Application for Blue Shield Individual and Family Health Plans

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

blue of california

APPLICATION MUST BE COMPLETED IN BLUE OR BLACK INK. Please make sure you answer all questions as completely and accurately as possible and include first month's premium to avoid a delay in processing or possible return of the application. Submit ALL pages, 1 through 26, as your complete application including any other supporting documentation to Blue Shield Attn: I&M -Applications, PO Box 3008, Lodi, CA 95241-9969 or fax: (888) 386-3420. Call Blue Shield at **(800) 431-2809**, or contact your agent for help filling out the application.
Please print using BLOCK CAPITAL LETTERS. Boxes should be marked as follows: ☒

(PRODUCER USE ONLY)
MARKET CODE

Reason for application: ☐ New enrollment ☐ Plan transfer ☐ Add family member to existing coverage

Part 1 – Primary applicant information –

Indicating the younger spouse/domestic partner as the primary applicant may reduce your monthly dues/premiums. You are eligible to apply for a Blue Shield individual and family health plan if you are: a California resident, under the age of 65 and not eligible for Medicare.

Applicant's Social Security number	First name	MI
___ ___ ___ – ___ ___ – ___ ___ ___ ___	Last name	

☐ Male ☐ Female	Married: ☐ Yes ☐ No Domestic partner: ☐ Yes ☐ No	Date of birth (month/day/year) ____/____/_____	Height (ft. in.)†	Weight (lbs.)†

Applicant's business phone ( )	Applicant's home phone ( )	Applicant's email address:
Applicant's fax No. ( )	Applicant's cell phone ( )	

If a current Blue Shield member, provide Subscriber number:

Home address (no P.O. Box)			Apt. No.
City	State	ZIP code	
Billing address (if different from above)			Apt. No.
City	State	ZIP code	
Mailing address (if different from home address)			Apt. No.
City	State	ZIP code	

Applicant's occupation†	Applicant's employer's ZIP code
Spouse/domestic partner's occupation†	Spouse/domestic partner's employer's ZIP code

List other name(s) used in past

Health Plan option (check one box only):

Active Start:
☐ Plan 25*
☐ Plan 25 Generic Rx*
☐ Plan 35*
☐ Plan 35 Generic Rx*

Access+
☐ HMO package
☐ Value HMO

Essential package:
☐ Plan 1750*
☐ Plan 3000*
☐ Plan 4500*

Balance:
☐ Plan 1000*
☐ Plan 1700*
☐ Plan 2500*

Shield Spectrum:
☐ PPO 5000*
☐ PPO 5500

Shield Savings:
☐ 1800/3600*
☐ 3500*
☐ 4000/8000*
☐ 5200*

Vital Shield:
☐ 900* ☐ 2900*

Vital Shield Plus:
☐ 400* ☐ 400 Generic Rx*
☐ 900* ☐ 900 Generic Rx*
☐ 2900* ☐ 2900 Generic Rx*

HMO only (visit **blueshieldca.com** to find a provider, or for questions call **800-431-2809**)

Personal Physician name:	Provider No.:	Med Group/IPA No.:
☐ Check if current patient	Requested effective date (see Part 7(b), Item 4 for information) ____/____/_____	

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
† Do not complete if applying only for a HIPAA guaranteed issue plan (see below).

C12900-RD-EXT (10/11)

Part 1 – Primary applicant information (continued):

HIPAA Guaranteed Issue Plans: Please note that HIPAA guaranteed issue plan rates may be higher than those of Blue Shield's underwritten plans. If you are applying for both HIPAA guaranteed issue coverage and an underwritten plan, complete the entire application. If you are applying for HIPAA guaranteed issue coverage only, complete Parts 1-4, 6-8 and 10-11. See Part 8 for more information.

Payment options: ☐ First month's dues by credit card (complete pages 25-26) ☐ First month's dues by check ☐ Automatic payment (complete pages 25-26) ☐ Monthly direct billing ☐ Quarterly direct billing
Note: First month's dues are required at time of application submission.

Have you been a resident of California for the past six months? ☐ Yes ☐ No If no, where was your last residence? _____
If no, medical records documenting a complete physical exam by a California physician within the last six months may be required.

Indicate language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other: _____

Preferred method of contact (check one): ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email ☐ Standard mail Best time to contact: _____ ☐ AM ☐ PM

Check here if you have previously had coverage with Blue Shield. ☐ If prior coverage, indicate prior Blue Shield ID No., if known: _____

Part 2 – Primary applicant supplemental plan choices

You may also purchase a dental plan and/or life insurance to supplement your medical coverage. Please note: HIPAA guaranteed issue plans are not eligible for supplemental dental plan or life insurance coverage options.

Dental plan option (check one): ☐ Dental HMO ☐ Dental PPO ☐ Value Smile ☐ Specialty Duo (dental + vision package)*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809**
Dental provider name: | Dental Provider No.

Life insurance* option (check one): Applicants under the age of 1 year are not eligible for life insurance. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. Child applicants can apply for up to a $30,000 life insurance option and spouse/domestic partner can apply for up to a $100,000 life insurance option below.
☐ $10,000 (ages 1-64) ☐ $30,000 (ages 1-64) ☐ $60,000 (ages 19-64) ☐ $90,000 (ages 19-49) ☐ $100,000 (ages 19-49)
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.
Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____
Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000/8000, and 5200) ☐

Part 3(a) – Spouse/domestic partner dependent applicant information – If a dependent applies for a separate medical plan he/she is considered a primary applicant and is then eligible to select a life insurance plan.

☐ Spouse ☐ Domestic Partner | Sex: ☐ Male ☐ Female | Social Security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

First name | MI

Last name

Date of birth (Month/Day/Year) ____/____/_____ | Height (ft. in.)† | Weight (lbs.)†

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one): **Active Start Plan*:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx **Access+:** ☐ Value HMO ☐ HMO package **Essential package*:** ☐ 1750 ☐ 3000 ☐ 4500 **Balance Plan*:** ☐ 1000 ☐ 1700 ☐ 2500 **Shield Spectrum PPO:** ☐ 5000* ☐ 5500 **Shield Savings*:** ☐ 1800 ☐ 3500 ☐ 4000 ☐ 5200 **Vital Shield*:** ☐ 900 ☐ 2900 **Vital Shield Plus*:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx

HMO only – visit **blueshieldca.com** to find a provider or for questions call **(800) 431-2809**. ☐ Check if current patient
Personal Physician name: | Provider No.: | Med group/IPA No.:

Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200) ☐

Dental plan option (check one): ☐ Dental HMO ☐ Dental PPO ☐ Value Smile ☐ Specialty Duo (dental + vision package)*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809**.
Dental provider name: | Dental Provider No.

Life insurance* option (check one only if applying for a separate medical plan):
☐ $10,000 ☐ $30,000 (ages 1-64) ☐ $60,000 (ages 19-64) ☐ $90,000 (ages 19-49) ☐ $100,000 (ages 19-49)
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.
Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____
Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
† Do not complete if applying only for a HIPAA guaranteed issue plan.

