

Blue Cross Blue Shield Application Check List

- All Medical questions must be answered, if any are answered yes, please give complete details, including Physicians name and address.
- Make sure that all applications are signed and dated. (especially on the back side of application)
- If paying via monthly Bank Draft, please also complete Bank Authorization, and attach a voided check.

You can fax your completed Application back to **(803)781-7750**

Or Mail to the following address:

Health Benefits ABC
Attn: David Greenhalgh
PO Box 186
Ballentine, SC 29002

FAX: (803) 781-7750

Please feel Free to call us at any time with additional questions
(800) 861-3834

APPLICATION FOR PERSONAL BLUEPLAN

1. Complete the application and sign PART THREE.
2. Please include a check for your first month's premium – you'll have 10 days to review coverage with no obligation.



P.O. Box 61153, Columbia, SC 29260-1153
www.SouthCarolinaBlues.com

PART ONE (Please PRINT IN INK.)

SECTION A – APPLICANT INFORMATION

Requested Effective Date ___ / ___ / ___ As of the requested effective date, will you be a resident of South Carolina? Yes No
(Only South Carolina residents are eligible for coverage.)

Last Name _____ First Name _____ M.I. _____ Male Female

Birthdate ___ / ___ / ___ Telephone Number: Home (____) _____ Work (____) _____

Social Security Number - -

Place of Employment _____

Street Address _____

City _____ State _____ ZIP _____ E-mail Address _____

Billing Address for Premium Notices, if different

Street Address _____

City _____ State _____ ZIP _____

| |
|----------------------------|
| For Office Use Only |
| Rider |

SECTION B – COVERAGE INFORMATION

Check desired Personal BluePlan, Coinsurance, Deductible, Out-of-pocket Maximum and Optional Benefits.

A. Choose One Plan Personal BluePlan 1 Personal BluePlan 2

Limited Benefits Health Insurance Coverage

Personal BluePlan 1 (70/50 Option) Personal BluePlan 2 (70/50 Option)

Personal BluePlan 3 Personal BluePlan 4

B. Choose One Coverage Option 90/70 80/60 70/50

C. Choose One Deductible \$250 \$500 \$1,000 \$2,000 \$5,000 (N/A with Plan 1)

D. Choose One Out-of-pocket Maximum \$1,500/\$3,000 \$2,500/\$5,000 \$5,000/\$8,000

E. Choose Optional Benefit(s)

Accident Medical Expense

Maternity (N/A with Plans 3 or 4)

Dental Coverage

Prescription Drug Insurance (N/A with Plans 3 or 4)

SECTION C – BILLING INFORMATION

Monthly Bank Draft: *Voided Check (not deposit slip) and Authorization Form Required*

Monthly Direct Bill

List Bill (through your employer): List Bill Account Number _____

| | |
|--|---|
| | FOR USE BY BLUE CROSS AND BLUE SHIELD ONLY |
| | Bank Number |
| | Account Number |

SECTION D – FAMILY INFORMATION (if to be insured)

Dependent children must be unmarried and either under age 19, or under age 23 if a full-time student.

| | | | | | | For Office Use Only |
|-----------|------------|------|--|-----|-----------|----------------------------|
| LAST NAME | FIRST NAME | M.I. | SOCIAL SECURITY NUMBER | SEX | BIRTHDATE | RIDER |
| Spouse | | | <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | / / | |
| Child | | | <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | / / | |
| Child | | | <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | / / | |
| Child | | | <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> | | / / | |

Check here if others are to be insured; list all pertinent information on another sheet.

PART TWO

SECTION A – HEALTH HISTORY

Height and Weight

| | | | | | | | |
|--------------------------|-------------|--------------------|--|--------------------------|-------------|-----------------|--|
| Applicant's Height | | Applicant's Weight | | Spouse's Height | | Spouse's Weight | |
| How Long At Same Weight? | | | | How Long At Same Weight? | | | |
| Recent Weight Change? | Lbs. Gained | Lbs. Lost | | Recent Weight Change? | Lbs. Gained | Lbs. Lost | |
| Reason | | | | Reason | | | |

SECTION B – DETAILS TO HEALTH HISTORY

In the last 10 years, have you or any other person listed on the application had a diagnosis of, advice for, indication of, symptoms related to, treatment for or any injury related to any of the following?

| | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| A. Heart or circulatory system, including high blood pressure, heart attack, chest pain, stroke, heart murmur, irregular heartbeat, varicose veins, phlebitis, poor circulation or rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> | F. The nervous system, including severe headaches, paralysis, seizures (indicate type), convulsions, epilepsy, nervousness, fainting, dizziness, mental or emotional disorders, anorexia, bulimia, psychiatric care, multiple sclerosis, cerebral palsy or attention deficit/hyperactivity disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Lung or respiratory system, including shortness of breath, asthma, hayfever or other allergies, chronic sinusitis (indicate below the number of occurrences in the past 12 months), chronic cough, tuberculosis, emphysema, pneumonia or cystic fibrosis | <input type="checkbox"/> | <input type="checkbox"/> | G. Eye, ear (indicate number of ear infections in the past 12 months), nose, throat, mouth or teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Genito-urinary system, kidney stones, (indicate number of times), cystitis, prostate, bladder infection, blood in urine, breast, breast implants, uterus, sexually transmitted disease, complications of pregnancy, fibrocystic breast disease, abnormal Pap smear or menstrual disorder | <input type="checkbox"/> | <input type="checkbox"/> | H. Any type of cancer, tumor, cyst, polyp or other growth, skin problem, goiter, thyroid, anemia, hemophilia, other glands, blood and blood forming organs or leukemia <input type="checkbox"/> Benign <input type="checkbox"/> Malignant | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Digestive system, including ulcer (indicate type), gallbladder, gastritis, gastrointestinal bleeding, rectal bleeding, intestinal problem, colitis, hemorrhoids, hernia (indicate type), pancreas, liver or spleen | <input type="checkbox"/> | <input type="checkbox"/> | I. Diabetes, elevated blood sugar, or blood, sugar or albumin in the urine | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Muscular or skeletal system, including back, joints (indicate joint involved), bones, muscles, spine, gout, arthritis, rheumatism, lupus, polio, muscular dystrophy, loss of limb or fracture (indicate location of any screws, pins or plates) | <input type="checkbox"/> | <input type="checkbox"/> | J. Alcohol or drug dependency, overdose, reaction or abuse (includes counseling by any organization or counselor) | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | K. Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or ever tested positive for the HIV virus | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | L. Sudden weight loss, night sweats, persistent fever, malaise, mouth infection or lymph node enlargement | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | M. Any other abnormality, deformity, developmental defect, anomaly, surgical procedure, acquired or congenital disease or disorder, or any abnormal test results | <input type="checkbox"/> | <input type="checkbox"/> |

NOTE: If you have answered "Yes" to any questions in this block, please circle all that apply and complete the section below. For more room, attach a sheet of paper, sign and date it.

| Item Number or Letter (A-M) & Patient Name | Doctor/Hospital Name & Address | Condition (Provide Complete Details) | Date Last Seen | Treatment/Medications Date Onset/Recovery Date | Results (Current Limitations) |
|--|--------------------------------|--------------------------------------|----------------|--|-------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

1. In the last 5 years, has any individual to be insured:
- A. Had any symptoms of or trouble with any physical, mental or emotional condition for which a doctor has not been seen, or for which treatment has been recommended but not already disclosed in this application? Yes No
If "Yes," please explain: _____
- B. Seen a doctor, been hospitalized, institutionalized or had an accident not already disclosed on this application? Yes No
If "Yes," please explain: _____
2. Is any individual to be insured pregnant? Yes No
If "Yes," who? _____
3. In the last 12 months, has any individual to be insured taken any prescription drugs? Yes No
If "Yes," please explain below:

| Name | Condition | Prescription Drug(s) | Dosage | How Often |
|------|-----------|----------------------|--------|-----------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

4. List name, complete address and phone number of all doctors seen in the last 10 years for each person to be insured.

| Individual to Be Insured | Doctor | Date Last Seen | Doctor's Complete Address and Phone Number |
|--------------------------|--------|----------------|--|
| | | | |
| | | | |
| | | | |
| | | | |

SECTION C – OTHER INSURANCE INFORMATION

1. Do you or does any member of your family to be insured have other health insurance coverage, including Medicare or TRICARE? Yes No
A. If you answered "Yes" to 1, will this policy replace that health insurance? Yes No
2. Have you or any member of your family to be insured been insured by Blue Cross and Blue Shield of South Carolina or Companion HealthCare in the past year? Yes No
If "Yes," who and under what identification number? _____
3. Have you or any member of your family to be insured been turned down for health insurance or had conditions excluded from coverage by Blue Cross and Blue Shield of South Carolina or another Company? Yes No
If "Yes," explain: _____

REMARKS _____

PART THREE

SECTION A – AUTHORIZATION AND AGREEMENTS

READ CAREFULLY BEFORE SIGNING

The undersigned authorize(s) release to Blue Cross and Blue Shield of South Carolina (Company) or its representatives of (1) All past and future medical records and other information deemed necessary by the Company to underwrite this application and to process claims and (2) All Medicare Part A and Part B claims information from the effective date of any coverage which may be approved pursuant to this application until the termination of such coverage for the purpose of processing claims.

It is fully understood and agreed (1) That the Company has the right to accept or reject any person applying for coverage in this application, and (2) If the Company approves coverage, the Company will determine the effective date of such coverage, and (3) That no insurance coverage shall be in force until the Company receives the application, approves coverage and assigns the date on which coverage shall become effective, and (4) If coverage is approved, the undersigned will receive a policy and identification card(s) from the Company, and (5) That any premium or policy fee submitted herewith may be retained by the Company pending approval of coverage. If any coverage is approved, the Company will retain the premiums thereof and the policy fee. If no coverage is approved, the Company will return any premium or fee paid.

