLUDED IN THE CONTRACT. YOU MAY CHOOSE TO DELETE SUBSTANCE ABUSE COVERAGE.**

Check this box if you want to **EXCLUDE** substance abuse coverage. Your premium will be slightly reduced if you delete substance abuse coverage.

Your decision to retain or delete substance abuse coverage applies to all family members applying for coverage under this contract.

**F Current / previous health insurance**

If you are approved for coverage, **your contract will not cover preexisting conditions for the first 12 months.** Conditions are considered to be preexisting if medical advice, diagnosis, care or treatment was recommended or received up to six (6) months immediately preceding the enrollment date of your coverage. You will not be subject to this exclusion to the extent you have maintained prior continuous qualifying creditable coverage. Please provide details of other coverages below.

Do you currently have any health insurance or have you had any health insurance within the past 63 days?  Yes  No

If Yes, you must complete the following section. Provide health insurance information for the past 12 months for you and any family member included on this application. Make sure to include information for other Blue Cross coverage.

Person(s) Covered	Insurance Company Name and Policy Number	Date Coverage Started mm/dd/yyyy	Date Coverage Ended (If active, state active) mm/dd/yyyy	Was the previous coverage individual or group coverage?

# Individual Application

## **G** Effective date of coverage

Have you completed an application for a Blue Cross short-term InstaCare contract to precede this coverage?

Yes  No

If **Yes**, please leave the requested effective date blank. We cannot process this application if the termination date of the InstaCare contract is more than 60 days beyond your signature date on this application.

If approved, coverage will be effective as indicated below:

- the date that coincides with the termination date of the InstaCare contract if you have applied for InstaCare and we have received this completed application by that date; or
- the day the completed application is received by mail in the home office of Blue Cross; or
- the day after the completed application is received in the home office of Blue Cross if delivered to the lobby or submitted electronically; or
- a later effective date as requested here \_\_\_\_\_ (This date cannot be more than 60 days beyond the signature date.)  
mm/dd/yyyy

If this application is not approved, no coverage will be effective.

## **H** Health history (complete information is required)

Answer all questions accurately and completely. Blue Cross relies on the information you provide on this application to determine whether you are eligible for coverage. Any false information, omissions or misstatements you provide in this application which affect the risk assumed by Blue Cross may result in the denial of a claim, rescission of the contract, or the issuance of a contract amendment.

DO NOT PROVIDE ANY GENETIC INFORMATION, INCLUDING FAMILY MEDICAL HISTORY INFORMATION.

You do not have to disclose tests to detect the presence of human immune deficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), or other bloodborne pathogens if such tests were administered to you at the time you were: (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) an emergency medical personnel who was tested as a result of performing emergency medical services while employed; (3) corrections employees or inmates; or (4) patients or employees of a secured facility. The term emergency medical personnel includes individuals employed to provide out-of-hospital medical emergency services, licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as employees or volunteers of an ambulance service who provide emergency medical services; a member of an organized first responder squad that is formally recognized by a political subdivision in Minnesota; crime lab personnel; other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law; and any individual who, in the process of executing a citizen's arrest, may have experienced a significant exposure.

1. In the past five (5) years, have you or any family member listed on this application been treated for or diagnosed as having diseases or disorders related to the following conditions? Check each item either "Yes" or "No" and circle conditions.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| A. HEART OR CIRCULATORY DISORDERS—Chest pain, rheumatic fever, heart murmur, stroke, high blood pressure, anemia, bleeding disorders, varicose veins, myocardial infarction or heart disease  | <input type="checkbox"/> | <input type="checkbox"/> |
| B. GASTROINTESTINAL DISORDERS—Stomach, gallbladder, liver, intestinal bleeding or disorders, ulcers, hernia, hemorrhoids, chronic diarrhea, rectal disorders, or any treatment for obesity  | <input type="checkbox"/> | <input type="checkbox"/> |
| C. GENITOURINARY DISORDERS—Kidney, urinary tract disorders, sexually transmitted diseases, infertility, disorders of the male reproductive system including prostate gland, disorders of the female reproductive system including menstrual disorders and abnormal pap smears | <input type="checkbox"/> | <input type="checkbox"/> |
| D. BREAST DISORDERS—Disorders of the male or female breast, including complications from breast implants  | <input type="checkbox"/> | <input type="checkbox"/> |
| E. RESPIRATORY DISORDERS—Asthma, emphysema, bronchitis, allergy or allergic reaction, lung, breathing disorder, or sleep apnea  | <input type="checkbox"/> | <input type="checkbox"/> |
| F. NERVOUS, EMOTIONAL, MENTAL, OR PERSONALITY DISORDERS—Depression, anxiety, adjustment disorders, autism, eating disorders, attention deficit disorders, hyperactivity, behavioral, or psychotic disorders   | <input type="checkbox"/> | <input type="checkbox"/> |