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Primary applicant's initials _____

Part 3(b) – Child dependent applicant information – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached. ☐

☐ Son ☐ Daughter | Social Security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

First name | MI

Last name

Date of birth (Month/Day/Year) ____/____/_____ | Height (ft. in.)† | Weight (lbs.)†

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one): **Active Start Plan*:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx **Access+:** ☐ Value HMO ☐ HMO package **Essential package*:** ☐ 1750 ☐ 3000 ☐ 4500 **Balance Plan*:** ☐ 1000 ☐ 1700 ☐ 2500 **Shield Spectrum PPO:** ☐ 5000* ☐ 5500 **Shield Savings*:** ☐ 1800 ☐ 3500 ☐ 4000 ☐ 5200 **Vital Shield*:** ☐ 900 ☐ 2900 **Vital Shield Plus*:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx Consider my child for a separate plan ☐

HMO only – visit **blueshieldca.com** to find a provider or for questions call **(800) 431-2809**. | ☐ Check if current patient

Personal Physician name: | Provider No.: | Med group/IPA No.:

Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200) ☐

Dental plan option (check one): ☐ Dental HMO ☐ Dental PPO ☐ Value Smile ☐ Specialty Duo (dental + vision package)*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809**. | Dental Provider No.

Dental provider name:

Life insurance* option for child applicants age 1 year or older: ☐ $10,000 ☐ $30,000

If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Part 3(c) – Child dependent applicant information – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached. ☐

☐ Son ☐ Daughter | Social Security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

First name | MI

Last name

Date of birth (Month/Day/Year) ____/____/_____ | Height (ft. in.)† | Weight (lbs.)†

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one): **Active Start Plan*:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx **Access+:** ☐ Value HMO ☐ HMO package **Essential package*:** ☐ 1750 ☐ 3000 ☐ 4500 **Balance Plan*:** ☐ 1000 ☐ 1700 ☐ 2500 **Shield Spectrum PPO:** ☐ 5000* ☐ 5500 **Shield Savings*:** ☐ 1800 ☐ 3500 ☐ 4000 ☐ 5200 **Vital Shield*:** ☐ 900 ☐ 2900 **Vital Shield Plus*:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx Consider my child for a separate plan ☐

HMO only – visit **blueshieldca.com** to find a provider or for questions call **(800) 431-2809**. | ☐ Check if current patient

Personal Physician name: | Provider No.: | Med group/IPA No.:

Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200) ☐

Dental plan option (check one): ☐ Dental HMO ☐ Dental PPO ☐ Value Smile ☐ Specialty Duo (dental + vision package)*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809**. | Dental Provider No.

Dental provider name:

Life insurance* option for child applicants age 1 year or older: ☐ $10,000 ☐ $30,000

If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

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Primary applicant's initials _____

Part 3(d) – Child dependent applicant information – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached. ☐

☐ Son ☐ Daughter | Social Security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

First name | MI

Last name

Date of birth (Month/Day/Year) ____/____/_____ | Height (ft. in.)† | Weight (lbs.)†

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one): **Active Start Plan*:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx **Access+:** ☐ Value HMO ☐ HMO package **Essential package*:** ☐ 1750 ☐ 3000 ☐ 4500 **Balance Plan*:** ☐ 1000 ☐ 1700 ☐ 2500 **Shield Spectrum PPO:** ☐ 5000* ☐ 5500 **Shield Savings*:** ☐ 1800 ☐ 3500 ☐ 4000 ☐ 5200 **Vital Shield*:** ☐ 900 ☐ 2900 **Vital Shield Plus*:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx Consider my child for a separate plan ☐

HMO only – visit **blueshieldca.com** to find a provider or for questions call **(800) 431-2809**. | ☐ Check if current patient

Personal Physician name: | Provider No.: | Med group/IPA No.:

Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200) ☐

Dental plan option (check one): ☐ Dental HMO ☐ Dental PPO ☐ Value Smile ☐ Specialty Duo (dental + vision package)*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809**. | Dental Provider No.

Dental provider name:

Life insurance* option for child applicants age 1 year or older: ☐ $10,000 ☐ $30,000

If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Part 3(e) – Child dependent applicant information – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached. ☐

☐ Son ☐ Daughter | Social Security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

First name | MI

Last name

Date of birth (Month/Day/Year) ____/____/_____ | Height (ft. in.)† | Weight (lbs.)†

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one): **Active Start Plan*:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx **Access+:** ☐ Value HMO ☐ HMO package **Essential package*:** ☐ 1750 ☐ 3000 ☐ 4500 **Balance Plan*:** ☐ 1000 ☐ 1700 ☐ 2500 **Shield Spectrum PPO:** ☐ 5000* ☐ 5500 **Shield Savings*:** ☐ 1800 ☐ 3500 ☐ 4000 ☐ 5200 **Vital Shield*:** ☐ 900 ☐ 2900 **Vital Shield Plus*:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx Consider my child for a separate plan ☐

HMO only – visit **blueshieldca.com** to find a provider or for questions call **(800) 431-2809**. | ☐ Check if current patient

Personal Physician name: | Provider No.: | Med group/IPA No.:

Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200) ☐

Dental plan option (check one): ☐ Dental HMO ☐ Dental PPO ☐ Value Smile ☐ Specialty Duo (dental + vision package)*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809**. | Dental Provider No.

Dental provider name:

Life insurance* option for child applicants age 1 year or older: ☐ $10,000 ☐ $30,000

If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

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† Do not complete if applying only for a HIPAA guaranteed issue plan.

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Primary applicant's initials _____

Part 4 – Prior medical coverage: must be completed.

1a. Did you or any applying family member have other health coverage (insurance) within the last 63 days? ☐ Yes ☐ No

1b. Did any applying child under age 19 have other continuous health coverage within the last 90 days? ☐ Yes ☐ No
If NO, go to question 3.
If YES, submit evidence of prior coverage, such as a certificate of creditable coverage from your previous health carrier and complete the following:

2. Name(s)	Type of coverage	Effective date	Cancel date	Health plan carrier and/or COBRA administrator
Primary applicant	☐ Group ☐ COBRA ☐ Individual ☐ Other	___/___/_____	___/___/_____	
Spouse/domestic partner dependent	☐ Group ☐ COBRA ☐ Individual ☐ Other	___/___/_____	___/___/_____	
Child dependent	☐ Group ☐ COBRA ☐ Individual ☐ Other	___/___/_____	___/___/_____	
Child dependent	☐ Group ☐ COBRA ☐ Individual ☐ Other	___/___/_____	___/___/_____	
Child dependent	☐ Group ☐ COBRA ☐ Individual ☐ Other	___/___/_____	___/___/_____	
Child dependent	☐ Group ☐ COBRA ☐ Individual ☐ Other	___/___/_____	___/___/_____	

3. If you or any applying family member currently has coverage, it will need to be cancelled if this application for coverage is approved by Blue Shield. Will you cancel your other coverage if this coverage is approved by Blue Shield? ☐ Yes ☐ No

4. If you or any applying family member are applying for a plan other than an HMO and had other health coverage within the last 63 days, submit a certificate of creditable coverage from your previous health carrier (this document is sent to you by your previous carrier and discloses when your coverage ended and how long you were covered). You can obtain a copy of your certificate of creditable coverage by contacting your previous health carrier. If this application is approved, Blue Shield will apply the individual's creditable coverage to reduce any waiting period on their pre-existing condition exclusion with this plan. The pre-existing condition exclusion does not apply to dependents under the age of 19 unless you are adding an applicant under 19 to a grandfathered plan (coverage issued prior to March 23, 2010). See the EOC /Policy booklet for more on pre-existing conditions. You can obtain a copy of the EOC /Policy by contacting Blue Shield at **(800) 431-2809**.

