



An Independent Licensee of the Blue Cross and Blue Shield Association

INDIVIDUAL APPLICATION

For new or existing customer, please complete entire application.

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

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
			- -

WOULD YOU LIKE A MEMBER ID NUMBER OTHER THAN YOUR SOCIAL SECURITY NUMBER ASSIGNED? **YES** **NO**

DATE OF BIRTH	SEX	MARITAL STATUS	HEIGHT	WEIGHT	FOR OFFICE USE ONLY
M M D D Y Y Y Y	<input type="radio"/> MALE <input type="radio"/> FEMALE	<input type="radio"/> MARRIED <input type="radio"/> SINGLE	ft. in.		

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

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
			-

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. IF YOU HAVE MORE THAN 3 CHILDREN, COMPLETE A SEPARATE SHEET. WHEN ADDING A DEPENDENT TO EXISTING COVERAGE, LIST ONLY THOSE DEPENDENTS YOU ARE ADDING.

ARE YOU LISTING ADDITIONAL DEPENDENTS ON ANOTHER PAGE? **YES** **NO**

SPOUSE'S LAST NAME	FIRST NAME	M.I.

DATE OF BIRTH	SEX	HEIGHT	WEIGHT	DATE OF MARRIAGE	SOCIAL SECURITY NUMBER
M M D D Y Y Y Y	<input type="radio"/> MALE <input type="radio"/> FEMALE	ft. in.		M M D D Y Y Y Y	- -

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

DATE OF BIRTH	SEX	HEIGHT	WEIGHT	RELATIONSHIP
M M D D Y Y Y Y	<input type="radio"/> MALE <input type="radio"/> FEMALE	ft. in.		

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

DATE OF BIRTH	SEX	HEIGHT	WEIGHT	RELATIONSHIP
M M D D Y Y Y Y	<input type="radio"/> MALE <input type="radio"/> FEMALE	ft. in.		

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

DATE OF BIRTH	SEX	HEIGHT	WEIGHT	RELATIONSHIP
M M D D Y Y Y Y	<input type="radio"/> MALE <input type="radio"/> FEMALE	ft. in.		

DO NOT WRITE BELOW. FOR OFFICE USE ONLY.

SPOUSE	1	2	3

APPLICANT'S NAME _____

APPLICANT'S SSN _____

(For child-only applications, enter the parent or legal guardian's name)

