

Blue Cross Blue Shield of Delaware **Blue Individual Application Checklist**

Thank you for your interest in Blue Cross Blue Shield of Delaware's Blue Individual insurance plans. To apply for coverage, please follow the instructions below.

1. Print the following application form.
2. Please complete all fields of this form in black or blue ink.
3. In Section III. of the application labeled "Coverage Level," please select the option that you've chosen under the appropriate heading (either BlueComp, BlueIPA, or BluePPO). Should you choose the BlueIPA, you must name a Primary Care Physician (PCP) in this section as well.
4. Please indicate your desired start date of coverage on the bottom of the first page in the "Requested Effective Date" section. Please note that coverage can begin on the first or the fifteenth of a month provided that all paperwork is received fifteen days early (for example, to obtain a first of a month start date, paperwork must be received prior to the fifteenth of the prior month). Additionally, coverage is dependent upon health underwriting.
5. Please make sure to complete Section V. of the application labeled "Health Statement." In this section you would list your Primary Care Physician along with the date, reason, and result of your last visit. If you do not have a Primary Care Physician, please list the last physician that you saw, along with the date, reason, and result of that visit.
6. Please be certain to sign the application.
7. Once complete, please mail this application along with a check payable to Blue Cross for your first month's premium payment to the following address:

Health Insurance Associates
260 Chapman Road, Suite 107
Newark, DE 19702
Attention: Tom

If you have any questions regarding the plans or the application process, please don't hesitate to contact us at 1-800-725-8862.

BlueIndividual
 APPLICATION FOR INDIVIDUAL COVERAGE
 (MEDICALLY UNDERWRITTEN)



1. Please **do not remove the mailing label** (if any).
2. Please print or type information.
3. **Sign** and return this application to the address shown above.
4. You must be a resident of the State of Delaware.
5. If anyone listed on this application is a "non-citizen resident" of the U.S. who has not resided in the U.S. for six (6) consecutive months, please provide the name(s) and explanation: _____

Incomplete applications will be returned. If additional information is needed from your physician(s), we will contact you. If this occurs, please allow 4-6 weeks to complete the application process.

I. APPLICANT INFORMATION—List all applicants. The oldest applicant accepted will be the policyholder. Use a separate sheet if more space is needed.

Last Name	First Name	M.I.	Date of Birth	Relationship	Social Security Number	Height	Weight
				Applicant: <input type="checkbox"/> Male <input type="checkbox"/> Female			
				<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			

Address _____
 (Number) (Street) (City) (State) (Zip Code)

Home Phone () _____ Business Phone () _____ E-mail Address _____

Are you married? Yes No

Employment information **must** be completed for both applicant **and** spouse even if spouse is not applying for coverage.

Applicant's Employer _____ Self-Employed? Yes No Occupation _____ Full-time Part-time

Spouse's Employer _____ Self-Employed? Yes No Occupation _____ Full-time Part-time

II. PREMIUM SELECTION—Please check one option: Individual Individual & Spouse Individual & Child(ren) Family

III. COVERAGE LEVEL. Please check one option below.

BlueComp Deductible Options:

- \$ 250 \$1,000 \$ 5,000
 \$ 500 \$1,500 \$10,000
 \$ 750 \$2,500

BlueIPA Options: (Complete PCP information below.)

- \$10 Copay / \$0 Deductible \$20 Copay / \$1,000 Deductible
 \$10 Copay / \$500 Deductible \$30 Copay / \$1,000 Deductible

BluePPO Deductible Options:

- \$250 \$1,000 \$2,500
 \$500 \$1,500 \$5,000

Maternity Option? Yes No (There is an additional cost for this option, and benefits are subject to a 12-month waiting period.)

Choose Billing Cycle: Monthly Quarterly (January, April, July, October)

Please Note: Applicants with prior Blue Cross Blue Shield coverage should submit a HIPAA Certificate to possibly reduce the 12-month pre-existing waiting period.

