BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Do not staple or tear.

Fort Dearborn Life Insurance Company

How to apply for Blue Cross Blue Shield of Arizona Individual Plans

Important: Any applicant designated on this application must be under age 65 and must be a permanent resident of Arizona. Anyone receiving Medicare disability benefits is NOT ELIGIBLE for this coverage.

For your convenience, you can choose to complete an application online at azblue.com instead of filling out this paper form.

You can apply for dependent coverage for your spouse and for your unmarried children who are under age 30. If you only need insurance for your children, you can apply for child-only coverage for your children under age 19. Blue Cross Blue Shield of Arizona (BCBSAZ) will review the medical history information of applicants to determine if they are eligible for coverage.

Please read the following directions carefully to ensure your application is processed as quickly as possible.

- Answer all questions, even if you currently have BCBSAZ coverage. If any part of any section is incomplete, it may result in processing delays.
- Fill in applicant name and social security number on every page. (Adding your social security number is optional.)
- **Make sure you list all your health conditions.** We care about everything you know about your medical condition.
- All persons named on this application who are age 18 or older MUST sign and date the signature page located on page 10.
- Print your answers in BLACK ink.
- Do not print in any shaded areas.
- Fill in boxes or ovals completely; do not just mark with an "x".
- Do not use commas, dashes, hyphens or any other punctuation.
- Use only capital letters, print clearly and leave one blank space between words.

  For example: 1 2 3 W HILL ST

- Do not use highlighters.
- Do not mark in the margins or other areas where answers are not required.

Applications must be sent with a $20.00 NON-REFUNDABLE fee. (No fee is required for child-only applications or from current BCBSAZ members.) Do not send the first month's premium.

Note: This application must be received by BCBSAZ within 30 days from the date of applicant's signature(s).

Notice to applicants that have lost group or COBRA Health Coverage: If your group or COBRA health plan (employer provided health coverage) terminated within the past 63 days, you may be eligible for Individual Portability Coverage. This coverage does not require medical underwriting and there is no preexisting condition waiting period. To qualify for this coverage you must meet specific criteria. If you think you may qualify for this coverage, please call us at (602) 864-4899, or toll free at (877) 864-4899, and ask for the Individual Portability Coverage brochure and application.

Note: You will lose your eligibility for Individual Portability Coverage if you become insured under any non-group policy.

Fort Dearborn Life Insurance Company is an independent company, is not affiliated in any way with BCBSAZ, and does not provide BCBSAZ products or services. Fort Dearborn Life Insurance Company's polices are not underwritten by BCBSAZ, and BCBSAZ is not responsible for any products or services offered by Fort Dearborn Life Insurance Company.

BlueCross BlueShield of Arizona

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Blue Cross Blue Shield of Arizona Individual Application

FOR NEW OR EXISTING CUSTOMER PLEASE COMPLETE ENTIRE APPLICATION.

APPLICATION FOR: ◯ NEW CUSTOMER ◯ EXISTING CUSTOMER ◯ COVERAGE CHANGE ◯ ADD DEPENDENT ◯ LOWER DEDUCTIBLE

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

BlueOptimum PPO	BlueValue PPO	BlueEssential PPO	BluePortfolio PPO	BluePreferred PPO	
◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000 ◯ $3,000 ◯ $5,000 ◯ $10,000	◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000 ◯ $3,000 ◯ $5,000 ◯ $10,000	◯ $250 ◯ $500 ◯ $1,000 ◯ $2,000 ◯ $3,000 ◯ $5,000 ◯ $10,000	◯ $1,750 ◯ $3,000 ◯ $5,500	◯ $250 ◯ $500 ◯ $1,000 ◯ $1,500 ◯ $2,500 ◯ $5,000	◯ BlueSecure HMO ◯ BlueSecure Plus HMO

TYPE OF COVERAGE ◯ INDIVIDUAL ◯ FAMILY ◯ CHILD-ONLY

IF FAMILY OR CHILD-ONLY COVERAGE, CHECK ALL THAT APPLY ◯ SPOUSE ◯ ONE CHILD ◯ TWO CHILDREN ◯ THREE OR MORE CHILDREN

APPLICANT TO BE NAMED AS CONTRACT HOLDER -OR- IF APPLYING FOR CHILD-ONLY COVERAGE, NAME OF PARENT OR LEGAL GUARDIAN LIVING IN ARIZONA:

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER (optional)

THIS LINE NOT APPLICABLE IF APPLYING FOR CHILD ONLY COVERAGE.

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

MAILING ADDRESS (NUMBER AND STREET)	APARTMENT UNIT	WORK TELEPHONE (AREA CODE & NO.)	EXTENSION

CITY	STATE	ZIP + FOUR	COUNTY OF RESIDENCE

HOME TELEPHONE (AREA CODE & NO.)	FAX (AREA CODE & NO.)	E-MAIL ADDRESS

EFFECTIVE DATE OF COVERAGE

◯ EARLIEST DATE AVAILABLE (Application approvals made on the 29th - 31th, the effective date is the 1st of the following month.)