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Part 5 – Health questionnaire

Answer all questions accurately and completely for each applicant. Blue Shield relies upon the information you provide in your application to determine whether you are eligible for coverage. While we may review your medical records in certain instances, do not assume we will review your medical records before issuing coverage. Blue Shield has the right to rescind your coverage if your answers are intentionally and materially inaccurate or incomplete. If coverage is rescinded, this means that you may lose coverage back to the original effective date. If your coverage is lawfully rescinded, Blue Shield may have the right to seek repayment from you for medical expenses that we already paid. You should be aware that we can and do review medical records in certain situations after a health services contract/policy has been issued to determine whether material facts were misrepresented or omitted on the application. It is therefore very important that you make every effort to answer all questions accurately and completely. Please note that even if you currently have coverage, or had prior coverage, with Blue Shield you must answer all questions in this health questionnaire. Your obligation to disclose medical information includes the obligation to disclose to Blue Shield any new or changed medical information arising after submission of this Application but before your enrollment date. Any failure to disclose new or changed information may result in rescission of your contract/policy, if that information would have been material to the issuance of coverage.

HIPAA Guaranteed Issue Plans: If you are applying for both HIPAA guaranteed issue coverage and an underwritten plan, complete the entire application. If you are applying for HIPAA guaranteed issue coverage only, complete parts 1-4, 6-8, and 10-11 (do not complete this Part 5). See Part 8 for more information.

Part 5(a) – Medical history

All questions must be answered. Check (✓) "Yes" or "No." Complete details of any "Yes" answer must be given in Part 5(b). **Where indicated below for questions 1 through 15, please print the first name of each individual applying for coverage.** Initial any changes/corrections you may make. If you do not understand a medical term being used, or are not sure whether you have or had a medical condition listed on this application, do not answer "No." Speak to your doctor or otherwise take steps to understand what the question means before answering. If you otherwise need help filling out the application, call Blue Shield at **(800) 431-2809**, or contact your agent. If you still aren't sure or don't recall if you have or had a listed medical condition, answer "Don't know" and then explain the answer in Part 5(b). **NOTE** – Each "Yes" or "Don't know" answer must be explained in Part 5(b) or the application will be deemed to be incomplete. If more than four child dependents are applying for coverage, please attach supplemental pages providing all information listed below for Section 5(a) and Sections 5(b), 5(c) and 5(d) if applicable, your signature and date. Check here if a supplemental page is attached. ☐

1. In the past 10 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	**Write in name of:**		
	Primary applicant _____	**Spouse/domestic partner** _____	**Child dependent** _____
Aortic or Mitral Valve Regurgitation or Stenosis, other Heart Valve condition	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Abnormality of the Veins or Arteries of the Brain, such as Aneurysm, AV Malformation	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Acquired Immune Deficiency Syndrome (AIDS) or AIDS – Related Complex (ARC), Kaposi's Sarcoma (KS)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Alzheimer's Disease or Dementia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bi-polar Disorder, Manic Depression, Schizophrenia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cancer, Malignant Tumor	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Connective Tissue Disorder, Scleroderma, Systemic Lupus	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Coronary Artery Disease (CAD), Heart Attack	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Disorder(s) of the blood vessels or heart, Heart Enlargement, Heart Failure, Heart Pacemaker	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hemophilia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hepatitis If yes, please specify Type (B, C, D, other?)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Joint Replacement (such as hip, knee, shoulder), Amputation, Prosthetic Limb	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Leukemia, Hodgkin's Disease, Lymphoma, Organ or bone marrow transplant	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Stroke or Transient Ischemic Attack (TIA), Bruit, or Carotid Stenosis (narrowing or stiffness of the arteries)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

2. In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	**Write in name of:**		
	Primary applicant _____	**Spouse/domestic partner** _____	**Child dependent** _____
Abnormal or Irregular Menstrual/Uterine Bleeding	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Alcohol Abuse, Dependence or Addiction; Drug Use or Abuse, Dependence or Addiction	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Allergies, Asthma, Reactive Airway Disease	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Anemia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Angina, Chest pain	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Anorexia, Bulimia or other eating disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Apnea or Sleep Apnea	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Arthritis, Osteoarthritis, Rheumatoid Arthritis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Autism	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

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2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	**Write in name of:** **Primary applicant**	**Spouse/domestic partner**	**Child dependent**
Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma, other Skin Cancer	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bleeding or Blood Disorder (except HIV test)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Birth Marks (Hemangioma)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bladder Disorder, Incontinence	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bone, Ligament, Tendon, Joint Injury or Disorder, Carpal Tunnel Syndrome	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bronchitis, Pneumonia, Breathing or other Lung Disorder(s)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cataracts, Glaucoma, Strabismus (crossed eyes), other Eye Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cerebral Palsy, Parkinson's	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Chronic (or recurrent) Muscle/Limb Weakness, Fatigue, or Tingling	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Chronic (or recurrent) Pain, including back pain	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cirrhosis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Congenital (Birth) Defect or Abnormality, Cleft Lip, Cleft Palate	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Crohn's Disease	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Curvature of the Spine, Scoliosis, other Spine Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Depression, Anxiety, Panic Attack(s), Obsessive Compulsive Disorder (OCD)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Deviated Nasal Septum, Sinusitis, Excessive Snoring or other Sinus Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Diabetes or other Endocrine (Glandular) Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Ear Infections, other Ear or Hearing Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Emphysema	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Epilepsy, Convulsions, Seizure Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Fibrocystic Breasts, Micro-Calcifications, other Breast Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Fractures, Retained Hardware (pins, screws, etc.)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Gastric Bypass, Stapling, Banding or other weight loss surgery	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Gout	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Heartburn or Reflux (recurrent), other Digestive Tract Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Headaches or Migraines	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Heart Murmur, Palpitations, Irregular Heart Beat	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hernia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Herniated or Bulging Disk, Sciatica	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
High Blood Pressure (Hypertension)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
High Cholesterol and/or high Triglycerides	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hormone or Growth Hormone Condition	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hyperactivity, Attention Deficit Hyperactivity Disorder (ADHD)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hypothyroidism, other Thyroid Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Implant(s), Prosthesis (other than breast)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Infertility, male or female	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
In-vitro Fertilization	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Kidney Infection, Bladder Infection, Kidney or Bladder Stones, Interstitial Cystitis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Melanoma	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Miscarriage (Spontaneous Abortion)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Multiple Sclerosis, Muscular Dystrophy	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Obesity	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Osteoporosis or Osteopenia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Ovarian Cyst(s), Polycystic Ovaries	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Pancreatitis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Paralysis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

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Primary applicant's initials _____

2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	**Write in name of: Primary applicant** _____	**Spouse/domestic partner** _____	**Child dependent** _____
Phlebitis, Blood Clots, Embolism, Varicose Veins, Peripheral Artery Disease (PAD)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Premature Birth	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Prostatitis, Enlarged Prostate (BPH), other Disorder of the male Reproductive (sex) Organs	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Psoriasis, Keratosis, Acne, Herpes, Shingles, other Skin Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Severe Burns	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Shortness of Breath	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Syphilis, Gonorrhea, Chlamydia, Genital Warts, Herpes, other Sexually Transmitted Disease	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Temporal Mandibular Joint Disorder (TMJ)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Tuberculosis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Tumor, Mass, Polyp, Cyst (other than ovarian)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Ulcer	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Ulcerative Colitis, other Bowel or Rectal Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Uterine Fibroid(s), Endometriosis, other Disorders of the Female Reproductive (sex) Organs	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

3. In the past 5 years, have you:	**Write in name of: Primary applicant** _____	**Spouse/domestic partner** _____	**Child dependent** _____
(a) Been an inpatient or outpatient in a hospital, surgical center, emergency room, or other medical facility?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(b) Had any kind of surgery, including biopsy, angioplasty, bypass or cosmetic/reconstructive surgery?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(c) Had any application for health or life insurance rescinded, declined, deferred, postponed, or restricted in any way?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(d) Had abnormal test results (Blood Test (except HIV test), X-Ray, CT Scan, MRI)?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

