

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at:
Fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), quarterly (every three months), or semi-annual (twice a year).

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: BlueCross BlueShield of Illinois

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at:

Thank you for choosing...



BlueCross BlueShield of Illinois

APPLICATION FOR INDIVIDUAL COVERAGE



**BlueCross BlueShield
of Illinois**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

DIRECT MARKETS

® Registered Service Marks of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans

HOME OFFICE USE ONLY

BATCH #:	
CWA :	

To help us process your application promptly, please remember to:

- Print all answers in **black** ink. Pencil will not be accepted.
- Make sure you personally sign the application as the Applicant/Owner. If your spouse is also applying for coverage,

have him/her personally sign the Spouse's Signature.

- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid to correct any information.

PART ONE Check one: New Policy Add Dependent Upgrade (increase of benefits)

SECTION A — PERSON(S) APPLYING FOR COVERAGE (please print)

PRIMARY APPLICANT

First Name, Middle Initial, Last Name			Sex (m/f)	Age	Date of Birth (mo/day/yr) / /	Home Phone # ()	E-mail (if available)
Height (ft., in.)	Weight (lbs.)	Occupation/Duties	Social Security # - -		Business Phone # ()	Spouse's Business # (if applying) ()	Fax # (if available) ()
Residence Street Address			City / State / ZIP		County	Best place and time to call (if necessary) <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon	

SPOUSE and DEPENDENT CHILDREN (dependent children must be under age 19, or under age 25 if unmarried, full-time student)

RELATION	SEX	NAME: Last	First	M.I.	HEIGHT (ft., in.)	WEIGHT (lbs.)	DATE OF BIRTH (mo/day/yr)	SOCIAL SECURITY NUMBER	FULL-TIME STUDENT
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F						/ /	- -	
	<input type="checkbox"/> M <input type="checkbox"/> F						/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> M <input type="checkbox"/> F						/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> M <input type="checkbox"/> F						/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> M <input type="checkbox"/> F						/ /	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have all listed applicants been residents of the U.S. for the last six (6) months? Yes No

SECTION B — COVERAGE APPLIED FOR (please choose only one plan)

- | | |
|--|---|
| <input type="checkbox"/> SelectBlue Plan
Deductible: <input type="checkbox"/> \$0 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80%
Do You Want Maternity Coverage? <input type="checkbox"/> Yes | <input type="checkbox"/> Traditional Blue Plan
Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80%
Do You Want Maternity Coverage? <input type="checkbox"/> Yes |
| <input type="checkbox"/> BlueValue Plan
Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80%
Do You Want Maternity Coverage? <input type="checkbox"/> Yes | <input type="checkbox"/> High Deductible Plan
Do You Want Maternity Coverage? <input type="checkbox"/> Yes
<input type="checkbox"/> BasicBlue Plan
Deductible: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500
Maternity Option Not Available |

Note: Do not cancel any current coverage you may have until you've received a policy from Blue Cross.

SECTION C — BILLING INFORMATION

REQUESTED EFFECTIVE DATE (mo/day/yr) _____ / _____ / _____ PREMIUM AMOUNT ENCLOSED \$ _____

- PREMIUM MODE: Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
 Two-Month Direct Bill

Billing Name and Address (if different than name and residence address given above)	City / State / ZIP
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PART TWO — EVIDENCE OF INSURABILITY

All health/medical information must be completed for all individuals (including dependents) applying for coverage.

SECTION A — HEALTH HISTORY / MEDICAL QUESTIONS

NOTE: If answering “Yes” to a question, please also **circle** the condition to which you are referring and give complete details in PART TWO, SECTION B.

1. Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment **within the last 10 years** for the following:
 - A. Migraines; headaches; carpal tunnel syndrome; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? Yes No
 - B. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; neurosis or psychosis; psychotherapy; marital or any form of counseling or therapy? Yes No
 - C. High blood pressure; chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack or stroke, or any other heart or circulatory disorder or condition? Yes No
 - D. Varicose veins; elevated cholesterol or lipids; anemia; blood clot or any other blood disorder? Yes No
 - E. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; or any breathing difficulty, lung or respiratory disease, disorder or condition? Yes No
 - F. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach or duodenum, or any other digestive disorder or condition? Yes No
 - G. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? (indicate type of hepatitis _____) Yes No
 - H. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? Yes No
 - I. Acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other skin disorder? Yes No
 - J. Kidney stones; reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? Yes No
 - K. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? Yes No
 - L. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; joint replacement; or manipulation therapy? Yes No
 - M. Thyroid disorder; goiter; Graves disease; diabetes; lupus; pituitary or adrenal disorder? Yes No
 - N. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any ear, eye, nose or throat disorder? Yes No
 - O. Acquired Immune Deficiency Syndrome (AIDS); AIDS-Related Complex (ARC); HIV positive or other immune disorders? Yes No
 - P. Question for Male Applicants Only
Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? Yes No
 - Q. Question for Female Applicants Only
Fibroid or uterine tumor; ovarian cyst; endometriosis; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? Yes No
2. Has any person applying for coverage been counseled for, diagnosed with, or treated for alcohol abuse, alcohol dependency or alcoholism **within the last 10 years**? Yes No
3. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical dependency **within the last 10 years**? Yes No
4. **During the last 5 years**, has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist? Yes No
5. Has any person applying for coverage been prescribed or taken any medication due to any disease, disorder, condition, injury or counseling **in the last 12 months**? Yes No
6. Has any person applying for coverage smoked or used any tobacco products – such as cigarettes, pipes, cigars, snuff or chewing tobacco – **in the last 12 months**? Yes No
7. Is any person applying for coverage **now** pregnant or an expectant parent? Yes No
If yes, list name and anticipated date of delivery in Part Two, Section B.
8. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin or penile implant), internal fixation (e.g. pins, plates or screws), prosthesis, pacemaker, valve replacement, shunt or monitoring device? Yes No
9. Has any person applying for coverage discussed, or been advised to have, medical treatment, testing, counseling, or surgery which has not yet been performed? Yes No
10. Has any person applying for coverage **ever** been hospitalized or been treated in the emergency room or had any physical impairment, deformity, congenital anomaly, sickness, operation, injury or hospitalization other than admitted to above? Yes No

QUESTION CONTINUES AT RIGHT

PART TWO — CONTINUED

SECTION C — OTHER INSURANCE INFORMATION

1. Does any person applying for coverage currently have, or did they previously have, Blue Cross and Blue Shield of Illinois coverage, either as a primary insured or as a dependent? Yes No **If yes, please complete the following:**

Member Name _____ Member No. _____ Group No. _____

2. Does any person to be covered have any Major Medical, HMO, or PPO Medical Insurance with any other Insurer? Yes No

3. Will the issuance of this coverage cause you to discontinue your existing coverage? Yes No

If yes, a Notice of Replacement Form must be submitted with your application.

If no, please explain _____

4. Has any person applying for coverage ever been declined, postponed, charged an extra premium for or had a rider applied to life, health, or disability insurance, or had any such insurance rescinded? Yes No

Note: Do not cancel any current coverage you may have until you've received a policy from Blue Cross.

PART THREE

PLEASE COMPLETE AND SIGN BELOW — *DO NOT DETACH.*

SECTION A — REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I apply for coverage as indicated in PART ONE, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical coverage) which is herein called the Company. **I have read all the statements in PARTS ONE and TWO, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on PARTS ONE and TWO of this application may be the basis for future claim denial or rescission.**

I have read and understand the Outline of Coverage that has been provided to me by my Blue Cross and Blue Shield agent.

I have been informed of the provisions of the Blue Cross and Blue Shield of Illinois health plans and the Medical Services Advisory (MSA®) Program by my Blue Cross and Blue Shield agent.

I authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide the Company or their authorized representative information, including copies of records, concerning advice, care, or treatment provided to me and/or my dependents, including without limitation, information relating to mental illness or use of drugs or alcohol.