It is further understood and agreed that the Company may deny claims and may void any coverage (subject to the policy's Time Limit on Certain Defenses provision) if the Company determines that any information was misrepresented on the application or any claim. If any coverage is voided, the Company will refund premiums paid minus any claims paid.

The undersigned hereby expressly acknowledges understanding that this policy constitutes a contract solely with Blue Cross and Blue Shield of South Carolina, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The "Association" permits Blue Cross and Blue Shield of South Carolina to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and Blue Cross and Blue Shield of South Carolina is not contracting as an agent of the Association. The undersigned further acknowledges and agrees to have not entered into this policy based on representations by any person other than Blue Cross and Blue Shield of South Carolina. No person, entity or organization other than Blue Cross and Blue Shield of South Carolina shall be held accountable or liable to the undersigned for any of Blue Cross and Blue Shield of South Carolina's obligations created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of South Carolina other than those obligations created under other provisions of this agreement.

The undersigned hereby represent(s) that the information on this application and any other information furnished by the undersigned is complete, true and correctly recorded.

SECTION B – SIGNATURES

I HAVE READ AND I FULLY UNDERSTAND EACH AND EVERY PART OF THIS APPLICATION FOR INSURANCE.

| | |
|---|----------------------|
| X _____ APPLICANT'S SIGNATURE <i>NOTE: If Applicant is a minor, a parent or legal guardian must sign. If legal guardian is signing, please attach legal documents.</i> | _____ DATE SIGNED |
| X _____ SPOUSE'S SIGNATURE (Only required if applying for coverage) | _____ DATE SIGNED |

| | | |
|--------------------------------------|----------------------|---|
| _____ AGENT'S NAME (PLEASE PRINT) | | |
| X _____ AGENT'S SIGNATURE | _____ DATE SIGNED | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> - <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> AGENT'S CODE |

FOR USE BY BLUE CROSS AND BLUE SHIELD

| Effective Date | CH | PF | PR | Approved | Rejected |
|----------------|----|----|----|----------|----------|
| | | | | | |

**For Additional Applications, or Answers to Any Questions,
Please Call Toll-Free:
1-800-868-2500**

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FOR UNDERWRITING

Please complete this form and send it to the following address if you have been seen by a licensed medical provider within the last 10 years.

Group & Individual Privacy Official (AF-600)
BlueCross BlueShield of South Carolina
I-20 at Alpine Road
Columbia, SC 29219
Fax: (803) 264-0174

Section 1: Authorization

I authorize my past or present treating physicians/hospitals/clinics, licensed medical providers, (known collectively as “providers”) to disclose to BlueCross BlueShield of South Carolina (“BlueCross”), or its designated agent, my protected personal health information concerning symptoms or conditions for which I may have been treated or given advice for, but does not include psychotherapy notes, in the 10 years prior to my signing this authorization. I further authorize Companion HealthCare to disclose to BlueCross my electronic claims history for the same time period, if any. I understand this authorization is voluntary. However, BlueCross reserves the right to deny enrollment or eligibility for benefits if I refuse to sign this form.

I understand that BlueCross or its designated agent may redisclose my protected personal health information and federal or state privacy laws may not protect it (e.g., in cases of disaster relief, public health reports or investigations or other situations permitted by law).

Section 2: Purpose

The purpose of this authorization is for BlueCross to obtain copies of documents related to my medical history in order to determine eligibility before enrollment, and the requested use or disclosure does not include psychotherapy notes.

Section 3: Options for Disclosures

I authorize the disclosure of my protected personal health information to BlueCross, or its designated agent, by sending copies of documents concerning my medical history in the 10 years prior to my signing this form by U.S. mail, by facsimile, hand delivery or by an electronic transmission.

Section 4: Expiration and Revocation

Expiration: This authorization will expire: 1) upon the effective date of my enrollment with BlueCross; or 2) upon BlueCross’ denial of coverage; or 3) upon my written revocation, whichever occurs first.

Revocation: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above.

BlueCross will condition my eligibility for insurance based on whether or not I sign this form. I understand that revocation of this authorization will not affect any action BlueCross took in reliance on this authorization before BlueCross received my notice of revocation.

Section 5: Signature

I, the undersigned, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction. I understand that, by signing this form, I am confirming my authorization for disclosure of my protected personal health information by past or present treating providers, the means by which BlueCross will receive such disclosures, the expiration of this authorization, the option of revoking of this authorization and the consequences of not signing this authorization.

Print Name: _____

Applicant’s Name: _____

Address: _____

Telephone Number: _____

Relationship to Applicant: _____

Applicant’s Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a copy of this Authorization Form.