4. In the past 12 months have you had, or do you currently have:	**Write in name of: Primary applicant** _____	**Spouse/domestic partner** _____	**Child dependent** _____
(a) Any illness or infection lasting more than a week, not mentioned elsewhere on this application?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(b) A physical injury requiring medical attention?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(c) Any medical diagnosis by a licensed health practitioner, not mentioned elsewhere on this application?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
5. In the past 12 months have you been advised or referred by a licensed health practitioner to have a medical exam, further testing, treatment, or surgery which has not yet been performed?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
6. Have you taken prescription medication(s) or been written a prescription for medication(s) in the past 12 months? If Yes or Don't know, please complete Part 5(c) below.	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
7. Are you currently receiving scheduled doses of medication administered by self-injection or through IV therapy in a physician's office or hospital setting?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Are you currently receiving insurance or workers' compensation benefits due to a disability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

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Primary applicant's initials _____

	Write in name of: Primary applicant	Spouse/domestic partner	Child dependent
9. Do/did you regularly smoke cigarettes?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(a) Average number of packs per day?			
(b) How many years?			
(c) Have you stopped?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(d) If yes, when?			
10. Do/did you regularly drink alcoholic beverages? (one drink equals 1 oz. liquor, 4 oz. wine, or 12 oz. beer)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(a) Average number of drinks per week?			
(b) How many years?			
(c) Have you stopped?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(d) If yes, when?			
11. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of alcohol or substance use (including if court ordered)? If Yes, please complete (a) and (b) below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(a) Type?			
(b) How long?			
12. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of mental, emotional, or behavioral disorder(s)? If Yes, please complete (a) and (b) below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(a) Type?			
(b) How long?			
13. Are you expecting a child with anyone, even if the expecting mother is not listed on the application?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
14. *Male and females*:			
(a) Are you, or your spouse, domestic partner or dependent (whether or not listed on the application), in the process of adoption or surrogate pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(b) Within the last 90 days have you, or your spouse, domestic partner or dependent performed a home pregnancy test, or had a pregnancy test performed at a clinic or a lab, which was positive?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
15. *Females only*:			
(a) Are you currently pregnant?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(b) If you are between the ages of 14-55, do you menstruate (have monthly periods)? (If no, please explain).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(c) If yes to (b) above, has it been more than 40 days since your last menstrual period?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(d) If you are 18 years of age or older, have you had a Pap test? (If yes, please provide date of last test & results in Part 5(b))	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(e)) If you are 18 years of age or older, do you have breast implants?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, what type? (check one) Implant Surgery Date:	☐ Silicone ☐ Saline	☐ Silicone ☐ Saline	☐ Silicone ☐ Saline

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

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Part 5 – Health questionnaire

Answer all questions accurately and completely for each applicant. Blue Shield relies upon the information you provide in your application to determine whether you are eligible for coverage. While we may review your medical records in certain instances, do not assume we will review your medical records before issuing coverage. Blue Shield has the right to rescind your coverage if your answers are intentionally and materially inaccurate or incomplete. If coverage is rescinded, this means that you may lose coverage back to the original effective date. If your coverage is lawfully rescinded, Blue Shield may have the right to seek repayment from you for medical expenses that we already paid. You should be aware that we can and do review medical records in certain situations after a health services contract/policy has been issued to determine whether material facts were misrepresented or omitted on the application. It is therefore very important that you make every effort to answer all questions accurately and completely. Please note that even if you currently have coverage, or had prior coverage, with Blue Shield you must answer all questions in this health questionnaire. Your obligation to disclose medical information includes the obligation to disclose to Blue Shield any new or changed medical information arising after submission of this Application but before your enrollment date. Any failure to disclose new or changed information may result in rescission of your contract/policy, if that information would have been material to the issuance of coverage.

HIPAA Guaranteed Issue Plans: If you are applying for both HIPAA guaranteed issue coverage and an underwritten plan, complete the entire application. If you are applying for HIPAA guaranteed issue coverage only, complete parts 1-4, 6-8, and 10-11 (do not complete this Part 5). See Part 8 for more information.

Part 5(a) – Medical history

All questions must be answered. Check (✓) "Yes" or "No." Complete details of any "Yes" answer must be given in Part 5(b). **Where indicated below for questions 1 through 15, please print the first name of each individual applying for coverage.** Initial any changes/corrections you may make. If you do not understand a medical term being used, or are not sure whether you have or had a medical condition listed on this application, do not answer "No." Speak to your doctor or otherwise take steps to understand what the question means before answering. If you otherwise need help filling out the application, call Blue Shield at **(800) 431-2809**, or contact your agent. If you still aren't sure or don't recall if you have or had a listed medical condition, answer "Don't know" and then explain the answer in Part 5(b). **NOTE** – Each "Yes" or "Don't know" answer must be explained in Part 5(b) or the application will be deemed to be incomplete. If more than four child dependents are applying for coverage, please attach supplemental pages providing all information listed below for Section 5(a) and Sections 5(b), 5(c) and 5(d) if applicable, your signature and date. Check here if a supplemental page is attached. ☐

1. In the past 10 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	**Write in name of:** Child dependent _____	Child dependent _____	Child dependent _____
Aortic or Mitral Valve Regurgitation or Stenosis, other Heart Valve condition	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Abnormality of the Veins or Arteries of the Brain, such as Aneurysm, AV Malformation	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Acquired Immune Deficiency Syndrome (AIDS) or AIDS – Related Complex (ARC), Kaposi's Sarcoma (KS)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Alzheimer's Disease or Dementia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bi-polar Disorder, Manic Depression, Schizophrenia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cancer, Malignant Tumor	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Connective Tissue Disorder, Scleroderma, Systemic Lupus	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Coronary Artery Disease (CAD), Heart Attack	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Disorder(s) of the blood vessels or heart, Heart Enlargement, Heart Failure, Heart Pacemaker	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hemophilia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hepatitis If yes, please specify Type (B, C, D, other?)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Joint Replacement (such as hip, knee, shoulder), Amputation, Prosthetic Limb	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Leukemia, Hodgkin's Disease, Lymphoma, Organ or bone marrow transplant	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Stroke or Transient Ischemic Attack (TIA), Bruit, or Carotid Stenosis (narrowing or stiffness of the arteries)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

2. In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	**Write in name of:** Child dependent _____	Child dependent _____	Child dependent _____
Abnormal or Irregular Menstrual/Uterine Bleeding	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Alcohol Abuse, Dependence or Addiction; Drug Use or Abuse, Dependence or Addiction	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Allergies, Asthma, Reactive Airway Disease	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Anemia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Angina, Chest pain	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Anorexia, Bulimia or other eating disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Apnea or Sleep Apnea	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Arthritis, Osteoarthritis, Rheumatoid Arthritis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Autism	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

