

Association Benefits

Application Instructions For Blue Cross Blue Shield Texas

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Association Benefits for review along with the completed application. If you do not have access to a fax machine, send the completed application to Association Benefits along with the \$30 non refundable application fee.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Blue Cross Blue Shield Texas** if you are not paying by credit card.

Mail completed application and check to:

Association Benefits
Attn: New Enrollment
9330 LBJ Frwy
Suite 900
Dallas, TX 75243

Association Benefits will review your application for completeness and accuracy before we submit it to Blue Cross Blue Shield Texas for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at (888)479-2112 or e-mail us at info@txrealmed.com.

Association Benefits

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

Association Benefits

FAX# 214-341-9942

Dear Association Benefits,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

I will contact Association Benefits at (888)479-2112 to verify receipt of my application.

****I understand that Association Benefits will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Association Benefits. I will mail the original signed application to :

Association Benefits

Attn: New Enrollment

9330 LBJ Frwy

Suite 900

Dallas, TX 75243

I will send the original application as soon as I have been contacted by Association Benefits with confirmation that my application has been received by fax and reviewed for completeness.

Signature: _____

Date: _____



Prem: _____ Fee: _____ For Home Office Use

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 Primary Applicant.
• If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information.

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

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

In addition to having a permanent residence in Texas, all persons applying for coverage must be a United States citizen, or if not a citizen, must be able to provide medical records from a licensed U. S. Physician, including but not limited to, a health evaluation conducted within the past two years.

PRIMARY APPLICANT

Form with fields for First Name, Middle Initial, Last Name, Social Security #, Sex, Age, Date of Birth, Height, Weight, Home Phone, Business Phone, Fax, Occupation/Duties, Spouse's Business #, Residence Street Address, City/State/ZIP, County, Email, and Best place and time to call.

Spouse and dependent CHILDREN you wish to cover (dependent children must be under age 25 and unmarried).

If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)? [] Yes [] No

Table with 10 columns: Name (First, Middle Initial, Last), Relation (spouse or child), Sex, Height (ft., in.), Weight (lbs.), Date of Birth (mo/day/yr), Social Security Number, Court Ordered for Dependents.

Is any Dependent coverage required by court order? [] Yes [] No If "yes," was it effective within the last 30 days? [] Yes [] No

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

PPO Select Blue Advantage

Deductible Plan: I [] \$250 II [] \$500 III [] \$1,000 IV [] \$1,500 V [] \$2,500 VI [] \$3,500 VII [] \$5,000 VIII [] \$10,000

PPO Select Saver

Deductible Plan: I [] \$500 II [] \$1,000 III [] \$1,500 IV [] \$2,500 V [] \$3,500 VI [] \$5,000 VII [] \$10,000

PPO Select Choice

Deductible Plan: I [] \$250 II [] \$500 III [] \$1,000 IV [] \$1,500 V [] \$2,500 VI [] \$3,500 VII [] \$5,000 VIII [] \$10,000

DENTAL INSURANCE COVERAGE I (We) hereby apply for Dental coverage and understand that all Applicants and Dependents approved for health coverage will be covered under the Dental coverage.

SECTION C - PAYOR AND BILLING INFORMATION

Requested Effective Date (mo./day/yr.) _____

Premium Mode: [] Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip) [] Monthly Direct Bill [] Two Month Direct Bill [] Quarterly Direct Bill [] List Bill Monthly (Available for two or more applicants billed at the same address)

A \$30.00 NONREFUNDABLE Application Fee must be submitted with completed application. Please make check payable to Blue Cross and Blue Shield of Texas.

Payor of premium (if different than applicant)

Will your employer be contributing towards the premium for this policy? [] Yes [] No

Table with 2 columns: Application Fee \$30.00, Premium (if enclosed) \$, TOTAL enclosed \$

Name: _____ Address/City/State/ZIP: _____ DOB: _____ SSN: _____

PART TWO – EVIDENCE OF INSURABILITY

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

SECTION A – HEALTH HISTORY/MEDICAL QUESTIONS

Please Complete the Following Health Questions: For this insurance to be in force, you must answer the following health questions fully and truthfully and provide all of the health information asked for, including routine physical examinations, and Blue Cross and Blue Shield of Texas must approve this application. No one may change this requirement for you in any way. If you commit fraud or intentionally misrepresent any information required on any enrollment form, your coverage may later be rescinded. Rescission voids your coverage from the effective date, and any premiums already paid (less any benefits paid) will be refunded. **Please do not mark over or strike out any signature, date or health question information. Important! Do not cancel any existing health or life coverage until notified of your acceptance.**

If you answer "Yes" to ANY questions on this page, please give details on the next page. Please note the timeframe reference for each question.