1. (Continued):
- |   |                          |                          |
|---|--------------------------|--------------------------|
| G. ENDOCRINE OR GLANDULAR DISORDERS—Diabetes, thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement  | Yes                      | No                       |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| H. NEUROLOGICAL OR NEUROMUSCULAR DISORDERS—Headache or migraine, head injury, seizure disorder, multiple sclerosis, cerebral palsy, paralysis, or chronic fatigue syndrome                                      |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| I. MUSCULOSKELETAL DISORDERS—Back disorders, scoliosis, temporomandibular joint disorder (TMJ), fibrositis, osteoporosis, fibromyalgia, carpal tunnel syndrome, gout, arthritis, joint disorders, or amputation |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| J. TUMOR, CYST, OR POLYP  |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| K. SKIN DISORDERS—Acne, rash, warts, or growth  |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| L. COLLAGEN DISEASE—Lupus, scleroderma, or rheumatoid arthritis   |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| M. GENERAL FATIGUE OR MALAISE, MONONUCLEOSIS, OR EPSTEIN-BARR SYNDROME  |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| N. EYES, EARS, NOSE, THROAT DISORDERS—Impairment of sight, cataracts, eye muscle, otitis media, earache, hearing impairment, nasal or sinus disorders, tonsillitis, or adenoiditis                              |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| O. IMMUNE DISORDERS—Congenital or acquired disease or disorder of the immune system, including AIDS or an ARC (AIDS Related Complex)  |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |

2. Have you or any family member listed on this application **EVER** been treated for or diagnosed as having cancer? Yes No

3. Have you or any family member listed on this application:
- |   |                          |                          |
|---|--------------------------|--------------------------|
| A. Had a medical operation within the last five (5) years?  | Yes                      | No                       |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Been hospitalized within the last 10 years?  |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Seen a doctor, chiropractor, psychologist, therapist, or any other health care professional for any reason other than a wellness/physical exam within the past five (5) years? |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Received speech, physical, behavioral, or occupational therapy within the past five (5) years?   |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Been diagnosed with or received a positive test for any disease or disorder of the immune system within the past five (5) years?   |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Had a health-related screening or diagnostic test such as a blood test, mammogram, x-ray/imaging, CT or MRI scan during the last five (5) years?                               |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Ever been treated for or currently have a congenital abnormality?  |                          |                          |
|   | <input type="checkbox"/> | <input type="checkbox"/> |

4. If you answered Yes to any questions in 1-3, please provide complete details here. Add an additional page if you need more space.

Ques. no. & letter	Family Member Name	Date of Onset	Diagnosis and Treatment including results of diagnostic tests	Days in hospital	Date of complete recovery (if ongoing, state ongoing)	Doctor, Clinic or Hospital Name and City

Check box if you are adding an additional page

# Individual Application

5. Have you or any family member listed on this application had a wellness/physical exam within the past 24 months? Yes  No

If Yes:

Family Member Name	Date of Physical	Doctor or Clinic Name	Were physical results all normal including any lab test(s)? YES or NO	If NO, list all abnormal findings, treatment received and outcome

6. Have you or any family member listed on this application taken any prescription medication within the past 24 months? Yes  No

If Yes:

Family Member Name	Drug Name and Dosage	Diagnosis	Dates Used	Doctor Name

7. During the past 12 months, have you or any family member listed on this application experienced back or neck pain, joint or muscle pain, headaches, stomach or abdominal pain, chest pain, shortness of breath or chronic cough, dizziness or fainting episodes, fever, swollen glands or lump, blood in stool or urine, or an injury for which a physician has not been consulted? Yes  No

If Yes:

Family Member Name	Dates and Details

8. Is any family member applying for coverage currently pregnant, currently an expectant father, or expecting a child through adoption within the next 12 months? Yes  No

If Yes:

Family Member Name	Expected Date of Birth or Adoption

9. In the past five (5) years, have you or any family member listed on this application:
- A. Used drugs on a regular basis, other than drugs prescribed by a physician, or been treated for the abuse of any drugs or alcohol? Yes  No
- B. Been convicted of a DWI or DUI or had his/her driver's license suspended or revoked for driving while under the influence of alcohol or a controlled substance? Yes  No
- C. Been medically advised by a health care professional to quit or reduce use of alcohol or drugs? Yes  No

If you answered Yes to any questions 9A-9C, please complete this section. Give complete details.

