Application for Enrollment

Individual Health Plans

Authorized Broker

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

azblue.com

76252

How to apply

Blue Cross Blue Shield of Arizona (BCBSAZ) offers the following guidelines and instructions to help you complete your application for health individual insurance coverage.

- Any applicant designated on this application must be under the age of 65 and not on Medicare. If you are a resident of Arizona and are interested in a Medicare Supplement plan, please call your broker.

  Applicants must be permanent Arizona residents.

- You can apply for coverage for yourself, your spouse and your children who are under the age of 30. Before children under the age of 18 will be enrolled, at least one parent or legal guardian must be approved and accept coverage.

- Please be sure that you fill in all information requested on the application even if you currently have coverage with Blue Cross Blue Shield of Arizona.

- BCBSAZ will review the medical history of all applicants provided on the application to determine eligibility and applicable premium rate. BCBSAZ requires you to provide medical history for all applicants for the last 10 years with the exception of a few questions that require you to provide information for any applicant that may have had a health/medical condition in their entire life. Please be sure to provide as much detail about each applicant's condition as possible. BCBSAZ needs to know everything you know about each applicant's medical history.

- All persons named on this application who are age 18 or older MUST sign and date the signature page of the application. BCBSAZ must receive your application within 30 days from the date of all applicant signature(s).

- Please print your answers in ink but avoid the use of red ink. Do not use pencil or highlighters. Fill in all ovals completely; do not just mark with an "x". Do not print in any shaded areas.

- This application must be sent with a $20.00 non-refundable fee, except no fee is required from current BCBSAZ members. Please do not send the first month's premium with your application. If BCBSAZ accepts you for coverage, BCBSAZ will bill you. **The application fee for a printed and mailed application is not refundable. However, no fee is required if you submit your application electronically by applying online at azblue.com or through the marketing website for your BCBSAZ broker.**

- **For applicants who 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 pre-existing condition waiting period. To qualify for this coverage you must meet specific criteria. If you think you may qualify for this coverage, please call BCBSAZ at (602) 864-4899, or toll free at (877) 864-4899 to speak with a representative. Please note that you will lose your eligibility for Individual Portability Coverage if you become insured under any non-group policy. If you think you may not qualify for underwritten coverage, you can apply for portability coverage while BCBSAZ reviews your application for underwritten coverage.

- Do you have a Certificate of Eligibility for the Health Insurance Premium Tax Credit from the Arizona Department of Revenue? If yes, please enclose a copy of your Certificate with this application.

Please see next page to begin the application.

Before you continue.....

Please answer the following questions:

- Is any male or female applicant age 19 or older an expectant parent (excluding parents with pending adoptions)? (If yes, any applicant age 19 or older who is expecting a child is not eligible for coverage at this time.) ○ YES ○ NO
- Is any applicant enrolled in Medicare? (If yes, any applicant who is enrolled in Medicare or currently eligible for Medicare (65 or older) is not eligible for coverage at this time.) ○ YES ○ NO

The following conditions will result in a declination of coverage of any applicant age 19 or older. Please review this list carefully before proceeding. Is there an applicant who has one of the conditions listed below? ○ YES ○ NO **If yes, please mark which applicant below.**

- Alzheimer's
- Autoimmune Disorders
- Crohn's Disease
- Cystic Fibrosis
- ESRD (End Stage Renal Disease)
- Hemophilia
- HIV or AIDS
- Multiple Sclerosis
- Muscular Dystrophy
- Parkinson's Disease
- Rheumatoid Arthritis
- Schizophrenia
- Transplant recipient or candidate

If yes to any of the above conditions, name the applicant(s) with the condition:_____

_____

Applicants age 19 and older with certain conditions are non-insurable by BCBSAZ. This list is not meant to be an all-inclusive list of conditions or diseases that are non-insurable. Other conditions may be non-insurable based on the applicant's medical information and BCBSAZ's medical underwriting guidelines. Applicants with any of these conditions are not eligible for coverage at this time.

NEW CUSTOMERS

How did you hear about BCBSAZ?