I understand that such information will be used by the Company for the purpose of evaluating my application for health insurance, or by Company representatives involved in evaluating, determining, or administering claims for insurance benefits for me or my dependents. I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed through the terms of coverage.

Date Signed _____	/	/	Applicant/Owner's Signature X _____
mo	day	yr	
Date Signed _____	/	/	Spouse's Signature (if to be covered) X _____
mo	day	yr	

I have personally, completely, and accurately reaffirmed the information supplied by the applicant. Further, I made no representations to the applicant other than those contained in the sales brochure.

Date Signed _____ Agent's Signature **X** _____

mo day yr

Agent's Name _____ Social Security # or Tax ID # _____

(please print)

* Registered Service Mark of Health Care Service Corporation
OB3941 8/00

SECTION B — PROXY

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation (hereinafter referred to as "HCSC") and such persons as the Board of Directors may designate by resolution as the undersigned's proxies to act on behalf of the undersigned at all meetings of members of HCSC and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meeting. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Applicant/Owner's Signature X _____	Date Signed _____
	mo day yr
Print Your Name as You Signed It _____	



**BlueCross BlueShield
of Illinois**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

DIRECT MARKETS

CONDITIONAL RECEIPT FOR

Proposed Insured: _____

Date of Application: _____ Amount Received: _____ Date of Receipt: _____

NO INSURANCE WILL BECOME EFFECTIVE UNLESS EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO PRODUCER IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.

Subject to the limitations shown below, insurance will become effective under the receipt if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Health Care Service Corporation, a Mutual Legal Reserve Company (Blue Cross and Blue Shield of Illinois) hereafter "HCSC," at its Home Office (or the office of the designated administrator).
2. The first full premium, according to the mode of premium payment chosen, has been paid and the check is honored on first presentation for payment.
"An effective date in compliance with HCSC guidelines" means the later of:
 - a. The requested coverage date, if any, shown on the application; or
 - b. The date upon which the application is approved by HCSC at its Home Office (or office of the designated administrator).
3. The policy is issued by HCSC exactly as applied for within 60 days from date of application, delivered, and accepted by the proposed insured.

Limitation:

This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided herein. In the event HCSC declines to issue a policy as applied for, the amount received by HCSC will be refunded.

Brian Van Vlierbergen

Signature of Secretary

Signature of Producer

Producer's Code

Blue Cross and Blue Shield of Illinois
Administrator: Hallmark Services Corp.
PO Box 2038
Aurora, Illinois 60507-2038

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF ILLINOIS. DO NOT PAY CASH OR MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

If you do not hear from HCSC regarding the proposed insurance within 30 days, please call 1-800-538-8833.

**THIS FORM LIMITS OUR LIABILITY.
BE SURE TO READ AND SIGN THE APPLICATION AND, IF DESIRED, THE AUTOMATIC PAYMENT REQUEST FORM.
KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.**

Applicant's Copy (if paying by check or money order)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Health Care Service Corporation. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAD NEVER BEEN IN FORCE. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Note to Producer: An applicant who is replacing existing health insurance with Blue Cross and Blue Shield coverage must read, sign, and date the adjacent replacement form at right. You must then submit that replacement form along with the application. This half of the form must remain with the applicant.

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1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this new policy, whereas a similar claim might have been payable under your present policy.
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The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

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Applicant's Social Security Number

Return this portion with the application

CUT HERE



**BlueCross BlueShield
of Illinois**

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____ Check One: Checking Account Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED _____

Applicant's Copy (if paying by automatic bank withdrawal)

▲ DETACH HERE ▲

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____ Check One: Checking Account Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED		
ADDRESS OF BANK		
CITY	STATE	ZIP
NAME OF INSURED, APPLICANT (PRINT)		
NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED	RELATIONSHIP TO INSURED	
SIGNATURE OF DEPOSITOR	DATE	
For Home Office Use Only:	BANK TRANSIT NUMBER	DEPOSITOR'S ACCOUNT NUMBER

PLEASE ATTACH VOIDED CHECK OR DEPOSIT SLIP

Company's Copy (if applicant is paying by automatic bank withdrawal)