PLAN FOR WHICH YOU ARE APPLYING			
BluePreferred <input type="radio"/> \$250 <input type="radio"/> \$500 <input type="radio"/> \$1,000 <input type="radio"/> \$2,500 <input type="radio"/> \$5,000	BluePreferred Basic <input type="radio"/> \$5,000 <input type="radio"/> \$10,000	BlueSelect <input type="radio"/> PLAN 1 <input type="radio"/> PLAN 2	BlueClassic <input type="radio"/> \$250 <input type="radio"/> \$500 <input type="radio"/> \$750 <input type="radio"/> \$1,250 <input type="radio"/> \$2,500 <input type="radio"/> \$5,000
TYPE OF COVERAGE			
IF FAMILY OR CHILD-ONLY COVERAGE, CHECK ALL THAT APPLY			
<input type="radio"/> INDIVIDUAL <input type="radio"/> FAMILY <input type="radio"/> CHILD-ONLY	<input type="radio"/> SPOUSE <input type="radio"/> ONE CHILD <input type="radio"/> TWO CHILDREN	<input type="radio"/> THREE OR MORE CHILDREN	
IF MY APPLICATION IS APPROVED, PLEASE BILL ME AS FOLLOWS:			
<input type="radio"/> MONTHLY SURE PAY ELECTRONIC BANK DRAFT (PLEASE COMPLETE THE SURE PAY APPLICATION)	THE EFFECTIVE DATE OF YOUR COVERAGE WILL DETERMINE THE DAY OF THE MONTH THAT YOUR PREMIUM WILL BE DUE. I PREFER MY COVERAGE TO BE EFFECTIVE:		
<input type="radio"/> MONTHLY PAPER BILL <input type="radio"/> QUARTERLY PAPER BILL (BILLED JAN./APRIL/JULY/OCT.)	<input type="radio"/> ON THE FIRST OF THE MONTH	<input type="radio"/> ON THE FIFTEENTH OF THE MONTH	<input type="radio"/> EARLIEST DATE AVAILABLE (FIRST OR FIFTEENTH)
OPTIONAL: INDICATE TERM LIFE INSURANCE FOR WHICH YOU ARE APPLYING. PLEASE COMPLETE THE DISCLOSURE AUTHORIZATION FORM, IF YOU ARE APPLYING FOR TERM LIFE INSURANCE.			
IF INDIVIDUAL/FAMILY COVERAGE:			
<input type="radio"/> \$20,000 <input type="radio"/> \$30,000 <input type="radio"/> \$50,000 – THIS AMOUNT IS AVAILABLE ONLY IF APPLICANT IS 19 YEARS OR OLDER	<input type="radio"/> DO NOT WISH TO APPLY	DEPENDENT LIFE: <input type="radio"/> YES <input type="radio"/> NO (AVAILABLE ONLY IF CONTRACTHOLDER HAS LIFE COVERAGE)	
IF CHILD-ONLY COVERAGE:			
<input type="radio"/> \$10,000 <input type="radio"/> \$20,000 <input type="radio"/> \$30,000 <input type="radio"/> 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 1 YEAR OF AGE.		
BENEFICIARY - LAST NAME	FIRST NAME	M.I.	RELATIONSHIP
CONTINGENT BENEFICIARY - LAST NAME	FIRST NAME	M.I.	RELATIONSHIP
IF APPLYING FOR TERM LIFE INSURANCE, WILL ALL OR PART OF THIS LIFE INSURANCE REPLACE EXISTING LIFE INSURANCE? <input type="radio"/> YES <input type="radio"/> NO			
IF YES, NAME OF PRESENT CARRIER			EFFECTIVE DATE OF COVERAGE
			M M D D Y Y Y Y
BROKER STATEMENT			
I ACKNOWLEDGE THAT THIS <input type="radio"/> IS <input type="radio"/> IS NOT A REPLACEMENT OF EXISTING LIFE INSURANCE.			
BROKER SIGNATURE <u>X</u> _____			

Life and disability plans are not underwritten by BCBSAZ. You can obtain information about products sold by CareAmerica Life Insurance Company by contacting your insurance broker.

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 on coverage or your contract could be rescinded/cancelled 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.

APPLICANT'S NAME _____

APPLICANT'S SSN _____

(For child-only applications, enter the parent or legal guardian's name)