○ Internet ○ Broker ○ Personal Recommendation ○ Newspaper ○ Radio ○ TV ○ Billboard ○ Facebook ○ Twitter ○ Linkedin ○ Other (please specify) _____

EXISTING CUSTOMERS

Please provide your member ID on the front of your card

_____

To improve our service in the future, please indicate your preferred language. ☐ English ☐ Spanish

PPO PLAN FOR WHICH YOU ARE APPLYING (DEDUCTIBLES ARE CALENDAR-YEAR: JANUARY—DECEMBER)

BlueOptimum Plus	BlueValue Plus	BlueEssential Plus	BlueBasic Plus	BluePortfolio Plus
○ $250	○ $250	○ $250	○ $250	○ 70%/$1,750
○ $500	○ $500	○ $500	○ $500	○ 90%/$1,750
○ $1,000	○ $1,000	○ $1,000	○ $1,000	○ 70%/$3,500
○ $2,000	○ $2,000	○ $2,000	○ $2,000	○ 80%/$3,500
○ $3,000	○ $3,000	○ $3,000	○ $3,000	○ 100%/$3,500
○ $5,000	○ $5,000	○ $5,000	○ $5,000	○ 100%/$5,500
○ $7,500	○ $7,500	○ $7,500	○ $7,500	
○ $10,000	○ $10,000	○ $10,000	○ $10,000	

Other BCBSAZ products, beyond those listed in this application form, are available.

BlueCross BlueShield of Arizona

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Contract Holder Information

THIS AREA IS TO BE FILLED IN BY THE APPLICANT NAMED AS CONTRACT HOLDER.

LAST NAME	SUFFIX	FIRST NAME	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SOCIAL SECURITY NUMBER

MAILING ADDRESS (NUMBER AND STREET)	APT.	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	MOBILE PHONE	FAX	EMAIL ADDRESS

DATE OF BIRTH (MM/DD/YYYY)	GENDER	MARITAL STATUS	DATE OF MARRIAGE (MM/DD/YYYY)	HEIGHT	WEIGHT
	○ MALE ○ FEMALE	○ SINGLE ○ MARRIED		ft. in.	lbs.

Have you used tobacco products in the last 12 months? ○Yes ○No

Do you currently have or have had other coverage within the last 18 months? ○Yes ○No **If yes, please complete the other coverage information below.** To ensure our records reflect any prior creditable coverage and your claims are paid accordingly, please provide information related to prior health coverage (including foreign health plan coverage).

HEALTH COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	POLICY HOLDER LAST NAME

ID/SOCIAL SECURITY NUMBER	GROUP/POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	CANCEL DATE (MM/DD/YYYY)

Dependent Information

ONLY YOUR SPOUSE, CHILD OR LEGAL WARD CAN QUALIFY AS A DEPENDENT FOR COVERAGE. IF THERE IS ALREADY A CONTRACT IN FORCE AND YOU ARE ADDING A DEPENDENT, LIST ONLY THOSE DEPENDENTS YOU ARE ADDING.

SPOUSE

SPOUSE'S LAST NAME	SUFFIX	FIRST NAME	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN

Have you used tobacco products in the last 12 months? ○Yes ○No	DATE OF BIRTH (MM/DD/YYYY)	GENDER	HEIGHT	WEIGHT
		○ MALE ○ FEMALE	ft. in.	lbs.

Do you currently have or have had other coverage within the last 18 months? ○Yes ○No **If yes, please complete the other coverage information below.** To ensure our records reflect any prior creditable coverage and your claims are paid accordingly, please provide information related to prior health coverage (including foreign health plan coverage).

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	POLICY HOLDER LAST NAME

ID/SOCIAL SECURITY NUMBER	GROUP/POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	CANCEL DATE (MM/DD/YYYY)

DEPENDENTS

1

LAST NAME	SUFFIX	FIRST NAME	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN

Have you used tobacco products in the last 12 months? ○Yes ○No	DATE OF BIRTH (MM/DD/YYYY)	GENDER	HEIGHT	WEIGHT
		○ MALE ○ FEMALE	ft. in.	lbs.