◯ NOT BEFORE THE FOLLOWING DATE: (MM/DD/YYYY)_____(You cannot choose an effective date of the 29th, 30th or 31st of the month.)

PREMIUM BILLING DATE

◯ 1ST OF THE MONTH

◯ 15TH OF THE MONTH

IF MY APPLICATION IS APPROVED, PLEASE BILL ME AS FOLLOWS:

◯ MONTHLY SURE PAY ELECTRONIC BANK DRAFT **(PLEASE COMPLETE THE SURE PAY AUTHORIZATION)** ◯ MONTHLY PAPER BILL ◯ QUARTERLY PAPER BILL

IF YOU ARE APPLYING FOR CHILD-ONLY COVERAGE: PROVIDE INFORMATION ON CO-CUSTODIAL PARENT OR LEGAL GUARDIAN, IF APPLICABLE

LAST NAME	FIRST NAME	M.I.	HOME TELEPHONE (AREA CODE & NO.)

SPOUSE AND/OR CHILDREN TO BE CONSIDERED FOR COVERAGE. WHEN ADDING A DEPENDENT TO EXISTING COVERAGE, LIST ONLY THOSE DEPENDENTS YOU ARE ADDING. If you have more than 3 children, complete a separate sheet and check box here. ☐

SPOUSE

SPOUSE'S LAST NAME	FIRST NAME	M.I.

DATE OF BIRTH (MM/DD/YYYY)	SEX	HEIGHT	WEIGHT	DATE OF MARRIAGE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
	◯ MALE ◯ FEMALE	ft. in.			

CHILDREN (DEPENDENT OR CHILD ONLY)

1

CHILD'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)	SEX	HEIGHT	WEIGHT	RELATIONSHIP
	◯ MALE ◯ FEMALE	ft. in.		

2

CHILD'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)	SEX	HEIGHT	WEIGHT	RELATIONSHIP
	◯ MALE ◯ FEMALE	ft. in.		

3

CHILD'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

DATE OF BIRTH (MM/DD/YYYY)	SEX	HEIGHT	WEIGHT	RELATIONSHIP
	◯ MALE ◯ FEMALE	ft. in.		

SPACE BELOW: FOR BROKER USE ONLY

ASSOCIATION NAME	ASSN#

BROKER NAME, MAILING ADDRESS AND PHONE

BROKER #

_____ ◯

APPLICATION FEE RECEIVED

APPLICANT'S NAME _____ APPLICANT'S SSN _____
(For child-only applications, enter the parent or legal guardian's name)

ELIGIBILITY FOR COVERAGE - THIS SECTION MUST BE COMPLETE

Is contract holder or any dependents listed on this application eligible for Medicare benefits? ○ YES ○ NO
If yes, that person is not eligible for this coverage. Please name person(s) receiving Medicare below.

LAST NAME | **FIRST NAME**

IF YOU WANT YOUR BILL MAILED TO A DIFFERENT ADDRESS, COMPLETE THIS SECTION

CARE OF (IF APPLICABLE) | **ADDRESS (NUMBER & STREET)**

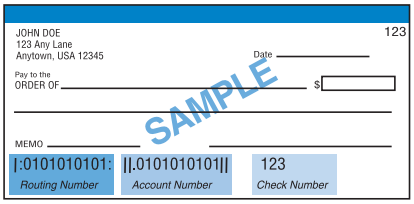
APARTMENT UNIT | **CITY** | **STATE** | **ZIP + FOUR**

SURE PAY AUTHORIZATION

Save the hassle of writing us a check. With Sure Pay, there's no bill to keep track of. No check to write. And nothing to mail (or forget to mail). Instead, your premium is automatically withdrawn from your checking or savings account. Just complete and sign this authorization. We'll handle all the details with your bank.

Please note that your first monthly premium may be deducted after your normal payment due date. If the first deduction is delayed, it may be for more than one monthly premium.

Please debit my: ○ Checking account ○ Savings account



ROUTING TRANSIT NUMBER | **ACCOUNT NUMBER**

Important: Remember to sign the authorization below.

I authorize BCBSAZ to start an automatic periodic charge to my checking or savings account as noted above. I also authorize my financial institution to reduce my account balance each period by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.

I want this charge to continue automatically until I write BCBSAZ telling them to discontinue my Sure Pay service. I agree to allow a reasonable time for discontinuation of Sure Pay withdrawals, and I understand BCBSAZ will refund premium that may be due to me based on the time necessary to terminate Sure Pay withdrawals.

I understand BCBSAZ and my financial institution have the right to discontinue this service if either elects to do so.

I further agree that if there are insufficient funds at the time my account is debited, the amount may be debited again that month or twice the amount the following month. My BCBSAZ coverage will be terminated if there are insufficient funds in two consecutive drafts.

I have read and agree to abide by the Sure Pay conditions as outlined on this authorization form. Any applicable refund of monies due will be released 30 days after the last draft date.

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

HOW DID YOU LEARN ABOUT THE BCBSAZ PLAN FOR WHICH YOU ARE APPLYING? (check one).

