

Blue Cross Blue Shield Companion HealthCare for Kids 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**

14. Is child pregnant? Yes No

15. In the last 10 years, has the child seen a doctor, had surgery, been hospitalized, institutionalized or had an injury requiring medical treatment not already disclosed in this application?

Yes No If "yes," please explain. _____

16. In the last 12 months, has the child taken prescription drugs? Yes No If "yes," list drug(s) below.

17. In the last 5 years, has the child had symptoms of, or trouble with, any physical, mental or emotional condition for which the applicant has not yet seen a doctor or for which treatment has been recommended? Yes No

If "yes," please explain. _____

18. List the name and address of applicant's doctor(s).

DOCTOR'S NAME

DOCTOR'S ADDRESS

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PARENT, GRANDPARENT OR LEGAL GUARDIAN – READ CAREFULLY BEFORE SIGNING:

I authorize release to Companion HealthCare Corporation of all past and future medical records of applicant needed to underwrite this application for coverage and to process claims.

I also understand that the coverage I am applying for to cover applicant will not be in effect until this application is accepted by Companion HealthCare and until the premium plus any policy fee is paid. Companion HealthCare assigns effective dates only on the first of the month. Further, I understand that I, as contractholder, will receive a contract and identification card for the applicant if this application is approved. If this application is not approved, any premium and policy fee I have paid will be returned to me.

I agree that the information given by me on this application is complete, true and correctly recorded.

I HAVE READ AND UNDERSTOOD EACH AND EVERY PART OF THIS APPLICATION.

Applicant's, Parent's, Grandparent's or Guardian's Signature _____ Date _____

If a grandparent is applying to cover applicant, please complete Parental Consent below:

Parental or Guardian Consent

This will serve to notify you that the grandparent of my child _____ who is under 18 years of age is making application
(name of child, please print)

for Companion HealthCare individual coverage for my child, with my full knowledge and consent, and I request that you consider my child for such coverage.

Signature _____ Print Name _____ Relationship _____ Date _____

For Companion HealthCare use only:

Applicant Accepted Not Accepted Effective Date _____

CHC Identification Number _____ Underwriter's Signature _____ Date _____

Agent's Signature _____ Agent's 6-Digit Code 012-001