RELATIONSHIP TO CONTRACT HOLDER: ○CHILD OR STEPCHILD ○CHILD UNDER CONTRACT HOLDER'S LEGAL GUARDIANSHIP*

Do you currently have or have had other coverage within the last 18 months? ○Yes ○No **If yes, please complete the other coverage information below.** To ensure our records reflect any prior creditable coverage and your claims are paid accordingly, please provide information related to prior health coverage (including foreign health plan coverage).

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	POLICY HOLDER LAST NAME

ID/SOCIAL SECURITY NUMBER	GROUP/POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	CANCEL DATE (MM/DD/YYYY)

2

LAST NAME	SUFFIX	FIRST NAME	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN

Have you used tobacco products in the last 12 months? ○Yes ○No	DATE OF BIRTH (MM/DD/YYYY)	GENDER	HEIGHT	WEIGHT
		○ MALE ○ FEMALE	ft. in.	lbs.

RELATIONSHIP TO CONTRACT HOLDER: ○CHILD OR STEPCHILD ○CHILD UNDER CONTRACT HOLDER'S LEGAL GUARDIANSHIP*

Do you currently have or have had other coverage within the last 18 months? ○Yes ○No **If yes, please complete the other coverage information below.** To ensure our records reflect any prior creditable coverage and your claims are paid accordingly, please provide information related to prior health coverage (including foreign health plan coverage).

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	POLICY HOLDER LAST NAME

ID/SOCIAL SECURITY NUMBER	GROUP/POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	CANCEL DATE (MM/DD/YYYY)

3

LAST NAME	SUFFIX	FIRST NAME	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN

Have you used tobacco products in the last 12 months? ○Yes ○No	DATE OF BIRTH (MM/DD/YYYY)	GENDER	HEIGHT	WEIGHT
		○ MALE ○ FEMALE	ft. in.	lbs.

RELATIONSHIP TO CONTRACT HOLDER: ○CHILD OR STEPCHILD ○CHILD UNDER CONTRACT HOLDER'S LEGAL GUARDIANSHIP*

Do you currently have or have had other coverage within the last 18 months? ○Yes ○No **If yes, please complete the other coverage information below.** To ensure our records reflect any prior creditable coverage and your claims are paid accordingly, please provide information related to prior health coverage (including foreign health plan coverage).

HEALTH PLAN COVERAGE NAME	CARRIER PHONE NO. (AREA CODE & NO.)	POLICY HOLDER LAST NAME

ID/SOCIAL SECURITY NUMBER	GROUP/POLICY NO.	EFFECTIVE DATE (MM/DD/YYYY)	CANCEL DATE (MM/DD/YYYY)

IF THERE ARE MORE THAN 3 DEPENDENTS PLEASE COMPLETE A SEPARATE SHEET OF PAPER AND CHECK HERE ☐

*Please note that if child(ren) is/are under contract holder's guardianship then guardianship papers must accompany your application for those dependents.

EFFECTIVE DATE—BCBSAZ DOES NOT ASSIGN EFFECTIVE DATES ON THE 29TH, 30TH, OR 31ST OF THE MONTH. APPLICATION APPROVALS MADE AFTER THE 26TH WILL HAVE AN EFFECTIVE DATE THE FIRST OF THE FOLLOWING MONTH.

◯ EARLIEST EFFECTIVE DATE ◯ NOT BEFORE THE FOLLOWING DATE: (MM/DD/YYYY) ____/____/____ (use this option if you do not want the policy to be in effect before a certain date).

BILLING ADDRESS—IF YOU WOULD LIKE YOUR BILL TO GO TO A DIFFERENT ADDRESS THAN THE MAILING ADDRESS SUPPLIED EARLIER PLEASE INDICATE IT HERE, OTHERWISE LEAVE BLANK.

C/O (IF APPLICABLE)	ADDRESS (NUMBER & STREET)		
APT./SUITE	**CITY**	**STATE**	**ZIP+FOUR**

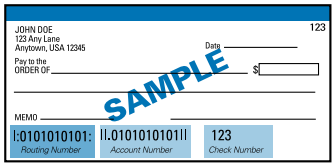
BILLING DATE—YOU HAVE THE OPTION TO BE BILLED ON EITHER THE 1ST OR 15TH OF THE MONTH. PLEASE INDICATE BELOW WHICH CYCLE YOU WOULD LIKE.