1

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)	<input type="radio"/>	<input type="radio"/>	o Eyes (Cataracts / Lens Implants, Glaucoma, Crossed / Lazy Eyes) State Site: <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="radio"/>	<input type="radio"/>	cc Male Organs (Prostate, Testicles [Cysts, Nodules, Lump, Infection], Impotence)	<input type="radio"/>	<input type="radio"/>
b Back, Neck, Spine, Disc, Scoliosis	<input type="radio"/>	<input type="radio"/>	p Female Organs (Uterus, Cervix, Ovaries); Menstrual Disorder/Irregular Bleeding, Fibroids, Abnormal Pap, Infertility	<input type="radio"/>	<input type="radio"/>	dd Manic Depressive Disorder, Depression, Anxiety / Panic Attacks, Attention Deficit, Hyperactivity, Schizophrenia	<input type="radio"/>	<input type="radio"/>
c Birth / Congenital / Physical (Defect, Deformity, Disease, Disorder)	<input type="radio"/>	<input type="radio"/>	q Fractures (Bone: _____ <input type="checkbox"/> R <input type="checkbox"/> L) Surgery: Pins / Plates / Screws (Present/ Removed), Cast Only [Circle Answers]	<input type="radio"/>	<input type="radio"/>	ee Muscular System (Chronic Fatigue, Fibromyalgia, Muscular Dystrophy)	<input type="radio"/>	<input type="radio"/>
d Blood, Bleeding Disorders	<input type="radio"/>	<input type="radio"/>	r Gallbladder, Intestinal/Stomach (Colitis, Crohn's Disease, Irritable Bowel Syndrome, Hemorrhoids, Acid Reflux)	<input type="radio"/>	<input type="radio"/>	ff Nervous System (Parkinson's Disease, Tremors, Multiple Sclerosis, Paralysis, Numbness, Weakness)	<input type="radio"/>	<input type="radio"/>
e Blood Vessels / Circulation Disorders (Varicose / Spider Veins, Arteries, Lymph System, Edema / Swelling)	<input type="radio"/>	<input type="radio"/>	s Headaches (Migraines, Stress, Muscle Tension)	<input type="radio"/>	<input type="radio"/>	gg Prosthetic Implants or Devices (Breast, Joint, Eye, Tendon)	<input type="radio"/>	<input type="radio"/>
f Bone, Joint [Knee, Shoulder, etc.] (Arthritis, Bursitis, Tendonitis, TMJ, Carpal Tunnel Syndrome, Bunions)	<input type="radio"/>	<input type="radio"/>	t Heart Conditions of Any Kind, Chest Pain/Pressure, Pacemaker, Heart Murmur, Arrhythmia (Irregular Heart Beat)	<input type="radio"/>	<input type="radio"/>	hh Psychiatric or Psychological Treatment or Counseling	<input type="radio"/>	<input type="radio"/>
g Brain / Head (Concussion, Injury, Tumor)	<input type="radio"/>	<input type="radio"/>	u Hernia [Circle Type and State Site] (Hiatal, Umbilical, Inguinal, Ventral) Site: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="radio"/>	<input type="radio"/>	ii Reconstructive Surgery (Plastic, Cosmetic, Restorative)	<input type="radio"/>	<input type="radio"/>
h Breast [Male or Female] (Fibrocystic, Lumps, Nodules, Discharge, Abnormal Mammogram)	<input type="radio"/>	<input type="radio"/>	v High Blood Pressure	<input type="radio"/>	<input type="radio"/>	jj Sexually Transmitted Diseases (HPV / Genital Warts, Genital Herpes, Chlamydia, Gonorrhea)	<input type="radio"/>	<input type="radio"/>
i Elevated Cholesterol, Triglycerides	<input type="radio"/>	<input type="radio"/>	w Hormonal / Endocrine (Thyroid [Nodule /Goiter], Pituitary, Adrenal Gland)	<input type="radio"/>	<input type="radio"/>	kk Skin (Lesions, Discoloration, Lumps, Scleroderma, Psoriasis, Cancer [Melanoma, Basal Cell, Squamous])	<input type="radio"/>	<input type="radio"/>
j Convulsions (Epilepsy, Seizure Disorder, Febrile Seizure)	<input type="radio"/>	<input type="radio"/>	x Illicit Drug Use or Abuse / Other Drug Abuse	<input type="radio"/>	<input type="radio"/>	ll Steroid Use (Anabolic, Prednisone, Decadron, Cortisone Injection)	<input type="radio"/>	<input type="radio"/>
k Developmental / Cognitive / Motor / Speech Delay	<input type="radio"/>	<input type="radio"/>	y Immune System / Inflammatory Disorder (Lupus Erythematosus, Gamma Globulin Deficiency, Gout)	<input type="radio"/>	<input type="radio"/>	mm Stroke / Transient Ischemic Attacks (TIA)	<input type="radio"/>	<input type="radio"/>
l Diabetes, Abnormal Glucose (High or Low)	<input type="radio"/>	<input type="radio"/>	z Kidney / Urinary Tract / Bladder (Stones, Infection, Blood in Urine, Incontinence)	<input type="radio"/>	<input type="radio"/>	nn Benign Tumors, Cysts, Polyps, Growths, Plantar Warts	<input type="radio"/>	<input type="radio"/>
m Ear, Nose, Throat (Otitis / Infection, Tubes, Hearing Problems, Tonsillitis, Deviated Nasal Septum)	<input type="radio"/>	<input type="radio"/>	aa Liver (Cirrhosis, Hepatitis [State Type: _____], Elevated Liver Enzymes)	<input type="radio"/>	<input type="radio"/>	oo Ulcers (Skin, Stomach, Intestine, Eye)	<input type="radio"/>	<input type="radio"/>
n Eating Disorders (Anorexia, Bulimia)	<input type="radio"/>	<input type="radio"/>	bb Lungs (Asthma, Bronchitis, Emphysema/ COPD, Pneumonia, Reactive Airway Disease, Recurrent Cough / Wheeze, Sleep Apnea)	<input type="radio"/>	<input type="radio"/>	pp Weight Problems, Gastric Bypass, Recent Weight Loss or Gain	<input type="radio"/>	<input type="radio"/>