○ PERSONAL RECOMMENDATION ○ NEWSPAPER ○ RADIO ○ TV ○ INTERNET ○ BILLBOARD ○ BROKER ○ OTHER

TO HELP SERVE YOU BETTER IN THE FUTURE, PLEASE INDICATE YOUR PREFERRED LANGUAGE: ○ ENGLISH ○ SPANISH

TERM LIFE INSURANCE (underwritten by Fort Dearborn Life Insurance Company*) IF YOU ARE APPLYING FOR TERM LIFE INSURANCE, PLEASE COMPLETE THE ATTACHED LIFE INSURANCE AUTHORIZATION FORM.

IF APPLYING FOR TERM LIFE INSURANCE, WILL ALL OR PART OF THIS LIFE INSURANCE REPLACE EXISTING LIFE INSURANCE? ○ YES ○ NO

NOTE: THIS TERM LIFE INSURANCE IS NOT AVAILABLE FOR ISSUE IF IT IS A REPLACEMENT OF ANOTHER LIFE INSURANCE POLICY AS DEFINED BY THE ARIZONA INSURANCE CODE AND REGULATIONS.

IF INDIVIDUAL/FAMILY COVERAGE:

○ $20,000 ○ $30,000 ○ $50,000 – THIS AMOUNT IS AVAILABLE ONLY IF APPLICANT IS 18 YEARS OR OLDER

○ DO NOT WISH TO APPLY

DEPENDENT LIFE*: ○ YES ○ NO
(AVAILABLE ONLY IF CONTRACTHOLDER HAS LIFE COVERAGE)
FULL-TIME STUDENT AGE 19-25? ○ YES ○ NO
*DEPENDENT CHILDREN ARE ONLY ELIGIBLE TO REMAIN ON YOUR TERM LIFE POLICY UNTIL AGE 19 OR AGE 25 IF THEY ARE A FULL-TIME STUDENT.

IF CHILD-ONLY COVERAGE:

○ $10,000 ○ $20,000 ○ $30,000 ○ DO NOT WISH TO APPLY

ALL CHILDREN LISTED ON THIS APPLICATION WILL RECEIVE COVERAGE IF APPROVED, WITH PREMIUMS CALCULATED ON A PER CHILD BASIS. NOT AVAILABLE TO CHILDREN UNDER 14 DAYS OLD.

BENEFICIARY - LAST NAME | **FIRST NAME** | **M.I.** | **RELATIONSHIP**

CONTINGENT BENEFICIARY - LAST NAME | **FIRST NAME** | **M.I.** | **RELATIONSHIP**

I ACKNOWLEDGE THAT THIS ○ IS NOT A REPLACEMENT OF EXISTING LIFE INSURANCE.

BROKER SIGNATURE X_____

**Fort Dearborn Life Insurance Company is an independent company, is not affiliated in any way with BCBSAZ, and does not provide BCBSAZ products or services. Fort Dearborn Life Insurance Company's polices are not underwritten by BCBSAZ, and BCBSAZ is not responsible for any products or services offered by Fort Dearborn Life Insurance Company.*

APPLICANT'S NAME _____ APPLICANT'S SSN _____
(For child-only applications, enter the parent or legal guardian's name)

Evidence of Insurability

Important: BCBSAZ will rely on the information provided to make a determination about coverage for all persons named on the application. **If information about any applicant's medical background is misstated or omitted, it could result in limitations and/or exclusions on coverage or your contract could be rescinded and considered never to have been in effect.** In that case, you would become responsible for all incurred medical expenses from the effective date of coverage.

Any change in the health status of any applicant that occurs between the date of this application and the effective date of coverage must be reported to Medical Risk Assessment at (602) 864-4040, or toll-free (800) 232-2345, ext. 4040.

Please consider the following questions carefully.

1 **In the past ten (10) years,** have you or any person on this application been aware of, been diagnosed, been treated (including maintenance therapy), been injured, experienced pain or other symptoms, had a history of, had tests or x-rays / CT scans / MRIs, taken medications, or been evaluated or advised by any type of health care professional regarding the following categories / conditions?

The categories on the following pages are only examples and do not limit the extent of the information requested. Fill in the "YES" or "NO" ovals for each category listed. Do not leave any items blank, do not write N/A (not applicable), and do not draw a line through the columns.