PREMIUM BILLING: ◯ 1st of the month ◯ 15th of the month

METHOD OF PAYMENT: ◯ Monthly Sure Pay Electronic Bank Draft (please complete section below)
◯ Monthly Paper Bill

SURE PAY AUTHORIZATION

COMPLETE THIS SECTION IF YOU SELECTED THE MONTHLY SURE PAY OPTION AS YOUR METHOD OF PAYMENT.
IF THE FIRST DEDUCTION IS DELAYED THE INITIAL AMOUNT MAY BE MORE THAN ONE MONTHLY PREMIUM.



PLEASE DEBIT MY: ◯ CHECKING ACCOUNT ◯ SAVINGS ACCOUNT

ROUTING TRANSIT NUMBER	ACCOUNT NUMBER

Important: Remember to sign the authorization below.

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 for discontinuation of Sure Pay withdrawals, and I understand BCBSAZ will refund premium that may be due to me based on the time necessary to terminate Sure Pay withdrawals.

I understand BCBSAZ 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 BCBSAZ 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. I understand that any applicable refund of monies will be released 30 days after the last draft date.

Authorized Signature on Account X _____ Date: (MM/DD/YYYY) ____/____/_____

SPACE BELOW: FOR BROKER USE ONLY

ASSOCIATION NAME	ASSN#	BROKER NAME, MAILING ADDRESS AND PHONE	BROKER # 01049
		INSURANCE PLUS INC STE 101 201 E SOUTHERN AVE TEMPE, AZ 85282- 4809685222	

_____ ◯

APPLICATION FEE RECEIVED

Evidence of Insurability

Blue Cross and Blue Shield of Arizona (BCBSAZ) needs to know everything you know about each applicant's medical history. The following questions cover many general medical conditions but are not intended to be all-inclusive. If injury or illness was greater than ten (10) years ago, but the applicant is still receiving treatment or follow-up, this too must be disclosed on the application. When the application is complete, it should disclose all medical conditions whether or not listed below.

IMPORTANT: BCBSAZ will rely on the information provided to make a determination about coverage and applicable premium for all persons named on the application. **If an applicant misrepresents or omits material information about the applicant's medical background, BCBSAZ may adjust the applicant's premium or apply a waiver that limits or excludes coverage for a particular condition. If the material misrepresentation or omission is fraudulent or intentional, BCBSAZ may rescind/cancel the contract and treat it as though it was never in effect.** If the contract is rescinded, you become responsible for all incurred medical expenses from the effective date of coverage.

If an applicant has any change in health status or develops a medical condition between the date of this application and the effective date of coverage, you must report this change to Medical Risk Assessment at (602) 864-4040, or toll-free (800) 232-2345, ext. 4040. This type of change can affect the premium rate for the policy. If you fail to report a change that occurred between the date of this application, and the date BCBSAZ issues your policy, and the change would have affected your premium, BCBSAZ may impose a waiver or adjust your premium to the rate that you otherwise should have paid, if BCBSAZ had known of the change. Any waiver or adjustment will apply retroactively, back to your effective date.

Please consider the following questions carefully. Please include any treatment from any health care provider including but not limited to a chiropractor, physical therapist, osteopath or medical doctor. If more than one applicant has a condition within a question, please attach a separate sheet of paper and provide the same criteria for the additional applicants for that question.

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.