Name (to be completed by BlueIPA applicants only)	Primary Care Physician (PCP) Name	PCP's identification Number	Current PCP?
(Applicant)			<input type="checkbox"/> Yes <input type="checkbox"/> No
(Spouse)			<input type="checkbox"/> Yes <input type="checkbox"/> No
(Dependent)			<input type="checkbox"/> Yes <input type="checkbox"/> No
(Dependent)			<input type="checkbox"/> Yes <input type="checkbox"/> No

Requested Effective Date: ___/___/___

BCBSD USE ONLY	Sub-Group No.:	Package No.:	Contract Type:	Effective Date:
AGENT'S USE ONLY	Agent Name: Atlantic States United Brokerage, Inc.	Agent No.: 241	Producer Name: Thomas Walls	Producer No.: 5453

IV. OTHER INSURANCE INFORMATION

1. I am applying for new coverage.
 - I am applying for a change in coverage. Describe: _____
 - I am transferring from other **Blue Cross Blue Shield of Delaware** coverage. I.D. Number: _____
 - I am transferring from **another Blue Cross Blue Shield company**. Please submit your **HIPAA Certificate of Coverage** to possibly reduce the 12-month pre-existing waiting period.
 - Would this new Blue Cross Blue Shield of Delaware coverage replace an existing policy? Yes No. If yes, please provide the name of the carrier: _____
2. Is anyone listed on this application eligible for Medicare? Yes No. If yes, please provide the following:
 Name of family member(s) _____
 Medicare Number(s) _____ Effective Date(s) _____
3. Please list anyone on this application who:
 - is eligible for health insurance through an employer or association: _____
 - has **not** had any health insurance for the past 12 months: _____
 - previously applied for Individual Coverage in the past 3 years and was denied for medical reasons: _____

V. HEALTH STATEMENT

Give the name and address of your primary physician, with date and reason for last visit.

Applicant:

Physician's name _____ Telephone () _____
 Address _____
 Applicant's Name _____ Date of last visit _____
 Symptom or condition _____

Other Family Member Applying (attach a separate sheet if necessary):

Physician's name _____ Telephone () _____
 Address _____
 Applicant's Name _____ Date of last visit _____
 Symptom or condition _____

Has any person included on this application had any known indication, diagnosis or treatment **within the last 7 years** of any of the conditions listed below? **Please check "Yes" or "No"** for each condition. **If "Yes," circle the appropriate condition.** Answering yes will not necessarily result in rejection of your application.

ALL QUESTIONS MUST BE CHECKED "YES" OR "NO."	YES	NO	APPLICANT OR NAME OF OTHER FAMILY MEMBER APPLYING:
1. Any cancer, cysts, tumors or unusual growths?	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Any metabolic or endocrine conditions/disorders (examples: diabetes, adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, chronic fatigue syndrome, AIDS, or any immune disorder)? ..	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Any alcohol, drug, or substance dependency, abuse, or addiction?	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Any disorder of the circulatory system or heart (examples: aneurysm, chest pain, elevated cholesterol level, heart attack, heart murmur, high blood pressure, irregular heart beat, phlebitis, rheumatic fever, stroke, or varicose veins)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Any emotional or psychological disorders (examples: adjustment disorder, anxiety, depression, obsessive-compulsive disorder, schizophrenia, or attempted suicide)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Any disorder of the lungs or respiratory system (examples: allergy, asthma, chronic obstructive pulmonary disease, emphysema, or tuberculosis)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Any disorder of the kidney or urinary system (examples: cystitis, renal failure, kidney stones, nephritis, prostatitis, or recurring bladder infections)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Any disorder of the brain or nervous system (examples: epilepsy, seizures, head trauma, migraines, multiple sclerosis, or paralysis)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Any disorder of the digestive system (examples: cirrhosis, chronic constipation, colitis, esophagitis, gall bladder/stones, hemorrhoids, chronic acid reflux, hepatitis, or ulcer)?	<input type="checkbox"/>	<input type="checkbox"/>	_____

ALL QUESTIONS MUST BE CHECKED "YES" OR "NO."