FILL IN YES OR NO FOR EACH ITEM		YES	NO	FILL IN YES OR NO FOR EACH ITEM		YES	NO	FILL IN YES OR NO FOR EACH ITEM		YES	NO
a	Allergies (Sinusitis, Rhinitis, Allergy Shots) Asthma, Reactive Airway Disease, Wheeze	◯	◯	o	Eyes (Cataracts / Lens Implants, Glaucoma, Crossed / Lazy Eyes) State Site: ☐ Right ☐ Left	◯	◯	cc	Lungs (Bronchitis, Emphysema/ COPD, Nodule, Pneumonia, Recurrent Cough / Wheeze, Sleep Apnea, TB/Positive TB test, Valley Fever)	◯	◯
b	Back, Neck, Spine, Disc, (Bulge, Herniation, Degeneration) Scoliosis	◯	◯	p	Female (Uterus, Cervix, Ovaries); Menstrual Disorder/Irregular Bleeding, Fibroids, Abnormal Pap, Endometriosis	◯	◯	dd	Male Organs (Prostate, Testicles [Cysts, Nodules, Lump, Infection], Impotence), Hypospadius	◯	◯
c	Birth / Congenital / Physical (Defect, Deformity, Disease, Disorder)	◯	◯	q	Foot Disorders/Deformities/Orthotics (Bunions, Club Foot, Plantar Fascitis, Flat Feet)	◯	◯	ee	Manic Depressive Disorder, Depression, Anxiety / Panic Attacks, Attention Deficit, Hyperactivity, Schizophrenia	◯	◯
d	Blood, Bleeding Disorders	◯	◯	r	Fractures (Bone: _____ ☐R ☐L) Surgery; Pins / Plates / Screws (Present/ Removed), Cast Only [Circle Answers]	◯	◯	ff	Muscular System (Chronic Fatigue, Fibromyalgia, Muscular Dystrophy)	◯	◯
e	Blood Vessels / Circulation Disorders (Varicose / Spider Veins, Arteries, Lymph System, Edema / Swelling)	◯	◯	s	Gallbladder, Intestinal/Stomach (Colitis [ulcerative], Crohn's Disease, Irritable Bowel Syndrome, Diverticulitis, Acid Reflux, Bleeding [Rectal])	◯	◯	gg	Nervous System (Parkinson's Disease, Tremors, Multiple Sclerosis, Paralysis, Numbness, Weakness)	◯	◯
f	Bone, Joint [Knee, Shoulder, etc.] (Arthritis, Bursitis, Tendonitis, TMJ, Carpal Tunnel Syndrome), Osteoporosis	◯	◯	t	Headaches (Migraines, Stress, Muscle Tension)	◯	◯	hh	Prosthetic Implants or Devices (Breast, Joint, Eye, Tendon)	◯	◯
g	Brain / Head (Concussion, Injury, Tumor), Plagiocephaly	◯	◯	u	Heart Conditions of Any Kind, Chest Pain/Pressure, Pacemaker, Heart Murmur, Arrhythmia (Irregular Heart Beat)	◯	◯	ii	Psychiatric or Psychological Treatment or Counseling	◯	◯
h	Breast [Male or Female] (Fibrocystic, Lumps, Nodules, Discharge, Abnormal Mammogram)	◯	◯	v	Hernia [Circle Type and State Site] (Hiatal, Umbilical, Inguinal, Ventral) Site: ☐R ☐L	◯	◯	jj	Sexually Transmitted Diseases (HPV / Genital Warts, Genital Herpes, Chlamydia, Gonorrhea)	◯	◯
i	Elevated Cholesterol, Triglycerides	◯	◯	w	High Blood Pressure	◯	◯	kk	Skin (Lesions, Discoloration, Lumps, Scleroderma, Psoriasis, Cancer [Melanoma, Basal Cell, Squamous])	◯	◯
j	Convulsions (Epilepsy, Seizure Disorder, Febrile Seizure)	◯	◯	x	Hormonal / Endocrine (Thyroid [Nodule/ Goiter], Pituitary, Adrenal Gland), Hypogonadism, Infertility	◯	◯	ll	Steroid Use (Anabolic, Prednisone, Decadron, Cortisone Injection)	◯	◯
k	Developmental / Cognitive / Motor / Speech Delay	◯	◯	y	Illicit Drug Use or Abuse / Other Drug Abuse	◯	◯	mm	Stroke / Transient Ischemic Attacks (TIA)	◯	◯
l	Diabetes, Abnormal Glucose (High or Low)	◯	◯	z	Immune System / Inflammatory Disorder (Lupus Erythematosis, Gamma Globulin Deficiency, Gout)	◯	◯	nn	Benign Tumors, Cysts, Polyps (Colon) , Growths, Plantar Warts, Hemorrhoids	◯	◯
m	Ear, Nose, Throat (Otitis / Infection, Tubes, Hearing Problems, Tonsillitis, Deviated Nasal Septum), Sleep Apnea	◯	◯	aa	Kidney / Urinary Tract / Bladder (Stones, Infection, Blood in Urine, Incontinence) Hydronephrosis	◯	◯	oo	Ulcers (Skin, Stomach, Intestine, Eye, Bleeding [Gastric])	◯	◯
n	Eating Disorders (Anorexia, Bulimia)	◯	◯	bb	Liver (Cirrhosis, Hepatitis [State Type:_____], Elevated Liver Enzymes)	◯	◯	pp	Weight Problems, Gastric Bypass, Recent Weight Loss or Gain	◯	◯

APPLICANT'S NAME _____ APPLICANT'S SSN _____
(For child-only applications, enter the parent or legal guardian's name)