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2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	**Write in name of:** **Child dependent** _____	**Child dependent** _____	**Child dependent** _____
Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma, other Skin Cancer	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bleeding or Blood Disorder (except HIV test)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Birth Marks (Hemangioma)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bladder Disorder, Incontinence	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bone, Ligament, Tendon, Joint Injury or Disorder, Carpal Tunnel Syndrome	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Bronchitis, Pneumonia, Breathing or other Lung Disorder(s)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cataracts, Glaucoma, Strabismus (crossed eyes), other Eye Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cerebral Palsy, Parkinson's	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Chronic (or recurrent) Muscle/Limb Weakness, Fatigue, or Tingling	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Chronic (or recurrent) Pain, including back pain	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Cirrhosis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Congenital (Birth) Defect or Abnormality, Cleft Lip, Cleft Palate	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Crohn's Disease	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Curvature of the Spine, Scoliosis, other Spine Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Depression, Anxiety, Panic Attack(s), Obsessive Compulsive Disorder (OCD)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Deviated Nasal Septum, Sinusitis, Excessive Snoring or other Sinus Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Diabetes or other Endocrine (Glandular) Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Ear Infections, other Ear or Hearing Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Emphysema	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Epilepsy, Convulsions, Seizure Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Fibrocystic Breasts, Micro-Calcifications, other Breast Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Fractures, Retained Hardware (pins, screws, etc.)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Gastric Bypass, Stapling, Banding or other weight loss surgery	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Gout	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Heartburn or Reflux (recurrent), other Digestive Tract Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Headaches or Migraines	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Heart Murmur, Palpitations, Irregular Heart Beat	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hernia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Herniated or Bulging Disk, Sciatica	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
High Blood Pressure (Hypertension)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
High Cholesterol and/or high Triglycerides	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hormone or Growth Hormone Condition	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hyperactivity, Attention Deficit Hyperactivity Disorder (ADHD)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Hypothyroidism, other Thyroid Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Implant(s), Prosthesis (other than breast)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Infertility, male or female	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
In-vitro Fertilization	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Kidney Infection, Bladder Infection, Kidney or Bladder Stones, Interstitial Cystitis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Melanoma	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Miscarriage (Spontaneous Abortion)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Multiple Sclerosis, Muscular Dystrophy	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Obesity	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Osteoporosis or Osteopenia	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Ovarian Cyst(s), Polycystic Ovaries	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Pancreatitis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Paralysis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

Primary applicant's initials _____

2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	**Write in name of:** **Child dependent** _____	**Child dependent** _____	**Child dependent** _____
Phlebitis, Blood Clots, Embolism, Varicose Veins, Peripheral Artery Disease (PAD)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Premature Birth	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Prostatitis, Enlarged Prostate (BPH), other Disorder of the male Reproductive (sex) Organs	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Psoriasis, Keratosis, Acne, Herpes, Shingles, other Skin Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Severe Burns	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Shortness of Breath	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Syphilis, Gonorrhea, Chlamydia, Genital Warts, Herpes, other Sexually Transmitted Disease	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Temporal Mandibular Joint Disorder (TMJ)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Tuberculosis	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Tumor, Mass, Polyp, Cyst (other than ovarian)	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Ulcer	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Ulcerative Colitis, other Bowel or Rectal Disorder	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
Uterine Fibroid(s), Endometriosis, other Disorders of the Female Reproductive (sex) Organs	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

	Write in name of: **Child dependent** _____	**Child dependent** _____	**Child dependent** _____
3. In the past 5 years, have you:			
(a) Been an inpatient or outpatient in a hospital, surgical center, emergency room, or other medical facility?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(b) Had any kind of surgery, including biopsy, angioplasty, bypass or cosmetic/reconstructive surgery?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(c) Had any application for health or life insurance rescinded, declined, deferred, postponed, or restricted in any way?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(d) Had abnormal test results (Blood Test (except HIV test), X-Ray, CT Scan, MRI)?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

	Write in name of: **Child dependent** _____	**Child dependent** _____	**Child dependent** _____
4. In the past 12 months have you had, or do you currently have:			
(a) Any illness or infection lasting more than a week, not mentioned elsewhere on this application?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(b) A physical injury requiring medical attention?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(c) Any medical diagnosis by a licensed health practitioner, not mentioned elsewhere on this application?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
5. In the past 12 months have you been advised or referred by a licensed health practitioner to have a medical exam, further testing, treatment, or surgery which has not yet been performed?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
6. Have you taken prescription medication(s) or been written a prescription for medication(s) in the past 12 months? If Yes or Don't know, please complete Part 5(c) below.	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
7. Are you currently receiving scheduled doses of medication administered by self-injection or through IV therapy in a physician's office or hospital setting?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Are you currently receiving insurance or workers' compensation benefits due to a disability?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

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	Write in name of: Child dependent	Child dependent	Child dependent
9. Do/did you regularly smoke cigarettes?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(a) Average number of packs per day?			
(b) How many years?			
(c) Have you stopped?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(d) If yes, when?			
10. Do/did you regularly drink alcoholic beverages? (one drink equals 1 oz. liquor, 4 oz. wine, or 12 oz. beer)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(a) Average number of drinks per week?			
(b) How many years?			
(c) Have you stopped?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(d) If yes, when?			
11. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of alcohol or substance use (including if court ordered)? If Yes, please complete (a) and (b) below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(a) Type?			
(b) How long?			
12. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of mental, emotional, or behavioral disorder(s)? If Yes, please complete (a) and (b) below.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(a) Type?			
(b) How long?			
13. Are you expecting a child with anyone, even if the expecting mother is not listed on the application?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
14. *Male and females*:			
(a) Are you, or your spouse, domestic partner or dependent (whether or not listed on the application), in the process of adoption or surrogate pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(b) Within the last 90 days have you, or your spouse, domestic partner or dependent performed a home pregnancy test, or had a pregnancy test performed at a clinic or a lab, which was positive?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
15. *Females only*:			
(a) Are you currently pregnant?	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
(b) If you are between the ages of 14-55, do you menstruate (have monthly periods)? (If no, please explain).	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(c) If yes to (b) above, has it been more than 40 days since your last menstrual period?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(d) If you are 18 years of age or older, have you had a Pap test? (If yes, please provide date of last test & results in Part 5(b))	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
(e)) If you are 18 years of age or older, do you have breast implants?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, what type? (check one) Implant Surgery Date:	☐ Silicone ☐ Saline	☐ Silicone ☐ Saline	☐ Silicone ☐ Saline

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

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Part 5(b) – Medical history and condition details

If you or any family member applying for coverage answered Yes or Don't Know to any question in Part 5(a), please provide complete details below. If you do not recall dates, specify "unknown." If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached. ☐

Name		
List Part 5(a) question number: _____ **If you answered "Don't Know", please explain:**		
Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? __________ Dates from: ___/___/____ to: ___/___/____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? __________ Date(s): __/__/____, __/__/____, __/__/____
Other comments/details:		
Full name of physician, clinic or hospital:		Specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name		
List Part 5(a) question number: _____ **If you answered "Don't Know", please explain:**		
Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? __________ Dates from: ___/___/____ to: ___/___/____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? __________ Date(s): __/__/____, __/__/____, __/__/____
Other comments/details:		
Full name of physician, clinic or hospital:		Specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name		
List Part 5(a) question number: _____ **If you answered "Don't Know", please explain:**		
Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? __________ Dates from: ___/___/____ to: ___/___/____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? __________ Date(s): __/__/____, __/__/____, __/__/____
Other comments/details:		
Full name of physician, clinic or hospital:		Specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

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Part 5(b) – Medical history and condition details

If you or any family member applying for coverage answered Yes or Don't Know to any question in Part 5(a), please provide complete details below. If you do not recall dates, specify "unknown." If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached. ☐

Name

List Part 5(a) question number: _____
If you answered "Don't Know", please explain:

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? __________ Dates from: ___/___/____ to: ___/___/____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? __________ Date(s): __/__/____, __/__/____, __/__/____

Other comments/details:

Full name of physician, clinic or hospital:		Specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name

List Part 5(a) question number: _____
If you answered "Don't Know", please explain:

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? __________ Dates from: ___/___/____ to: ___/___/____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? __________ Date(s): __/__/____, __/__/____, __/__/____