1 Has any applicant been diagnosed with or treated in the past 10 years for a **head** or **brain** disease, condition or injury? *For Example:* Carotid Artery Disease, Cerebral Aneurysm, Concussion/Head Injury, Craniocynostosis, Hydrocephalus, Migraine/Cluster Headaches, Stroke (Cerebrovascular Accident), Transient Ischemic Attack (TIA), ***or any other head or brain disease, condition or injury not listed.*** **If yes,** please circle condition(s) above or if not listed write it in below. Indicate applicant(s) with the condition(s) and supply information to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4 Condition(s) (if not circled above): _____ Treating physician: _____	◯ YES ◯ NO If yes, please provide: Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____ Ongoing Symptoms: ◯ YES ◯ NO Tell us more about your treatments and/or surgeries: _____ _____ _____ _____ _____ _____ _____
2 Has any applicant been diagnosed with or treated in the past 10 years for an **eye, ear, nose** or **throat** condition or disease? ***For Example:*** Allergies (except for seasonal), Cataracts, Corneal Ulcers, Corneal Scars, Degeneration (such as lattice degeneration, macular degeneration, retinal degeneration), Deviated Septum, Retinal Detachment/Retinal Tear, Eye deviations (such as lazy eye or crossed eyes), Glaucoma, Hearing Loss, Mastoiditis, Meniere's Disease, Nasal Polyps, Nodules, Sinusitis, Vocal Cord Polyps ***or any other eye, ear, nose or throat disease, condition or injury not listed.*** **If yes,** please circle condition(s) above or if not listed write it in below. Indicate applicant(s) with the condition(s) and supply information to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4 Condition(s) (if not circled above): _____ Treating physician: _____	◯ YES ◯ NO If yes, please provide: Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____ Ongoing Symptoms: ◯ YES ◯ NO Tell us more about your treatments and/or surgeries: _____ _____ _____ _____ _____ _____ _____

3 Has any applicant been diagnosed with or treated in the past 10 years for a **breast** or **skin** condition or disease?

For Example: Breast Cancer, Fibroadenoma, Fibrocystic Breast, Psoriasis, Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma ***or any other breast or skin condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

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4 Has any applicant been diagnosed with or treated in the past 10 years for a **lung** condition or disease?

For Example: Asthma, Bronchitis, Lung Cancer, Cystic Fibrosis, Emphysema / Chronic Obstructive Pulmonary Disease (COPD), Pleurisy, Pneumonia, Sleep Apnea, Tuberculosis, Valley Fever ***or any other lung condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

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5 Has any applicant been diagnosed with or treated in the past 10 years for a **heart** condition or disease?

For Example: Angina (chest pain) or Heart Attack and/or Coronary Artery Disease (CAD), Arrhythmia, Congestive Heart Failure, Heart Valve Problems, Heart Pacemaker, Elevated Blood Pressure (Hypertension), Arterialsclerosis, Peripheral Vascular Disease, Phlebitis (blood clots), Varicose Veins ***or any other heart condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

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6 Has any applicant been diagnosed with or treated in the past 10 years for a **back** condition, disease, or injury?

For Example: Sprain/Strain/Back Pain, Spinal Injury, Fracture, Sciatica, Curvature, Herniated/Ruptured Disc, Degenerative Disk Disease ***or any other back condition, disease, or injury not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

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7 Has any applicant been diagnosed with or treated in the past 10 years for a **stomach, esophagus, intestinal,** or **abdominal** condition or disease?

For Example: Celiac Disease, Colitis, Diverticular Disease, Gastroesophageal Reflux (GERD), Gall Stones, Hernia, Irritable Bowel Syndrome (IBS), Pancreatitis, Polyps, Cirrhosis, Crohn's Disease, Enlarged/Fatty Liver, Hepatitis, Hiatial Hernia, Obesity, Peptic Ulcer, Rectocele ***or any other stomach, esophagus, intestinal or abdominal condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

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8 Has any applicant been diagnosed with or treated in the past 10 years for a **diabetic, endocrine** or **hormonal** condition or disease?

For Example: Adrenal Disorders, Diabetes, Pituitary Disorders, Hypothyroidism/ Hyperthyroidism or any other ***diabetic, endocrine or hormonal condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

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9 Has any applicant been diagnosed with or treated in the past 10 years for a **kidney, bladder** or **urinary tract** condition or disease?

For Example: Renal Failure/End Stage Renal Disease (ESRD), Urinary Tract Malformations, Fallen Bladder (Cystocele), Hematuria (blood in urine), Incontinence, Kidney Stones, Bladder Stones, Urinary Reflux (VUR) ***or any other kidney, bladder or urinary tract condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

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10 Has any applicant been diagnosed with or treated in the past 10 years for a **reproductive** condition or disease?