IN THE PAST 10 YEARS:	YES	NO
2 Has surgery (major or minor, reconstructive, restorative, non-cosmetic, inpatient or outpatient) been performed on any applicant?	◯	◯
3 Has any applicant been advised to have surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) that has not yet been performed?	◯	◯
4 Has any applicant been aware of, evaluated, diagnosed, tested or x-rayed, treated or advised or experienced pain or other symptoms for any other conditions or injuries not listed, not yet diagnosed, or for which treatment has not been completed?	◯	◯
5 Has any applicant been diagnosed, treated, or evaluated for or experienced or been aware of symptoms related to alcoholism, use or abuse of alcohol, or conditions which may be related to alcohol use or abuse (cirrhosis, hepatitis, cardiac disease, DTs, blackouts)?	◯	◯
6 Has any applicant discussed his/her level of alcohol consumption with a health care professional and/or been advised to either decrease his/her intake of alcohol or stop drinking completely?	◯	◯

If the answer is "yes" to any item in questions 1 - 6, indicate the question number or letter and provide full details below, including the onset and ending dates of injury/illness/symptoms and treatment. Providing **full details** may reduce the need for medical records and should include specifics concerning the type of disorder; conditions or symptoms; body location; tests or treatment advised, ordered or received; names and addresses of health care providers. **Use extra paper if needed.**

LAST NAME	FIRST	QUESTION # OR LETTER

ONSET DATE (MM/YYYY)	Description, i.e. symptoms, diagnosis, condition, illness
END DATE (MM/YYYY)	Types of Treatment, Testing, Monitoring, Surgery, or Medication
ONGOING SYMPTOMS/ TREATMENTS? YES ◯ NO ◯	Name and Addresses of Past and Present Physicians, Hospitals, etc.

LAST NAME	FIRST	QUESTION # OR LETTER

ONSET DATE (MM/YYYY)	Description, i.e. symptoms, diagnosis, condition, illness
END DATE (MM/YYYY)	Types of Treatment, Testing, Monitoring, Surgery, or Medication
ONGOING SYMPTOMS/ TREATMENTS? YES ◯ NO ◯	Name and Addresses of Past and Present Physicians, Hospitals, etc.

(Additional box to record your details is located on top of next page.)

APPLICANT'S NAME _____ APPLICANT'S SSN _____
(For child-only applications, enter the parent or legal guardian's name)

LAST NAME	FIRST	QUESTION # OR LETTER

ONSET DATE (MM/YYYY)	Description, i.e. symptoms, diagnosis, condition, illness
END DATE (MM/YYYY)	Types of Treatment, Testing, Monitoring, Surgery, or Medication
ONGOING SYMPTOMS/ TREATMENTS? YES ○ NO ○	Name and Addresses of Past and Present Physicians, Hospitals, etc.

If additional details need to be added, complete a separate sheet and check here ☐

7 In the past ten (10) years has any applicant been arrested or convicted for DUI / DWI? If "YES," please provide details below.

YES	NO
○	○

NAME	NO. TIMES?	STATE	DATE (MM/YYYY)	STATE	DATE (MM/YYYY)

8 Has any applicant **EVER** been aware of, evaluated, advised, tested (other than routine screenings), diagnosed or treated for cancer or malignant neoplasms (e.g. tumors, leukemia, Hodgkin's or melanoma)?

YES	NO
○	○

9 Has any applicant **EVER** been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions or tested positive for the presence of antibodies to the AIDS virus (HIV)?

YES	NO
○	○

If the answer is "YES" to questions **8** - **9**, please provide details below, including the onset and ending dates. Use extra paper if needed.

LAST NAME	FIRST	QUESTION # OR LETTER

ONSET DATE (MM/YYYY)	Description, i.e. symptoms, diagnosis, condition, illness
END DATE (MM/YYYY)	Types of Treatment, Testing, Monitoring, Surgery, or Medication
ONGOING SYMPTOMS/ TREATMENTS? YES ○ NO ○	Name and Addresses of Past and Present Physicians, Hospitals, etc.

APPLICANT'S NAME _____ APPLICANT'S SSN _____
(For child-only applications, enter the parent or legal guardian's name)

10 Are any medications being taken by any applicant? YES ○ NO ○
List all medications being taken (regularly or as needed). Use extra paper if needed, and check here ☐

NAME OF PERSON	NAME OF DRUG	REASON FOR TAKING	DATE OF LAST USE (MM/YYYY)

11 **Is any male or female applicant applying for coverage currently an expectant parent?** YES ○ NO ○
If yes, the applicant(s) expecting a child are not eligible for coverage *at this time.*

12 **Females only:** All females age 13 or older listed on this application must complete this section.

NAME	DO YOU MENSTRUATE?	PERIOD IN LAST 30 DAYS?
	YES ○ NO ○	YES ○ NO ○

If no, explain: _____

NAME	DO YOU MENSTRUATE?	PERIOD IN LAST 30 DAYS?
	YES ○ NO ○	YES ○ NO ○

If no, explain: _____

NAME	DO YOU MENSTRUATE?	PERIOD IN LAST 30 DAYS?
	YES ○ NO ○	YES ○ NO ○

If no, explain: _____

Important: If any menstruating females listed on this application misses a menstrual period after this application has been submitted, it is considered to be a change in health status and must be reported to Medical Risk Assessment.

IF ANY PART OF ANY SECTION IS NOT COMPLETE, IT MAY RESULT IN PROCESSING DELAYS.