IN THE PAST 10 YEARS:	YES	NO
2 Has surgery (major or minor, cosmetic or non-cosmetic, inpatient or outpatient) been performed on any applicant?	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>
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)?	<input type="radio"/>	<input type="radio"/>
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?	<input type="radio"/>	<input type="radio"/>

APPLICANT'S NAME _____

APPLICANT'S SSN _____

(For child-only applications, enter the parent or legal guardian's name)

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.**

THE COST OF OBTAINING MEDICAL RECORDS IS THE RESPONSIBILITY OF THE APPLICANT.

LAST NAME				FIRST				QUESTION # OR LETTER
ONSET DATE M M Y Y Y Y				Description, i.e. symptoms, diagnosis, condition, illness				
END DATE M M Y Y Y Y				Types of Treatment, Testing, Monitoring, Surgery, or Medication				
ONGOING SYMPTOMS/TREATMENTS? YES <input type="radio"/> NO <input type="radio"/>				Name and Addresses of Past and Present Physicians, Hospitals, etc.				

LAST NAME				FIRST				QUESTION # OR LETTER
ONSET DATE M M Y Y Y Y				Description, i.e. symptoms, diagnosis, condition, illness				
END DATE M M Y Y Y Y				Types of Treatment, Testing, Monitoring, Surgery, or Medication				
ONGOING SYMPTOMS/TREATMENTS? YES <input type="radio"/> NO <input type="radio"/>				Name and Addresses of Past and Present Physicians, Hospitals, etc.				

LAST NAME				FIRST				QUESTION # OR LETTER
ONSET DATE M M Y Y Y Y				Description, i.e. symptoms, diagnosis, condition, illness				
END DATE M M Y Y Y Y				Types of Treatment, Testing, Monitoring, Surgery, or Medication				
ONGOING SYMPTOMS/TREATMENTS? YES <input type="radio"/> NO <input type="radio"/>				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)

LAST NAME	FIRST	QUESTION # OR LETTER		
<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="text-align:center;">ONSET DATE</td></tr> <tr><td style="text-align:center;">M M Y Y Y Y</td></tr> </table>	ONSET DATE	M M Y Y Y Y	Description, i.e. symptoms, diagnosis, condition, illness	
ONSET DATE				
M M Y Y Y Y				
<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="text-align:center;">END DATE</td></tr> <tr><td style="text-align:center;">M M Y Y Y Y</td></tr> </table>	END DATE	M M Y Y Y Y	Types of Treatment, Testing, Monitoring, Surgery, or Medication	
END DATE				
M M Y Y Y Y				
<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="text-align:center;">ONGOING SYMPTOMS/TREATMENTS?</td></tr> <tr><td style="text-align:center;">YES <input type="radio"/> NO <input type="radio"/></td></tr> </table>	ONGOING SYMPTOMS/TREATMENTS?	YES <input type="radio"/> NO <input type="radio"/>	Name and Addresses of Past and Present Physicians, Hospitals, etc.	
ONGOING SYMPTOMS/TREATMENTS?				
YES <input type="radio"/> NO <input type="radio"/>				