Other comments/details:

Full name of physician, clinic or hospital:		Specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name

List Part 5(a) question number: _____
If you answered "Don't Know", please explain:

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? __________ Dates from: ___/___/____ to: ___/___/____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? __________ Date(s): __/__/____, __/__/____, __/__/____

Other comments/details:

Full name of physician, clinic or hospital:		Specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Part 5(c) – Current or recent prescription medications

If you or any family member applying for coverage answered Yes or Don't know to question 6 in Part 5(a) regarding prescription medications, please provide complete details below. If you do not recall dates specify "unknown." If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached. ☐

Name			
Medication		Dates from: ____/____/_______ to: ____/____/_______	
Reason for prescription	Still on medication? ☐ Yes ☐ No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number ( )	
Address			Suite
City		State	ZIP code
Name			
Medication		Dates from: ____/____/_______ to: ____/____/_______	
Reason for prescription	Still on medication? ☐ Yes ☐ No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number ( )	
Address			Suite
City		State	ZIP code
Name			
Medication		Dates from: ____/____/_______ to: ____/____/_______	
Reason for prescription	Still on medication? ☐ Yes ☐ No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number ( )	
Address			Suite
City		State	ZIP code
Name			
Medication		Dates from: ____/____/_______ to: ____/____/_______	
Reason for prescription	Still on medication? ☐ Yes ☐ No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number ( )	
Address			Suite
City		State	ZIP code
Name			
Medication		Dates from: ____/____/_______ to: ____/____/_______	
Reason for prescription	Still on medication? ☐ Yes ☐ No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number ( )	
Address			Suite
City		State	ZIP code
Name			
Medication		Dates from: ____/____/_______ to: ____/____/_______	
Reason for prescription	Still on medication? ☐ Yes ☐ No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number ( )	
Address			Suite
City		State	ZIP code

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Part 5(d) – Recent health practitioner visit(s)

Have you or any family member applying for coverage visited a physician, mental health practitioner, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health practitioner in the past 2 years? ☐ Yes ☐ No If Yes, please provide complete details below.

Medical records may be requested for all children up to 7 months of age. For children under 6 years of age, be sure to include the date and results of the most recent well child exam. If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached. ☐

Name

Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? __________ Dates from: ___/___/____ to: ___/___/____ Dates from: ___/___/____ to: ___/___/____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? __________ Date(s): __/__/____, __/__/____, __/__/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name

Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? __________ Dates from: ___/___/____ to: ___/___/____ Dates from: ___/___/____ to: ___/___/____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? __________ Date(s): __/__/____, __/__/____, __/__/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name

Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? __________ Dates from: ___/___/____ to: ___/___/____ Dates from: ___/___/____ to: ___/___/____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? __________ Date(s): __/__/____, __/__/____, __/__/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

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Part 5(d) – Recent health practitioner visit(s) (continued)

Name		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? ___________ Dates from: ___/___/_____ to: ___/___/_____ Dates from: ___/___/_____ to: ___/___/_____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? ___________ Date(s): __/__/____, __/__/____, __/__/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? ___________ Dates from: ___/___/_____ to: ___/___/_____ Dates from: ___/___/_____ to: ___/___/_____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? ___________ Date(s): __/__/____, __/__/____, __/__/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____/_____ (month/year) Ended: _____/_____ (month/year)
Does the condition still exist? ☐ Yes ☐ No	Present status?	
Medical ID card number (if available):	Hospitalized? ☐ Yes ☐ No If Yes, number of hospitalizations? ___________ Dates from: ___/___/_____ to: ___/___/_____ Dates from: ___/___/_____ to: ___/___/_____	ER visits? ☐ Yes ☐ No If Yes, number of ER visits? ___________ Date(s): __/__/____, __/__/____, __/__/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ( )	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

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Primary applicant's initials _____

Part 6 – Authorization for release of information

By signing this form you are authorizing the release of your and/or your dependents' healthcare information by a healthcare provider, insurer, insurance support organization (which includes consumer reporting agencies, MIB Group Inc and Milliman Inc), health plan, or your insurance agent, to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, Blue Shield) for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing this form you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization (which includes consumer reporting agencies, MIB Group Inc and Milliman Inc), health plan, or your insurance agent for the purpose of investigating or evaluating any claim for benefits. In addition, Blue Shield may make a brief report to MIB Group Inc regarding information received in the underwriting process. The healthcare information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under the federal health information privacy laws.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your and/or your dependents' eligibility for coverage and enrollment determinations upon receipt of this signed authorization.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid: 1) for thirty (30) months from the date of this authorization for the purposes of processing your application and reporting information, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

Applicant/parent or legal guardian	Today's date
Applicant's spouse/domestic partner	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date

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Continue to Part 7 - your signature and today's date are required in that section.

Part 7(a) - Applicant verification of accuracy

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature. Keep a copy of this application for your records.

I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application, including all information provided in the medical history section of this application, is accurate, true and complete. If Blue Shield determines that information on this application is materially inaccurate, not true or incomplete, I understand that coverage may be cancelled or, if the inaccuracy, untruthfulness, or incompleteness was intentional, coverage may be rescinded. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

For applicants with a language preference other than English: If I indicated in Part 1 that I have a language preference other than English and have completed the English-version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.

Signature of applicant/parent or legal guardian	Today's date	Print name (and relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name (and relationship if applicant is a minor)
Signature of family member age 18 and over (if applying)	Today's date	Print name (and relationship if applicant is a minor)
Signature of family member age 18 and over (if applying)	Today's date	Print name (and relationship if applicant is a minor)

Continued on the next page

Primary applicant's initials _____

Part 7(b) – Authorizations, terms and conditions

Please read the following terms and conditions carefully. Each applicant age 18 and older Is required to review the completed application and provide their own authorization and signature. Keep a copy of this application for your records.

1. **Application for coverage**: It is important to know that Blue Shield of California or Blue Shield of California Life & Health Insurance Company (as applicable) has the right to decline your application for coverage. Note: I understand that Blue Shield may use any medical information in reviewing my application, including any medical condition which occurs after the signature and submission of the application, and before a decision by Blue Shield is communicated. I understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.
2. **First month's dues/premiums**: Blue Shield requires first month's dues/premium at the time of application submission. Attach a personal check or money order to this application in an amount equal to one month's dues/premiums; or to pay by credit card, complete Part 11. Find your estimated monthly dues/premiums in the rate book provided to you. Failure to submit full payment of dues/premiums will delay processing and the effective date of coverage. Please note that processing of your payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If your application is not approved, your check or automatic payment authorization for your credit card or checking account will be destroyed.
3. **Dues/premiums**: Dues/premiums are to be paid by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the *Health Service Agreement/Policy.*
4. **Effective date of coverage**: If your application is approved, Blue Shield will notify you of your effective date of coverage. If Blue Shield cannot honor your requested effective date, or is unable to issue coverage before your requested date, coverage will begin as soon as possible. If additional dues/premiums are owed, payment must be received within the time specified in the notice from Blue Shield to avoid changing the effective date. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Acceptance of Application**: You understand that only Blue Shield can accept your application and approve coverage. Your agent or broker cannot approve this application for coverage or change any terms or conditions of coverage.
6. **Parents/guardians**: If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 7. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach the court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):
   - ☐ Parent or legal guardian only: _____(name) or,
   - ☐ My designee _____(include name and relationship) or,
   - ☐ Qualified medical child support order designee _____(include name and relationship).
   - ☐ Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.
7. **Authorization for spouse/domestic partner to make changes**: If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield. ☐ **Yes** ☐ **No**
8. **Authorization for your agent to provide/obtain information**: Check here if you do **not** authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application, including medical information. ☐
9. **Process to authorize Blue Shield to release personal and health information to a third party**: If you would like to authorize your spouse, domestic partner or a third party to access your personal health information, please complete the form titled Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party. To obtain this form go to **blueshieldca.com** and click on the Privacy link at the bottom of the page, or call **(800) 431-2809**.
10. **Response to requested information**: You agree to cooperate with Blue Shield (or Blue Shield Life, as applicable) by providing, or by providing access to, documents and other information requested to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or information may be cause to rescind or cancel your coverage.
11. **HIV or genetic testing prohibited**: No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits an HIV test from being required or used by a health insurance company or health care service plan as a condition of obtaining health coverage.