13 Has anyone applying for coverage on this application ever been enrolled on a BCBSAZ policy under a different name, such as maiden name or name change? YES ○ NO ○

PREVIOUS LAST NAME	PREVIOUS FIRST NAME	DATE OF BIRTH

14 Is any applicant partially or fully disabled from either a physical or mental condition? YES ○ NO ○
If any applicant has been determined to be 100% disabled, that person is not eligible for coverage.

NAME	NATURE OF DISABILITY, SPECIFY BODY PART AFFECTED	% DISABILITY
NAME	NATURE OF DISABILITY, SPECIFY BODY PART AFFECTED	% DISABILITY

APPLICANT'S NAME _____ APPLICANT'S SSN _____
(For child-only applications, enter the parent or legal guardian's name)

15 Has any application for a policy of life or health insurance on any applicant ever been declined, postponed, modified or required an extra premium?

YES	NO
○	○

NAME	TYPE OF INSURANCE	DATE (MM/YYYY
INSURANCE COMPANY	**REASON**	

NAME	TYPE OF INSURANCE	DATE (MM/YYYY
INSURANCE COMPANY	**REASON**	

16 Will this coverage for which you are applying replace any other coverage you have?

NO ○ **YES** ○ - Temporary Coverage **YES** ○ - Other (Specify):_____

If this coverage will replace current BCBSAZ group or any current coverage from another Blue Cross and/or Blue Shield plan, you may be eligible for conversion coverage. Conversion coverage does not require medical underwriting, but has higher premiums and different benefits from your previous coverage. If you are interested in such coverage, please contact your current Plan or BCBSAZ for more details.

If you are applying for a PPO plan

SERVICES FOR PRE-EXISTING CONDITIONS ARE NOT COVERED UNTIL 11 CONSECUTIVE MONTHS AFTER YOUR CONTRACT EFFECTIVE DATE. A pre-existing condition is defined as a condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was recommended or received during the 12 months before your contract effective date.

If you are applying for an HMO plan

There is no pre-existing condition waiting period. HMO plans have a waiting period of 12 months from the effective date of the contract for normal maternity services.

More information on pre-existing condition waiting periods is in the BCBSAZ Health Plans for Individuals and Families brochure and the contract booklet. A contract booklet will be sent to you upon enrollment or upon request prior to enrollment.

Important: Until this application is effective, do not cancel any insurance you may have. Please make sure you sign page 10 of this application.

APPLICANT'S NAME _____ APPLICANT'S SSN _____
(For child-only applications, enter the parent or legal guardian's name)

Please read carefully, upon acceptance, this application becomes part of your contract.

Acknowledgment

Please read the information below carefully. Upon acceptance, these acknowledgements become part of your contract.

1. I have carefully read all of this application and understand that, if accepted for coverage, this application becomes part of my contract with Blue Cross Blue Shield of Arizona (BCBSAZ) and, if applicable, with Fort Dearborn Life Insurance Company*.

2. I acknowledge and understand that coverage shall:
   - Become effective on the date assigned by BCBSAZ.
   - Be subject to its own waiting periods, limitations, medical waivers and other provisions, regardless of any prior coverage.

3. I acknowledge and understand that the information provided on this application is material to BCBSAZ's decision to offer health care coverage and that BCBSAZ will rely on the accuracy of such information to make a determination about each applicant's eligibility for coverage. If a material misrepresentation or omission is discovered after coverage has been issued, BCBSAZ may rescind the contract and declare it null and void as of the effective date of coverage.

4. I acknowledge that as part of this contract of insurance with BCBSAZ each applicant must fully cooperate with BCBSAZ in investigating any health conditions, claims or other relevant information needed to perform its business functions.

5. I authorize any physician, practitioner, hospital, clinic or other health related provider or facility to furnish my health information including information related to drug use, alcoholism, mental illness, HIV, AIDS and genetic testing to BCBSAZ and its representatives. I understand I am responsible for any costs associated with obtaining medical records. BCBSAZ may use this information and any of my information already in its possession, to evaluate my application, determine eligibility and for claims processing. This information may, in certain circumstances, be disclosed to third parties without my permission if permitted by law.

6. BCBSAZ sells health and dental coverage products either directly or through independent licensed insurance brokers. Commission payments to brokers are one of the costs factored into premiums, but BCBSAZ's premium calculation is not based on whether a product is sold directly or by a broker. BCBSAZ generally pays a commission to the broker of record or permitted assignee until the contract is terminated or the contract holder terminates his/her relationship with the broker or becomes ineligible. Your broker is required under the agreement with BCBSAZ to give you information on his/her commission rate with BCBSAZ. More detailed information about broker commissions and compensation to BCBSAZ Licensed Inside Sales Representatives for sales of BCBSAZ individual products is available for review at azblue.com or you may obtain a copy by calling BCBSAZ at (602) 864-4021.

If you are applying for child-only coverage:

7. On behalf of the named child(ren), I hereby apply for enrollment, I understand that if BCBSAZ and/or Fort Dearborn Life Insurance Company* accept this application, I will be the contract holder on behalf of the child(ren) named on this application consistent with the terms above.