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

	YES	NO
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

NAME	NO. TIMES?	STATE	DATE	STATE	DATE
M M Y Y Y Y	M M Y Y Y Y	M M Y Y Y Y	M M Y Y Y Y	M M Y Y Y Y	M M Y Y Y Y

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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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		
<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="text-align:center;">ONSET DATE</td></tr> <tr><td style="text-align:center;">M M Y Y Y Y</td></tr> </table>	ONSET DATE	M M Y Y Y Y	Description, i.e. symptoms, diagnosis, condition, illness	
ONSET DATE				
M M Y Y Y Y				
<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="text-align:center;">END DATE</td></tr> <tr><td style="text-align:center;">M M Y Y Y Y</td></tr> </table>	END DATE	M M Y Y Y Y	Types of Treatment, Testing, Monitoring, Surgery, or Medication	
END DATE				
M M Y Y Y Y				
<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="text-align:center;">ONGOING SYMPTOMS/TREATMENTS?</td></tr> <tr><td style="text-align:center;">YES <input type="radio"/> NO <input type="radio"/></td></tr> </table>	ONGOING SYMPTOMS/TREATMENTS?	YES <input type="radio"/> NO <input type="radio"/>	Name and Addresses of Past and Present Physicians, Hospitals, etc.	
ONGOING SYMPTOMS/TREATMENTS?				
YES <input type="radio"/> NO <input type="radio"/>				

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?
Please list all medications being taken (regularly or as needed). Use extra paper if needed.

YES NO

NAME OF PERSON	NAME OF DRUG	REASON FOR TAKING	DATE OF LAST REFILL
			M M Y Y Y Y
			M M Y Y Y Y
			M M Y Y Y Y
			M M Y Y Y Y
			M M Y Y Y Y

11 Is any male or female applicant applying for coverage currently an expectant parent?
If yes, the applicant(s) expecting a child are not eligible for coverage *at this time*.

YES NO

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?	DATE OF LAST PERIOD
	YES <input type="radio"/> NO <input type="radio"/>	YES <input type="radio"/> NO <input type="radio"/>	M M Y Y Y Y

If no, explain: _____

NAME	DO YOU MENSTRUATE?	PERIOD IN LAST 30 DAYS?	DATE OF LAST PERIOD
	YES <input type="radio"/> NO <input type="radio"/>	YES <input type="radio"/> NO <input type="radio"/>	M M Y Y Y Y

If no, explain: _____

NAME	DO YOU MENSTRUATE?	PERIOD IN LAST 30 DAYS?	DATE OF LAST PERIOD
	YES <input type="radio"/> NO <input type="radio"/>	YES <input type="radio"/> NO <input type="radio"/>	M M Y Y Y Y

If no, explain: _____

IMPORTANT: If any menstruating females listed on this application miss 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 questions 1-12 is not completed, this application will be returned to the applicant, resulting in processing delays.

13 Have you or any member of your family applying for coverage ever had BCBSAZ insurance before?

YES NO

LAST NAME	FIRST	DATE (YEAR TO YEAR)
		Y Y Y Y TO Y Y Y Y
ID NUMBER	CITY	STATE

14 Is any applicant currently receiving any type of physical or mental disability insurance benefits?
If any applicant has been determined to be 100% disabled, that person is not eligible for coverage.