- 1. Has any person applying for coverage been advised to seek treatment for alcohol use or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism within the last **10 years**? Yes No
- 2. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use or dependency within the last **10 years**? Yes No
- 3. 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: Please check Yes or No. If any boxes are checked "Yes" (Yes), also circle the condition, e.g. (**migraines**) and give details on the next page.

- | | |
|--|---|
| <ul style="list-style-type: none"> A. Migraines; headaches; carpal tunnel syndrome; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to HBP, provide 3 readings and their dates w/in the last year _____ and _____ and _____ D. Varicose veins/spider veins/varicosities; elevated cholesterol or lipids; anemia; blood clot or any other blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No G. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? (indicate type of hepatitis _____) <input type="checkbox"/> Yes <input type="checkbox"/> No H. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? (indicate diagnosis and location _____) <input type="checkbox"/> Yes <input type="checkbox"/> No I. Acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other skin disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No | <ul style="list-style-type: none"> J. Kidney stones; reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? <input type="checkbox"/> Yes <input type="checkbox"/> No K. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? <input type="checkbox"/> Yes <input type="checkbox"/> 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; bunions; joint replacement; or manipulation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No M. Thyroid disorder; goiter; Graves disease; diabetes; lupus; pituitary or adrenal disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No N. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No O. Has anyone applying for coverage ever been diagnosed as having or told by a medical doctor that you have AIDS, HIV, or ARC disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No P. Have you or any person applying for coverage ever been tested positive for antibodies for the AIDS virus? <input type="checkbox"/> Yes <input type="checkbox"/> No Q. Has any person applying been diagnosed by a member of the medical profession as having AIDS and/or has any proposed insured received treatment from a member of the medical profession for AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No R. Questions for Male Applicants and Dependents 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? <input type="checkbox"/> Yes <input type="checkbox"/> No S. Questions for Female Applicants and Dependents Only Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? <input type="checkbox"/> Yes <input type="checkbox"/> 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 medications due to sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss in the last **12 months**? Yes No
- 6. Have you, your spouse (if to be insured), or any child (to be insured) smoked or used any tobacco products – such as cigarettes, pipes, cigars, snuff or chewing tobacco – in the last **12 months**? YOU Yes No YOUR SPOUSE Yes No YOUR CHILD Yes No. If Yes, Name _____
- 7. A. **Question for Female Applicants and Dependents Only:** Is any female applying for coverage now pregnant? Yes No
B. **Question for Male Applicants and Dependents Only:** Is any male applying for coverage now an expectant parent? Yes No
If "Yes" to either question, coverage cannot be offered.
- 8. Does any person applying for coverage **have or ever had** and 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 treatment, testing, counseling, therapy, 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 on this page? Yes No
- 11. Is each person applying for coverage a permanent resident of Texas, except for court-ordered Dependents? Yes No

PART TWO – CONTINUED

SECTION B – DETAILS OF HEALTH HISTORY

If you answered “Yes” to ANY questions on the previous page, please provide further information using the chart below. Be sure to use the “correct” example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

	Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment, Advice Given, and Medications Prescribed	Name, Address and Phone Number of Doctors and Hospitals
			What is it?	Date that is Started	Date of Recovery (if applicable)			
Correct Example:	3C	Joe Smith	high blood pressure	6/95	none	no, ongoing	40mg Atenolol once	Dr. Jones St. Mary's Peoria, IL (309) 555-1212

Previous Coverage Information In order to receive credit for pre-existing condition waiting periods, you must provide coverage information for the last 18 months for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this application. (If more than one plan was in effect, attach additional pages.)