For Example: Sexually Transmitted Diseases, Abnormal Menstruation/Bleeding, Abnormal PAP Smear, Testicular Hernia/Torsion, Undescended Testicles, Endometriosis, Fibroids, Irregular Menstrual Cycle/No Menstruation, Ovarian Cysts, Pelvic Inflammatory Disease (PID), Polycystic Ovarian Disease, Prolapsed Uterus ***or any other reproductive condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

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11 Has any applicant been diagnosed with or treated in the past 10 years for a **bone** or **joint** injury, condition or disease?

For Example: Amputation/Prosthesis, Arthritis, Bursitis, Tendonitis, Epicondylitis (Tennis Elbow), Degenerative Joint Disease, Osteoporosis, Carpal Tunnel Syndrome, Fractures, Knee Injury, Rotator Cuff ***or any other bone or joint injury, condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

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_____

12 Has any applicant been diagnosed with or treated in the past 10 years for a **neurologic, neuromuscular** or **musculoskeletal** condition or disease?

For Example: Chronic Fatigue Syndrome (CFS), Epilepsy/Seizure Disorder, Fibromyalgia, Lupus, Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's), Parkinson's Disease, Tourette's Syndrome, Cerebral Palsy, Scleroderma ***or any other neuromuscular condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

_____

_____

_____

_____

_____

_____

_____

13 Has any applicant been diagnosed with or treated in the past 10 years for a **blood** condition or disease?

For Example: Anemia, Hemophilia, Leukemia (Acute & Chronic) ***or any other blood condition or disease not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

_____

_____

_____

_____

_____

_____

_____

14 Has any applicant been diagnosed with or treated in the past 10 years for a **mental/behavioral** disorder, disease or condition?

For Example: Anorexia, Anxiety/OCD/PTSD/Panic Disorders, ADD/ADHD, Bi-Polar (manic depressive), Bulimia, Depression, Insomnia, Schizophrenia ***or any other mental disorder, disease or condition not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:
Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO
Tell us more about your treatments and/or surgeries:

_____

_____

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_____

15 Has any applicant been diagnosed with or treated in the past 10 years for **substance abuse?**

For Example: Alcohol Abuse/Dependence, Drug Abuse/Dependence ***or any other substance abuse or dependence not listed.***

If yes, please circle condition(s) above or if not listed write it in below.

Indicate applicant(s) with the condition(s) and supply information to the right:

◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2
◯ Dependent 3 ◯ Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

◯ YES ◯ NO If yes, please provide:

Onset Date (MM/YY): _____/_____ End Date (MM/YY): _____/_____

Ongoing Symptoms: ◯ YES ◯ NO

Tell us more about your treatments and/or surgeries:

_____

_____

_____

_____

_____

_____

_____

General Medical Questions

It is important that you have disclosed all known medical information so that BCBSAZ may properly underwrite your application for insurance. In order to help determine if anything was overlooked as the body systems were reviewed, the following questions are designed to help prompt your recollection.