YES NO

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

Table with columns: NAME, TYPE OF INSURANCE, DATE (M M Y Y Y Y), INSURANCE COMPANY, REASON

Table with columns: NAME, TYPE OF INSURANCE, DATE (M M Y Y Y Y), INSURANCE COMPANY, REASON

16 IF APPLYING FOR BlueSelect: Do any dependents (including those attending school) listed on this application live in a county that is different than the one indicated for the contract holder? If yes, list dependent's name and county of residence below.

YES NO

Table with columns: NAME, COUNTY

17 Are any dependents listed on this application full time students age 19-25? If yes, list below. (Please note that children over age 19 who are not students are not eligible for coverage on BluePreferred or BlueClassic as dependents.)

YES NO

Table with columns: NAME, SCHOOL NAME, CITY, STATE, EXPECTED DATE OF GRADUATION (M M Y Y Y Y)

18 Is contract holder or any dependents listed on this application eligible for Medicare benefits? If yes, that person is not eligible for this coverage.

YES NO

Table with columns: NAME OF PERSON (S) RECEIVING MEDICARE

19 Will this coverage for which you are applying replace any other coverage you have? NO YES - Temporary Coverage (E.G. Option One) YES - Other (Specify):

If this coverage will replace current BCBSAZ group or any current coverage from another Blue Cross Blue Shield plan, you may be eligible for conversion coverage. Conversion coverage does not require medical underwriting, but is 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.

20 If your insurance is expiring, what is the expiration date? [M M D D Y Y Y Y]

IMPORTANT: UNTIL THIS APPLICATION IS APPROVED, DO NOT CANCEL ANY INSURANCE YOU MAY HAVE. PLEASE MAKE SURE YOU SIGN 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**

- A. I have carefully read all of this application and understand its terms and conditions. On behalf of myself and the persons listed on this application, I hereby apply for enrollment subject to all of its terms and conditions. I also 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 CareAmerica Life Insurance Company (CareAmerica Life).
- B. I acknowledge and agree that coverage shall become effective only when a) this application has been accepted by BCBSAZ and/or CareAmerica Life, after its review of the health history I have furnished, and b) a contract has been issued by BCBSAZ and/or CareAmerica Life. Such contract, if issued, shall have an effective date assigned by the Corporation and its coverage shall be subject to its own waiting periods, limitations, medical waivers and other provisions, regardless of any prior coverage.
- C. I acknowledge that the information I have provided on this application is material to the medical underwriting process and that BCBSAZ will rely on the accuracy of such information to make a determination about each applicant's eligibility for coverage.

I represent that, to the best of my knowledge, the information provided on this application is complete and accurate. I understand that if I have misstated or omitted any information on this application, any contract issued covering me and my dependents may be rescinded, that is, declared null and void as of the effective date of coverage, and that such misstatement or omission may subject me to criminal or civil penalties. I also understand that failure to cooperate with an investigation concerning information disclosed or omitted on this application will result in rescission of the contract.

I understand and acknowledge that I alone am responsible for any information stated or omitted on this application, regardless of whether any other person advised me or assisted me in filling out this application, or if they filled out some or all of the application for me.

I further understand that, in the event of rescission, BCBSAZ will seek reimbursement for claims or expenses paid on my behalf and/or on behalf of my dependents. The amount of the paid claims or expenses will be deducted from the premium refund due to me, if any. If the amount of paid claims or expenses exceed the premiums paid, BCBSAZ will seek payment from me for the difference. I understand I may be responsible to pay reasonable attorney's fees and court costs BCBSAZ may incur in collecting amounts due under this contract.

- D. BCBSAZ, CareAmerica Life, its reinsurers, and their authorized representatives may obtain medical information in order to evaluate this application. Any cost for obtaining medical records is the responsibility of the applicant. Personal information may be collected from someone other than myself, or one of the proposed covered persons.