I have reviewed all responses pertaining to me in this application. I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature.)

Signature of applicant/parent or legal guardian	Today's date	Print name (and relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name

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Important: Return the application within 30 days of your date(s) and signature(s).

Primary applicant's initials _____

Part 8 – Statement of Guaranteed Issue Eligibility if applying for a HIPAA guaranteed issue plan

If you do not qualify for an underwritten plan, Blue Shield offers an alternative that you may want to consider.

The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people in certain instances to maintain coverage if they lose existing group health plan coverage. Depending on your responses to the statements below, you may be eligible for guaranteed issue in accordance with HIPAA, and Blue Shield will automatically accept your application for one of its HIPAA guaranteed issue plans without medical underwriting. Each person on the application must meet HIPAA eligibility requirements to qualify for a HIPAA guaranteed issue plan. Please note that HIPAA guaranteed issue rates may be higher than those of Blue Shield's underwritten plans.

If you are applying individually for coverage on behalf of any dependents who are not eligible for a HIPAA guaranteed issue plan, their coverage will be subject to medical underwriting, except for children who were enrolled under any prior creditable coverage within 30 days of the birth or placement for adoption. A dependent child who is 25 years of age or younger or a dependent spouse applying for HIPAA guaranteed issue must complete a separate Statement of HIPAA Guaranteed Issue Eligibility (Blue Shield will accept copies of the Statement of Guaranteed Issue Eligibility). For additional applications or current HIPAA guaranteed issue plan rates, please contact your insurance agent, or call Blue Shield at **(800) 431-2809**.

Note: Children under the age of 19 are only eligible for a HIPAA guaranteed issue plan if applying as a dependent for family coverage because they are otherwise eligible for guaranteed issue coverage under CA state law.

Statement of Guaranteed Issue Eligibility and checklist if applying for a HIPAA guaranteed issue plan

Name of applicant(s) requesting HIPAA guaranteed issue coverage: _____ _____ _____

Please complete the following questionnaire if you are interested in a HIPAA guaranteed issue policy so that your eligibility for HIPAA guaranteed issue coverage may be verified.

☐ Yes	☐ No	1. I have had a total of at least 18 months of healthcare coverage (including COBRA or Cal-COBRA, if applicable) without a lapse in coverage of more than 63 days (excluding employer-imposed waiting periods).
☐ Yes	☐ No	2. My most recent coverage was through an employer-sponsored health plan (COBRA and Cal-COBRA are considered employer-sponsored coverage).
☐ Yes	☐ No	3. I accepted and exhausted any available COBRA and/or Cal-COBRA coverage (if COBRA/Cal-COBRA were not available, check "yes"). COBRA/Cal-COBRA coverage dates ___/___/_____ through ___/___/_____ COBRA administrator _____ Telephone _____ Insurance carrier _____ Telephone _____ If your most recent coverage was employer-sponsored and you were not eligible for COBRA and/or Cal-COBRA coverage, please explain: _____
☐ Yes	☐ No	4. I am currently eligible for coverage under a group or employer-sponsored health plan, Medicare, or Medicaid.
☐ Yes	☐ No	5. My most recent coverage terminated because of nonpayment of dues/premium or fraud.

If your answers to statements 1, 2, and 3 are "yes," and your answers to statements 4 and 5 are "no," please complete the remaining sections below to apply for a HIPAA guaranteed issue plan. Note: Submit evidence of prior coverage, such as a certificate of creditable coverage from your previous health carrier and/or verification from your previous COBRA/CalCOBRA administrator.

HIPAA guaranteed issue coverage options (please select one)

A. If you know that you will not qualify, or do not want to apply for an underwritten plan, check this box:

☐ Issue the HIPAA guaranteed issue plan only. Since I have chosen this option, I understand that I will not be considered for an underwritten plan.

B. If you are applying for both HIPAA guaranteed issue and an underwritten plan, select one of the following:

☐ Issue the HIPAA guaranteed issue plan at the earliest effective date, so that I am covered during the underwriting process of the individual plan. (I understand that if my application for the underwritten plan is approved, I will automatically be transferred to the underwritten plan. If it is not approved, I will continue to receive HIPAA guaranteed issue coverage.)

☐ Issue the HIPAA guaranteed issue plan only if I am not approved for the underwritten plan. (I understand that I will not have any individual Blue Shield coverage until my application for the underwritten plan is processed and either approved or declined.)

HIPAA guaranteed issue plan options (please select one)

☐ Access+ HMO package
☐ Shield Savings 4000/8000*
☐ Shield Spectrum PPO 5500
☐ Access+ Value HMO
☐ Shield Spectrum PPO 5000*

By signing this statement, I verify that I have read and understood the eligibility conditions for HIPAA guaranteed issue listed above, and that all of the information I have provided is true and correct.

Signature of applicant or legal guardian | Today's date (required) | Print name

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

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Primary applicant's initials _____

Part 9 – Producer information: to be completed by an authorized Blue Shield agent

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely. This attestation must be completed by the producer and submitted with each Blue Shield IFP application.

1. Are you aware of any information not disclosed in this application, which may have a bearing on this risk? ☐ Yes (if yes, attach explanation) ☐ No

2. Review and select one of the following:
   - ☐ I did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice of any kind from me.
   - ☐ I assisted the applicant in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

3. Did you see any of the following applicants sign the application?
   a. Primary Applicant: ☐ Yes ☐ No
   b. Spouse/Domestic Partner: ☐ Yes ☐ No ☐ Not applying
   c. Family member(s) age 18 or above: ☐ Yes ☐ No ☐ Not applying
   If no to (a), (b), or (c) above, provide details: _____

4. Do you want the health service agreement/policy sent directly to the subscriber? ☐ Yes ☐ No

Producer name		
E-mail address ☐ Update e-mail	Producer number	
Telephone number ( ) ☐ Update phone	Fax number ( )	☐ Update fax
Producer address		
		☐ Update address
City	State	ZIP code
Super producer name	Super producer number	

Producer signature (required) _____ Today's date (required) _____ Print name _____

Producers: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information. IFP applications can be faxed toll-free 24 hours a day, 7 days a week, to **(888) 386-3420**.