YES NO

APPLICANT OR NAME OF OTHER FAMILY MEMBER APPLYING:

10. Any disorder of the muscles or skeletal system (examples: arthritis, bursitis, carpal tunnel syndrome, gout, back or spine trouble, external deformity, osteomyelitis, osteoporosis, rheumatism, or scoliosis)? _____
11. Any disorder of the skin (examples: collagen disorder, eczema, or psoriasis)? _____
12. Any disorder of the blood (examples: anemia, hemophilia, leukemia, or sickle cell)? _____
13. Any breast or gynecological disorders (examples: endometriosis, infertility, irregular menstruation, or breast condition)? _____
14. Any venereal disease (examples: gonorrhea, herpes, or syphilis)? _____
15. Any disorders of the eye, ear, nose or throat (examples: allergy, deafness, or cataracts)? _____
16. Any of the following conditions or procedures: alzheimer's, cystic fibrosis, hodgkin's, muscular dystrophy, myasthenia gravis, palsy, parkinson's, polio, or transplants? _____
17. Any congenital conditions? _____
18. Any premature births, caesarean deliveries or miscarriages? _____
19. Is any person named on this application currently pregnant? _____
 Expected delivery date: ____/____/____
20. Has any person included on this application had any health issue not previously mentioned on this application for which advice, diagnosis, care or treatment (including medical, surgical or hospital care) may or may not have been sought in the past 7 years? _____
21. Is any applicant scheduled for surgery or hospital admission within the next six months? _____
 Please list the condition _____
 Date of scheduled service ____/____/____
 Attending physician _____
 Telephone () _____
22. Has any applicant smoked, snuffed, or chewed tobacco at any time during the past 24 months? (Please name each applicant who has.) _____

- If you have checked "yes" to any of the questions ABOVE, enter details below. (If more space is required, use a separate sheet.)
- **All** questions must be checked "yes" or "no," or your application will be returned.
- **Failure to disclose conditions** may result in voiding of coverage and denial of benefits.

Name of Family Member Applying	Ques. No.	Illness or Condition	Last Treatment Month Day Year / /	Operation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Attending Physician Name and Address
			Month Day Year / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			Month Day Year / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			Month Day Year / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	

If any person included in this application is presently taking prescription drugs, please provide the following information:

Name of Family Member Applying	Drug and Daily Dosage	Illness or Condition

VI. TERMS OF AGREEMENT

I hereby apply on behalf of myself, my spouse and my dependent children (if listed on this application) for a Blue Cross Blue Shield of Delaware (BCBSD) health insurance contract.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I have the authority to act for myself, my spouse and all of my dependent children including those who have reached the age of 18.
2. The contract will be effective only for those applicants approved by BCBSD.
3. If BCBSD accepts this application, I will receive a copy of the contract and an identification card. The contract will state plan benefits for insureds and define the conditions under which the benefits will be available. If I am a new member, the carrier holding my ID card will specify the effective date of my coverage.
4. A pre-existing condition is any condition anyone covered under this contract had before the contract's effective date.
BCBSD has a 12-month waiting period before pre-existing conditions will be covered under this contract. BCBSD will apply this waiting period to any condition (whether physical or mental), for which medical advice, diagnosis, care, or treatment was recommended or received from a health care provider by anyone covered by my contract within a six (6) month period ending on the day this contract is effective.
5. The contract, application and any attached amendments shall constitute the entire agreement and shall supersede any previous agreements.
6. I will pay the premiums to BCBSD when due.
7. In the event there is an error made in any payment of benefits, I agree to refund to BCBSD the amount of any overpayment of benefits to which I am not entitled.
8. I will notify BCBSD in writing if there have been any changes to the health of any person listed on this application, that occur prior to acceptance of this application by BCBSD.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly stated. They are representations that are made to induce the issuance of and form part of the consideration for a BCBSD contract. I also understand that failure to enter accurate, complete, and updated medical information in writing, prior to acceptance of this application by BCBSD, may result in the denial of benefits, cancellation or voiding of my contract, or attachment of an exclusionary amendment to my contract denying coverage for the affected individual or condition that was not disclosed.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any physician, hospital or other health care provider who is provided a signed copy of this authorization to furnish to BCBSD any medical information, reports or copies of records which may be requested by BCBSD or any of its agents or representatives, in order to determine eligibility for coverage under the health insurance contract for which application has been made. I will be directly responsible to the provider for any charge for this service.