8. I understand that both parents are entitled to have equal access to medical and other records of a child directly from the custodian of the records, unless otherwise limited by court order or applicable law, and a copy of such court order has been provided to BCBSAZ

** Fort Dearborn Life Insurance Company is an independent company, is not affiliated in any way with BCBSAZ, and does not provide BCBSAZ products or services. Fort Dearborn Life Insurance Company's polices are not underwritten by BCBSAZ, and BCBSAZ is not responsible for any products or services offered by Fort Dearborn Life Insurance Company.*

For questions about this application, please call your broker or BCBSAZ at (602) 864-4899 or toll-free at (877) 864-4899.

For questions concerning status of medical review of your application or receipt of medical information, please call (602) 864-4040 or (800) 232-2345, ext. 4040.

For questions concerning the general status of your application or enrollment, please call (602) 864-4115 or (800) 232-2345, ext. 4115.

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

Additional forms are available from your broker, the BCBSAZ website at azblue.com in the Forms section, or by calling (602) 864-4899 or toll-free at (877) 864-4899.

Please sign and date this page.

SIGNATURES

All persons named on this application age 18 and older **MUST** sign and date this form, acknowledging their understanding of and their agreement to the conditions listed above. A copy of the Acknowledgment is available to you or your authorized representative upon request.

Individual/Family Coverage Signature(s)

Today's Date (MM/DD/YYYY)

Contract holder X _____

X _____

X _____

X _____

X _____

Child-only Coverage Signature(s)

Today's Date (MM/DD/YYYY)

X _____
(Parent or legal guardian designated as contract holder)

Relationship _____

Today's Date (MM/DD/YYYY)

X _____
(Co-parent or legal guardian*)

Relationship _____

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

* Co-parents or legal guardians who want authority to make changes to the child's contract must sign the application.

Before you mail this application, please check the following:

☐ Did all persons named on this application (age 18 and older) sign and date application above? (If applying for child only coverage, did the parent(s) or legal guardian(s) sign and date application above?)

☐ **Important:** Have all questions been answered? If not, it may result in processing delays.

☐ If you are applying for the optional term life insurance, be sure to complete the attached Life Insurance Authorization form.

☐ If you indicated you would like to make your monthly payment with **Sure Pay (electronic bank draft),** then be sure to fill out the separate Sure Pay authorization on page 3.

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

☐ **Did you attach the $20.00 application fee payable to Blue Cross Blue Shield of Arizona?**
(Please note: If you are applying for child-only coverage, or if you are a current BCBSAZ customer and you are applying for a coverage change, adding a dependent or lowering your deductible, the $20 application fee is not necessary.)

☐ Please return all pages of this application to:

ATTN: Cash Control
Blue Cross Blue Shield of Arizona
P.O. Box 81049
Phoenix, AZ 85069-1069

Instructions for Completing Confidential Information Release Form

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Please complete the Confidential Information Release Form if you would like Blue Cross Blue Shield of Arizona (BCBSAZ) to share your personal information with the individual or organization you specify on the form. Each individual 18 and over should complete a separate form.

This authorization is voluntary. We will not condition our claim payment activities, your enrollment in our health plan or your eligibility for benefits on you giving us this authorization.

Examples of Use

Here are a few examples for which the form may be used. Complete the form if you would like BCBSAZ to share certain or all of your personal information with:

- Another adult such as a spouse, parent, child or personal representative so they can discuss your claims or billing questions with BCBSAZ.
- Your broker during or after the enrollment process for the level of service he or she is to provide (enrollment, claims and/or billing questions, etc.).
- Your attorney for a specific legal issue that arises, such as a personal injury case.

Specific Instructions

Information to be Disclosed: Indicate the specific information you want us to share (application, enrollment, eligibility, EOBs, claims, medical records, etc.)

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

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

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

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

Expiration Date: This authorization will automatically expire 90 days after your last coverage date. You have the right to revoke this authorization earlier by contacting the Privacy Office.

Identification Number and Group Number: Enter your BCBSAZ ID number if you've received one; otherwise enter your social security number.

Signature: Print and sign your name and date the form.

Group Name and Number: If applicable, enter the name and number of the employer or other insured group under which you are covered.

Personal Representative: A personal representative is a legal designation and generally refers to the parent of an unemancipated minor, Legal Guardian, or Holder of Power of Attorney. If you are the Personal Representative and are completing this form for someone else, please complete the last two rows and attach copies of relevant legal documents.

Confidential Information Release Form

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

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

You must use a separate form for the release of HIV-related information. Return this completed form with your application. Current BCBSAZ customers should mail this completed form to Blue Cross Blue Shield of Arizona, Attention: Enrollment Services, P.O. Box 13466, Phoenix, AZ 85002. Blue Cross Blue Shield of Arizona (BCBSAZ) will not condition its payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits in our health plan on you giving this authorization.