1 Has any applicant in the last three years had an abnormal **x-ray or other radiographic** test? (i.e. MRI, CAT Scan, PET Scan) **If yes,** please indicate applicant(s) and describe to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4	◯ YES ◯ NO If yes describe:
2 Has any applicant in the last three years been advised that he/she had any **abnormal lab values**, whether or not treatment was recommended? ***For Example:*** Blood Sugar, Cholesterol/Triglycerides, Liver Function Tests, PSA *or any other abnormal lab value not listed.* **If yes,** please indicate applicant(s) and describe to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4	◯ YES ◯ NO If yes describe:
3 Has any applicant been advised to have **diagnostic studies or surgery** (inpatient or outpatient), whether planned, scheduled, pending or simply recommended? ***For Example but not limited to:*** placement of ear tubes, biopsies, bone spurs, skin growths, scopes (colonoscopies), cysts, etc. **If yes,** please indicate applicant(s) and describe to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4	◯ YES ◯ NO If yes describe:
4 Has any applicant, within the last 10 years, had surgery (other than cosmetic) which has not been previously disclosed on this application? **If yes,** please indicate applicant(s) and describe to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4	◯ YES ◯ NO If yes describe:
5 Is any applicant currently in the process of a **medical work-up** for symptoms not yet diagnosed or resolved? ***For Example, but not limited to:*** Scans (MRI, CAT, EKG, bone), cardiac evaluation, scopes, laboratory testing, x-rays, etc. **If yes,** please indicate applicant(s) and describe to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4	◯ YES ◯ NO If yes describe:
6 Has any applicant EVER been made aware of, evaluated for, advised of, tested for (other than routine screening), diagnosed with or treated for **cancer** or malignant neoplasms, other than what has already been disclosed on the application so far? **If yes,** please indicate applicant(s) and describe to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4	◯ YES ◯ NO If yes describe:

7 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)? **If yes,** please indicate applicant(s) and describe to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4	◯ YES ◯ NO If yes describe: _____ _____ _____ _____ _____
8 Are there any additional **medications** (including injections) currently prescribed or recommended for any applicant other than what you've previously listed?	◯ YES ◯ NO If yes, fill in the details in the table below:

APPLICANT	NAME OF DRUG	REASON FOR TAKING	DATE OF LAST USE MM/YYYY
◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4			
◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4			
◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4			

9 Are there any applicants with **additional conditions or injuries** not otherwise specified on this application? **If yes,** please indicate applicant(s) and describe to the right: ◯ Contract holder ◯ Spouse ◯ Dependent 1 ◯ Dependent 2 ◯ Dependent 3 ◯ Dependent 4	◯ YES ◯ NO If yes describe: _____ _____ _____ _____ _____

Until you have effective coverage based on this application, do not cancel any other health coverage you may have. Please make sure all applicants sign page 13 of this application.

Please read this application carefully. Upon acceptance, this application and the acknowledgments below become part of your contract with BCBSAZ.