I understand that I have the right to revoke this authorization at any time by giving written notice of my revocation to BCBSD who will promptly implement it. Revocation of this authorization will not affect any action that BCBSD or any health care provider took before I provide written notice of revocation. I understand that failure to execute this authorization may result in a denial of my application for coverage. This authorization shall continue until BCBSD notifies me of its decision to accept or reject this application.

I have carefully read this Application and Authorization to Release Medical Information and agree to the terms and conditions specified.

All applicants have signed below, except for dependent children under the age of 18.

_____ Signature of Applicant (DO NOT PRINT)	_____ Printed Name of Applicant	____/____/____ Date
_____ Signature of Spouse or Child Age 18 or Older (DO NOT PRINT)	_____ Printed Name of Spouse or Child Age 18 or Older	____/____/____ Date
_____ Signature of Child Age 18 or Older (DO NOT PRINT)	_____ Printed Name of Child Age 18 or Older	____/____/____ Date

Before mailing this application, please remember to:

- answer all 22 health questions.
- enter current information in the height and weight columns.

Note: If you have prior Blue Cross Blue Shield coverage, please submit a *HIPAA Certificate of Coverage*.

Premiums are not required at the time of application, but coverage will not be in effect until payment is received.



Authorization Agreement for EasyPay Automatic Withdrawals

By signing below, I deem all information to be true solely with respect to withdraws of my individual health insurance premium. I authorize Blue Cross Blue Shield of Delaware and the financial institution designated below to initiate automatic deductions by direct debit from my bank account for payment of my health insurance premiums. I understand the automatic withdrawal of the amount billed will be debited (withdrawn) on the billing due date I have selected.

INVALID/RETURNED DIRECT DEPOSIT TRANSMISSIONS: I understand and agree to pay \$20.00 for any invalid or returned deposit transmissions due to incorrect bank information supplied by me or if my payment is returned due to insufficient funds.

Subscriber Name: _____ Joint Account Name (if applicable): _____

Subscriber Identification Number: _____

Bank Name: _____

Bank Address: _____

Bank Transit/ABA Routing Nine-Digit Number (numbers only, no symbols)*: _____

Account Number: _____

Type of Account: (checking, savings, money market, etc): _____

Monthly Withdraw Date (circle one): 27th of the previous month, 3rd or 5th _____

Frequency of Current Payments (circle one): annually, semi-annually, quarterly or monthly _____

***The first nine digits in the lower left-hand corner of a check represent your Bank Transit/ABA Routing Number.**

Subscriber Signature: _____ Date: _____

Joint Account Signature: _____ Date: _____

Please attach a copy of a voided check — not your deposit slip — for verification purposes. (See check facsimile below.)

If at anytime you wish to be removed from the *EasyPay* system, you must notify us in writing at the address below.

Should you have any questions regarding your *EasyPay* process, please feel free to contact us:

**By email: premiumbilling@bcbsde.com
By phone: 302.421.3209 or 800.548.1050**

Your Name	1234
000 Any Street	Date: _____
Any City, USA 00000	\$ _____
Pay to the order of _____	_____ Dollars
Memo _____	_____
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