Information to be Disclosed: I authorize BCBSAZ to disclose the following information, including information about communicable diseases, alcohol and drug abuse treatment and genetic testing: *(Please check all that apply.)*

- ☐ Application, Enrollment, Eligibility Information
- ☐ Billing/Payment Information
- ☐ Claims/EOB Information
- ☐ Medical Records
- ☐ Precertification Information
- ☐ Account Information
- ☐ Other (please describe): _____

Person Whose Information May Be Released: _____

Who May Receive the Indicated Information:

Name: _____

Company Name: _____

Street Address: _____

City, State, Zip Code _____

Purpose of Use/Disclosure:

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

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

- ☐ Change My Mailing Address
- ☐ Update My SurePay/Banking Information

Unless you revoke this authorization earlier, it will expire 90 days after the expiration or termination of your coverage with BCBSAZ. It is possible for the protected health information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal health information privacy laws. **You may revoke this authorization by giving written notice to the BCBSAZ Privacy Office, Mail Stop C302, P.O. Box 13466, Phoenix, AZ 85002-3466. Revocation of this authorization will not affect any action BCBSAZ took in reliance on this authorization before it received your written notice of revocation.**

_____ Printed Name	_____ Identification Number
_____ Signature	_____ Date (MM/DD/YYYY)
_____ Group Name (if applicable)	_____ Group Number (if applicable)
_____ Personal Representative's Name*	_____ Relationship to Individual
_____ Personal Representative's Signature	_____ Date (MM/DD/YYYY)

*Please attach a copy of the relevant legal document(s).

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

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Life Insurance Authorization Form

To authorize BCBSAZ to disclose your information to CSA General Insurance Agency, Inc. in connection with your life insurance application.

Blue Cross Blue Shield of Arizona (BCBSAZ) will not condition its payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits in our health plan upon you giving this authorization.

By signing this form, you authorize BCBSAZ to disclose the information contained in your BCBSAZ Individual Application and your BCBSAZ subscriber identification number, if any, to CSA General Insurance Agency, Inc. The purpose of the disclosure is to allow both CSA General Insurance Agency, Inc. and BCBSAZ to perform administrative services in connection with any life insurance you may receive as a result of completing and submitting the Individual Application.

This authorization will expire upon the termination of your policy with BCBSAZ or, if you do not obtain a policy with BCBSAZ, within six (6) months from the date set forth below. It is possible for the protected health information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal health information privacy laws.

You may revoke this authorization by giving written notice to the BCBSAZ Privacy Office, C105, BCBSAZ, P.O. Box 13466, Phoenix, AZ 85002-3466. Your revocation will not affect any action BCBSAZ took in reliance upon this authorization before it received your written notice of revocation.

Those individuals 18 years or older should sign and complete the information below.

Printed Name	Social Security Number
Signature	Date
Printed Name	Social Security Number
Signature	Date
Printed Name	Social Security Number
Signature	Date
Printed Name	Social Security Number
Signature	Date
Personal Representative's (PR) Name	PR's Relationship to Individual
Signature	Date

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

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Application Submission Checklist

Please verify all information to ensure your application is processed as quickly as possible.

Personal information, for all applicants (page 2)

- ☐ Name
- ☐ Social Security number (if applicable)
- ☐ Gender
- ☐ Date of birth
- ☐ Height and weight
- ☐ Address
- ☐ Relationship of dependent(s) to contract holder

Plan for which you are applying (page 2)

- ☐ Plan selected: PPO, HMO
- ☐ Deductible level (if applicable)
- ☐ Type of coverage
- ☐ Billing
- ☐ Effective date

Sure Pay and life insurance, optional (page 3)

- ☐ If you prefer convenient billing by electronic bank draft, please fill out the Sure Pay authorization, including routing number, account number and signature.
- ☐ If you would like to elect optional term life insurance, be sure to complete all sections. By completing the Life Authorization form, you will allow BCBSAZ to share information with CSA General Insurance Agency, Inc. and for both entities to perform administrative services in connection with your life insurance.

Evidence of Insurability - Medical history (pages 4 - 8)

- ☐ Please make sure ALL of the ovals are filled in completely; do not just mark with an "x." Fill in "yes" or "no"; do not leave any items blank. If you are unsure whether a medical question pertains to your health history, please call the BCBSAZ Medical Risk Assessment department at (800) 232-2345, ext. 4040.
- ☐ If you answer "yes" to any evidence of insurability questions (sections 1 - 6, pages 4 and 5), please be sure to fill out the detail section(s) on pages 5 and 6. Use extra paper, if necessary, and check the box indicating extra sheets are attached. When filling out the boxes or extra sheets with more detail, please include all of the following:
  - Name of person the condition pertains to
  - Onset and end dates
  - Symptoms/diagnosis
  - Question number and letter
  - Ongoing symptoms or treatment
  - Name(s) of past and present providers
- ☐ Please make sure all questions on pages 6 - 8 are answered.

Signatures, release form and application fee

- ☐ Please make sure that all required signatures are made on page 10.
- ☐ If you wish BCBSAZ to share personal information with an individual or organization, please complete the Confidential Information Release Form, attached to the application.
- ☐ Applications must be sent with a $20 non-refundable fee. No fee is required for child-only applications.

If you have questions regarding this application, contact the BCBSAZ Individual Sales department at:

(602) 864-4899 or toll free at (877) 864-4899

Our business hours are 8:00 a.m. to 4:30 p.m., Monday - Friday.