Ques. no. & letter	Family Member Name	Dates and details regarding drug and/or alcohol use, DWI or DUI, and any treatment including medical facility name	Driver's License Number

10. Do you or any other family member listed on this application drink alcohol? Yes No

If Yes:

Family Member Name	Average amount of alcohol used weekly

11. Have you or any other family member listed on this application been advised by a health care professional to have an evaluation, testing or treatment for a medical, dental, or mental health condition that has not yet been performed? Yes No

If Yes:

Family Member Name	Dates and Details

12. Have you or any family member listed on this application ever been declined coverage, charged an increased rate, or had benefits excluded from coverage for any health coverage? Yes No

If Yes:

Family Member Name	Dates and Details

13. Do you or any family member listed on this application plan to travel in a foreign country in the next year? Yes No

If Yes:

Family Member Name	Date of Departure	Destination	Date of Return

14. Provide names of the physicians/health care professionals with the most complete knowledge of the medical history for you and all family members applying for coverage.

Family Member Name	Provider Name	Provider Address

**Authorization and representation**

I understand and agree that coverage, if approved, will commence in accordance with section G on page 4. I have included payment with this application. For administrative convenience, Blue Cross will deposit in a bank any payment I submit with this application, but such deposit shall not constitute an approval of this application or issuance of coverage. If this application is rejected, any money submitted will be refunded. When I provide a check as payment, I authorize Blue Cross either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Cross uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Cross receives my payment and I will not receive my check back from my financial institution.

I understand if Blue Cross approves this application, coverage will be provided under an individual contract. I understand that Blue Cross does not issue individual coverage through any arrangement with an employer. Blue Cross is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

# Individual Application

In order to process this application, Blue Cross may collect personal information regarding my, or my family members listed on this application, health history and motor vehicle driving records from persons other than myself. The information collected by Blue Cross or Blue Cross authorized agents may in certain circumstances be disclosed to third parties without authorization. I have the right to see my personal records that are maintained by Blue Cross and to correct personal information Blue Cross has collected about me or my family members listed on this application. Upon my request, Blue Cross will furnish a more detailed notice of Blue Cross information practices. The sole purpose for collecting this information is to underwrite this application for coverage.

I agree to authorize and request any hospital, clinic, institution, physician, pharmacy and pharmacy related service organizations or other persons to furnish Blue Cross full details of diagnosis, treatment, medical history, pharmaceutical records and any other information and conclusions about me and my family members listed on this application. Blue Cross needs this information to underwrite this application. Blue Cross keeps this information confidential, but may release it if you authorize release, or if state or federal law permits or requires release without authorization. For purposes of obtaining information in connection with this application, reinstatement, or change in policy benefits, this release is valid as long as the applicant is continually insured with the insurer. You are entitled to receive a copy of any release you sign. Blue Cross will not request the release of information about bloodborne pathogen tests that were administered to individuals described on page 4 of this application.

Blue Cross primarily relies upon the information provided and full disclosure of the information listed on this application in the decision whether to accept the applicant and/or family members listed on this application for coverage. The approval or disapproval of this application may or may not include review of actual medical records, which I agree to obtain upon Blue Cross' request. Therefore, I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the application, even if the applicant, and/or family members listed on this application, currently have coverage or have had prior coverage with Blue Cross. Blue Cross may also review its records relating to my enrollment in current or prior coverage through Blue Cross or one of its affiliated companies.

I understand and agree that payment of a claim does not preclude the right of Blue Cross to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

I agree to notify Blue Cross immediately of any change in my (or my spouse/same sex domestic partner or family member's) health condition between the date of this application and the effective date of coverage. Failure to notify Blue Cross of any change in my (or my spouse/same sex domestic partner or family member's) health condition may result in the denial of a claim(s), rescission of the contract or the issuance of a contract amendment.

Upon request, I agree to furnish additional information needed concerning eligibility of any family member applying for coverage.

I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand and agree Blue Cross will act in reliance upon the information I have provided on this application and that any false information, omissions or misstatements on this application which materially affect either the acceptance of risk or hazard assumed by Blue Cross may result in the denial of a claim(s), rescission of the contract, or the issuance of a contract amendment.

X _____	X _____	X _____	X _____
Date	Applicant Signature	Date	Spouse/Same Sex Domestic Partner Signature (if applying for coverage)
X _____	X _____	X _____	
Date	Parent, Legal Guardian or Guarantor Signature (if applicant is a minor)	Please print name of Parent, Legal Guardian or Guarantor (if applicant is a minor)	

As Parent, Legal Guardian or Guarantor, I understand that: (1) the applicant is the contractholder; (2) I guarantee payment to Blue Cross; and (3) any Blue Cross issued payments will be made to the applicant or contractholder and not to me.

**J Agent**

**IF APPLICATION COMPLETED BY AGENT, COMPLETE AND SIGN BELOW**

If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded on this application are complete and accurate as provided by the applicant.

X _____	( )	_____	_____
Agent Signature		Agent Telephone Number	Date