Part 10 – Billing and payment information

Calculate estimated monthly dues/premiums

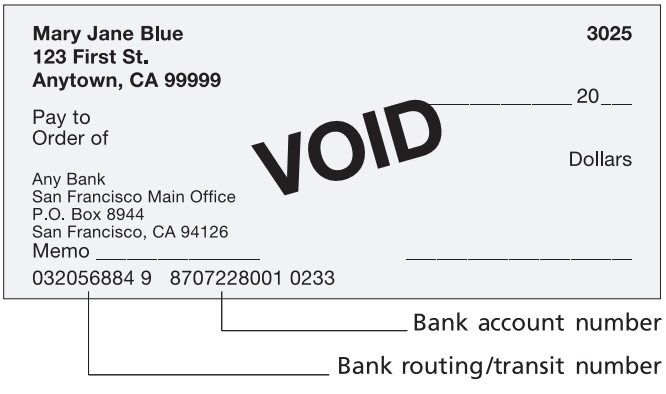
- Using the rate book provided to you, calculate your estimated rates or talk to your agent to get estimated rates. You may receive rates higher than your agent quoted you based on Underwriting determination.
- First month's dues/premium are required at the time of application submission. For the first month's dues/premium, staple a personal check or money order to your application in an amount equal to the dues/premiums for one month, payable to Blue Shield. If paying first month's dues/premium by credit card, please fill out the Automatic Payment Authorization Form.

Easy$Pay and credit card automatic payment options

Subsequent dues/premiums must be paid in advance through one of the following options:

- Easy$Pay monthly payment – monthly payments are handled automatically, via electronic transfer from your checking or savings account.
- Credit card payment – monthly/quarterly payments are handled automatically, via charge to your credit card.

To sign up for automatic payments, complete the automatic payment authorization form on the next page and return it with your application. If you have selected Easy$Pay as your payment option, please staple a deposit slip or blank check marked "VOID" to your authorization form in addition to your first month's estimated dues/premiums check. If you prefer not to attach a voided check or deposit slip, you must provide the routing/transit number of your financial institution.



Submit completed applications to:

PO Box 3008
Lodi, CA 95241-9969

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Please note that this page has been left intentionally blank.

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Part 11 – Automatic payment authorization form

Check all that apply: ☐ Paying first month's dues/premium by credit card
☐ Enrolling in automatic payment for recurring payments
☐ Changing current automatic payment authorization (processing may take up to 30 days)

Applicant information

Applicant name			
Mailing address			Apt. No.
City	State	ZIP code	
Applicant's daytime phone number ( )			

Method of payment

Easy$Pay debit: ☐ Checking account ☐ Savings account

Payment date: ☐ 1st of month ☐ 15th of month (Note: HMO and Dental HMO must use 1st of the month.)			
Payment frequency: Monthly			
Bank routing/transfer number			
Bank account number			
Name(s) on bank account			
Name of financial institution			
Branch address			
City	State	ZIP code	
Branch telephone number ( )			

Credit Card (Visa or MasterCard only)

Payment date: 1st of month			
Payment frequency: ☐ Monthly ☐ Quarterly			
Cardholder name			
Cardholder billing address			Apt. No.
City	State	ZIP code	
Credit card number			
Card type: ☐ Visa ☐ MasterCard	Expiration date (mm/yyyy) ___/_____		

If paying first month's dues/premium by credit card, the estimated first month's payment is:* $ _____

* This is only an estimate of monthly dues/premium. Blue Shield will provide notice of actual monthly dues/premium if my application for coverage is accepted. All dues/premium must be received prior to the original effective date for coverage to be in effect.

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Authorization and Signature(s)

Automatic Payment by debit from checking/savings account:
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date (or within 1 to 2 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record and I will be responsible for making my payment by check or money order, along with a return item service charge.

Automatic Payment by credit card:
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to charge (and/or apply credits, if correcting errors to previous charges) the credit card identified on this form on the payment date (or within 1 to 2 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. If the credit card transaction ever fails (e.g., over limit, expired), Blue Shield will mail a bill to me to my address on record and I will be responsible for making my payment by check or money order.

Additional information if paying first month's dues/premium only by credit card:
If only the first month's dues/premium box is checked, this authorization is only valid to charge the first month's dues/premium owed to Blue Shield. I understand my credit card will be charged for the estimated first month's dues/premium immediately upon receipt of my application; however, this payment does not constitute approval of my application, and if my application is accepted, a different rate may apply. If I am accepted at a different rate, the difference in dues/premium must be paid prior to the original effective date of coverage. Blue Shield will not automatically charge the difference in rate owed to the credit card without a separate authorization from the applicant.

Notice to Change/Cancel Required:
I will continue to be debited/charged the amount of dues/premium owed until I cancel this Automatic Payment authorization upon at least 10 calendar days notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 431-2809**. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form (if the bank account is a joint account, all accountholders must sign) and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

_____ Signature

_____ Print Name

_____ _____ _____ – _____ _____ – _____ _____ _____ _____
Social Security number

_____/_____/_____
Date

_____ Signature

_____ Print Name

_____ _____ _____ – _____ _____ – _____ _____ _____ _____
Social Security number

_____/_____/_____
Date

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Part 11 – Automatic payment authorization form

KEEP THIS COPY FOR YOUR RECORDS

Check all that apply: ☐ Paying first month's dues/premium by credit card
☐ Enrolling in automatic payment for recurring payments
☐ Changing current automatic payment authorization (processing may take up to 30 days)

Applicant information

Applicant name			
Mailing address			Apt. No.
City	State	ZIP code	
Applicant's daytime phone number ( )			

Method of payment

Easy$Pay debit: ☐ Checking account ☐ Savings account			
Payment date: ☐ 1st of month ☐ 15th of month (Note: HMO and Dental HMO must use 1st of the month.)			
Payment frequency: Monthly			
Bank routing/transfer number			
Bank account number			
Name(s) on bank account			
Name of financial institution			
Branch address			
City	State	ZIP code	
Branch telephone number ( )			
Credit Card (Visa or MasterCard only)			
Payment date: 1st of month			
Payment frequency: ☐ Monthly ☐ Quarterly			
Cardholder name			
Cardholder billing address			Apt. No.
City	State	ZIP code	
Credit card number			
Card type: ☐ Visa ☐ MasterCard	Expiration date (mm/yyyy) ___/_____		
If paying first month's dues/premium by credit card, the estimated first month's payment is:* $ _____			

* This is only an estimate of monthly dues/premium. Blue Shield will provide notice of actual monthly dues/premium if my application for coverage is accepted. All dues/premium must be received prior to the original effective date for coverage to be in effect.

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Authorization and Signature(s)

Automatic Payment by debit from checking/savings account:
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date (or within 1 to 2 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record and I will be responsible for making my payment by check or money order, along with a return item service charge.

Automatic Payment by credit card:
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to charge (and/or apply credits, if correcting errors to previous charges) the credit card identified on this form on the payment date (or within 1 to 2 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. If the credit card transaction ever fails (e.g., over limit, expired), Blue Shield will mail a bill to me to my address on record and I will be responsible for making my payment by check or money order.

Additional information if paying first month's dues/premium only by credit card:
If only the first month's dues/premium box is checked, this authorization is only valid to charge the first month's dues/premium owed to Blue Shield. I understand my credit card will be charged for the estimated first month's dues/premium immediately upon receipt of my application; however, this payment does not constitute approval of my application, and if my application is accepted, a different rate may apply. If I am accepted at a different rate, the difference in dues/premium must be paid prior to the original effective date of coverage. Blue Shield will not automatically charge the difference in rate owed to the credit card without a separate authorization from the applicant.

Notice to Change/Cancel Required:
I will continue to be debited/charged the amount of dues/premium owed until I cancel this Automatic Payment authorization upon at least 10 calendar days notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 431-2809**. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form (if the bank account is a joint account, all accountholders must sign) and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

_____ Signature

_____ Print Name

_____ _____ _____ – _____ _____ – _____ _____ _____ _____
Social Security number

_____/_____/_____
Date

_____ Signature

_____ Print Name

_____ _____ _____ – _____ _____ – _____ _____ _____ _____
Social Security number

_____/_____/_____
Date

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