If you are applying for child-only coverage:

- E. On behalf of the named child(ren), I hereby apply for enrollment subject to all of the contract terms and conditions. I understand that if this application is accepted by BCBSAZ and/or CareAmerica Life, I will be the contract holder on behalf of the child(ren) named on this application. I also understand that this application becomes part of any contract issued by BCBSAZ and/or CareAmerica Life on behalf of the named child(ren). I further understand that, in the event of rescission, BCBSAZ will seek reimbursement from the contract holder for claims paid on behalf of the child(ren).
- F. BCBSAZ will not disclose confidential information from the child's file without the contract holder's specific written consent, or when applicable, the consent of the child(ren), except as permitted by applicable law. **I understand that both parents are entitled to have equal access to medical and other records of a child directly from the custodian of the records, unless otherwise provided by court order or law, and a copy of such court order or law has been provided to BCBSAZ (A.R.S. § 25-403, 25-408).**

FOR QUESTIONS ABOUT THIS APPLICATION, please call your broker at:

TO AUTHORIZE ANOTHER TO HAVE ACCESS TO YOUR PERSONAL INFORMATION, a Confidential Information Request form must be completed.

ADDITIONAL FORMS are available from your broker.

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 and Authorization to Obtain and Disclose Information is available to you or your authorized representative upon request.

Individual/Family Coverage Signatures(s)

Date

Contract holder X _____
X _____
X _____
X _____
X _____

M	M	D	D	Y	Y	Y	Y
M	M	D	D	Y	Y	Y	Y
M	M	D	D	Y	Y	Y	Y
M	M	D	D	Y	Y	Y	Y
M	M	D	D	Y	Y	Y	Y

Child-only Coverage Signature(s)

Date

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

Relationship _____

X _____
(Co-parent or legal guardian*)

Relationship _____

M	M	D	D	Y	Y	Y	Y
M	M	D	D	Y	Y	Y	Y

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.

Note: This application must be received by BCBSAZ within 15 days from the date of applicant's signature(s) and will become VOID 90 days from that date, requiring submission of a new, updated 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, the application will be returned to applicant, resulting in processing delays.
- 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 application. Don't forget to attach a voided check.
- If you are applying for the optional life term life insurance, be sure to complete the attached Disclosure Authorization form.
- 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 coverage change, adding a dependent or lowering your deductible, the \$20 application fee is not necessary.)
- Please return this application to: ATTN:



An Independent Licensee of the Blue Cross and Blue Shield Association

Disclosure Authorization Form

(To authorize BCBSAZ to disclose your information to CSA Marketing Resources, 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 on 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 Marketing Resources, Inc., an entity which performs administration on behalf of life insurance carriers. The purpose of the disclosure is to allow both CSA Marketing Resources, 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 on 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.**

SURE PAY AUTHORIZATION FORM

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 form. Mail it to us, along with a voided blank check, and 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.

Complete and sign form, then mail to:
Enrollment Services, Blue Cross Blue Shield of Arizona
P.O. Box 13466, Phoenix, AZ 85002-3466

Person to be billed:

_____ Last name	_____ First	_____ Initial	
_____ Address	_____ City	_____ State	_____ ZIP code
_____ Social Security No.	_____ Daytime phone		

Pay your premiums the convenient way with Sure Pay!

Please debit my: Checking account Savings account

_____ Financial institution	_____ Account number		
_____ Address	_____ City	_____ State	_____ ZIP code
_____ Authorized signature(s) on account	_____ Date		
_____ Authorized signature(s) on account	_____ Date		

If applicant is different from person to be billed, provide information on applicant below:

_____ Name	_____ Social Security No.
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Important: Remember to sign the authorization below and attach a blank check marked "void."

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

I want this charge to continue automatically until I write Blue Cross Blue Shield of Arizona telling them to discontinue my Sure Pay service. I agree to allow them reasonable time (usually 15 days) to do so.

I understand Blue Cross Blue Shield of Arizona 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 Blue Cross Blue Shield of Arizona 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.

Signature

Date