Acknowledgments

1. I have carefully read this application form and the information I provided. I understand and agree that it will be part of the contract with Blue Cross Blue Shield of Arizona (BCBSAZ) for any applicant accepted for coverage.
2. I understand and agree that:
   - The information I've provided is material to BCBSAZ's decision to offer health care coverage;
   - BCBSAZ will rely on the accuracy of the information to determine each applicant's eligibility for coverage and applicable premium;
   - BCBSAZ may rescind the contract and declare it null and void as of the effective date of coverage, if an applicant makes a fraudulent misstatement or intentional misrepresentation or omission that was material to BCBSAZ's decision to issue coverage.
   - BCBSAZ may impose a waiver limiting or excluding coverage for a condition, or adjust the premium, if an applicant misrepresents or omits material information that would have resulted in a waiver or different premium.
   - I am obligated to tell BCBSAZ if any applicant has a change in health status or develops a medical condition between the date of this application and the effective date of any coverage that is issued. BCBSAZ may impose a waiver or adjust my premium if BCBSAZ later learns of a misstatement or omission.
3. I understand and agree that each applicant must fully cooperate with BCBSAZ to investigate any health conditions or claims, and to provide any other relevant information BCBSAZ may need to process this application and perform its business functions.
4. I understand that Applicants, if approved, may be assigned a non-preferred rate based on his/her tobacco status and the results of the underwriting process. Non-preferred rates are higher than preferred rates.
5. I authorize any physician, practitioner, hospital, clinic or other health related provider or facility to furnish BCBSAZ and its representatives with my health information, including information related to drug use, alcoholism, mental illness, HIV and AIDS, but excluding information about genetic testing and family history. I agree to be responsible for any costs associated with obtaining medical records. BCBSAZ may use this information, and any of my information already in its possession, to evaluate my application, determine my premium rate, determine eligibility and process claims. My information may, in certain circumstances, be disclosed to third parties without my permission if permitted by law.
6. I understand that:
   - BCBSAZ sells health and dental coverage products either directly or through independent licensed insurance brokers.
   - Commission payments to brokers are one of the costs factored into premiums, but BCBSAZ's premium calculation for any product on which a broker commission may be paid for new sales is not based on whether a product is sold directly or by a broker. Certain products are available only though non-brokered, online, direct sales at azblue.com.
   - BCBSAZ generally pays a commission to the broker of record or permitted assignee until this contract is terminated or I, as the contract holder, terminate my relationship with the broker or the broker becomes ineligible.
   - BCBSAZ broker contracts require the broker to give me information on the broker's commission rate with BCBSAZ. I can also get more detailed information about broker commission and compensation paid to BCBSAZ licensed inside sales representatives for sales of BCBSAZ individual products at azblue.com or by calling BCBSAZ at (602) 864-4021.
7. I understand and agree that coverage will be effective on the date assigned by BCBSAZ, and subject to waiting periods, limitations, medical waivers and other provisions, regardless of any prior coverage I may have, including the following:
   - **An 11-month waiting period for pre-existing conditions may apply for members age 19 and older**. A pre-existing condition is defined as a condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months before my contract effective date, or a condition which was documented in my medical records during that same 12 month period. A condition exists when an individual had signs or symptoms, whether or not a specific injury, illness or disease was diagnosed.
8. I apply for enrollment on behalf of any spouse and child(ren) named on this application. I understand that if BCBSAZ accepts this application, I will be the contract holder on behalf of the named spouse and child(ren). I understand that no child under age 18 will be covered under this policy unless I or my spouse is accepted for coverage.
9. 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. If equal access is not allowed, I have provided BCBSAZ with a copy of any such court order or law.
10. I understand and agree that BCBSAZ and its authorized representatives may contact me at the phone number(s) I provided in this application (including any mobile phone number) about matters concerning: this application, any insurance coverage I may obtain, and health and wellness initiatives and information that may be available or relevant to any coverage.
11. If I provided an email address in this application, I agree to receive communications electronically from BCBSAZ at that email address, including a Summary of Benefit Coverage. I understand that I may contact BCBSAZ at (877) 475-8440 to obtain a paper copy of the Summary of Benefit Coverage.

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 Acknowledgments is available to you or your authorized representative upon request.

SIGNATURE	TODAY'S DATE (MM/DD/YYYY)
X _____	_____
X _____	_____
X _____	_____
X _____	_____

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

If you would like Blue Cross Blue Shield of Arizona (BCBSAZ) to share personal information with additional people not listed on this application please complete a Confidential Information Release form at the end of this application.

Please return all pages of this application to:

For questions about this application, please call your broker.

To authorize another to have access to your personal information, the Confidential Information Release form included at the end of this application must be completed.

Additional forms are available from your broker.

Instructions for Completing Confidential Information Release Form

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

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 applicant 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 BCBSAZ.
- 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 Whose Information May Be Released: Enter the name of the person whose information should be disclosed. This will normally be your name.

Who May Receive the Indicated Information: Tell us with who you are authorizing to receive your information.

Purpose of Use/Disclosure: Tell us why you want us to share your information.

Authority to Update My Records: Tell us if the person you indicate is authorized by you to update our records if you move to a different address, change banks or change bank accounts.

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 the 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.

Confidential Information Release Form

(To authorize BCBSAZ to disclose and/or update your information)

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

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, AZ 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 Whose Information May Be Released: _____

Who May Receive the Indicated Information:

Name: _____

Company Name: _____

Address: _____

City, State, Zip Code: _____

Purpose of Use/Disclosure:

- ◯ To assist with obtaining a health care policy
- ◯ To assist with claims processing and/or payments
- ◯ Other Purpose of Use/Disclosure: _____

Authority to Update My Records: I also authorize _____ to be able to:

- ◯ To change my mailing address information
- ◯ Update my Sure Pay/Banking information

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, Mail Stop C302, 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 (MM/DD/YYYY)
_____ Group Name (if applicable)	_____ Group Number (if applicable)
_____ Personal Representative's Name*	_____ Relationship to Individual
_____ Personal Representative's Signature	_____ Date (MM/DD/YYYY)

*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.