Name of Policyholder	Date of Birth / /	<input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Applicant <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	Group or Policy Number	ID Number
Employer's Name Name and address of other insurance company, TPA, HMO	Employment Date ___/___/___ Effective Date ___/___/___ Will coverage be continued? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," Expected Cancel Date ___/___/___	Type of Coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Employer-Sponsored OR <input type="checkbox"/> Individual Purchase		Type of Policy <input type="checkbox"/> Self <input type="checkbox"/> Family <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child	

Replacement of Coverage Will this insurance replace any health insurance currently in force? Yes No
If “Yes,” read the statement below and complete the following:

List all coverage that will be replaced

Insured	Name of Company	Policy Number	Termination Date

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

If “Yes” is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Blue Cross and Blue Shield of Texas. 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 contract.

1. Health conditions which you may presently have may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. 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 contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning the medical/health history of any person applying for coverage. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Blue Cross and Blue Shield of Texas.

Acknowledgements: The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows: **1.** This application does not provide coverage of any kind unless approval is provided by Blue Cross and Blue Shield of Texas (the Company); and the application, if not previously approved or declined, will be considered with drawn on the 60th day after its date. **2.** Medical expense coverage will not be available until the effective date of the health contract and payment, in full, of the first month's premium. **3.** The medical expense benefits applied for and if issued, shall not cover any illness, accident, or physical impairment which existed or occurred prior to the effective date of the Applicant's coverage until the Applicant shall have held coverage under the contract for a period of 12 months if PPO Select Saver or PPO Select Choice is selected, or 18 months if PPO Select Blue Advantage is selected. **4.** No agent can accept risks or modify policies or requirement of the Company. **5.** The Company is not bound by any statement not written in this application. **6.** If a spouse is included for medical expense coverage, the premium will be calculated based on the age of each adult. **7.** Fraud or any intentional misrepresentation of a material fact may result in rescission of coverage or denial of a claim under the terms of the policy.

Agreement: I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following underwriting approval and payment in full of the first months premium and receipt and acceptance by the Company of any required Amendatory Endorsement and/or Coverage Exclusion Rider, if applicable. The undersigned Applicant and agent acknowledge that the Applicant has read the completed application and that he/she realizes that any false statement material to the risk or misrepresentations therein may result in loss of coverage under the policy.

Medical Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

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 and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Signatures: I acknowledge receipt of the Required Outline of Coverage and I certify that:

- 1.** Premiums are being paid by me as a personal expense. **2.** My employer is not contributing to any part of the premium, either directly or through reimbursement. **3.** Since my employer does not sponsor an employee health plan, neither my employer nor I deduct any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code.

The Patient Protection Act Disclosure Statement will be provided upon request. (Also available at www.bcbstx.com)

Important: Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant's* Signature: _____ Date Signed: _____

Spouse's signature (ONLY if to be insured): _____ Date Signed: _____

*Parent/Guardian Signature (if Primary Applicant is a Minor): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the Required Outline of Coverage, and if requested, Patient Protection Act Disclosure Statement.

Policy(ies) should be mailed to Agent Applicant

Agent Agency # 000017444 _____ % _____
BCBSTX Assigned Agent # percent Tax I.D.

Agent Agency # _____ % _____
BCBSTX Assigned Agent # percent Tax I.D.

Please PRINT Name Joe Collins

Please PRINT Name _____

Address 9330 LBJ Frwy, Suite 900, Dallas, TX 75243

Address _____

City, State, Zip Dallas, TX 75243

City, State, Zip _____

Phone (888) 479-2112 Fax (214) 341-9942

Phone (____) _____ Fax (____) _____

Signature _____ Date _____

Signature _____ Date _____

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor 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 meetings. 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.

Primary Applicant's Signature: **X** _____

Print Your Name as You Signed It: _____ Date Signed: _____ / _____ / _____

FC849a7/83 REV. 0203

Automatic Premium Payment Program

Authorization Agreement



Take these 3 simple steps to hassle-free monthly premium payments

- Complete and sign this authorization agreement.
- Verify with your financial institution that they can accept automated electronic withdrawals.
- Return this authorization and a blank check marked VOID for the account from which funds are to be withdrawn to:

Blue Cross and Blue Shield of Texas
 P.O. Box 833819
 Richardson, Texas 75083-3819

AGREEMENT

I, as account holder, hereby authorize Blue Cross and Blue Shield of Texas (BCBSTX) to initiate withdrawals on a monthly basis from my account at the financial institution named in this authorization for payment of monthly insurance premium due for the named policyholder; and, I authorize the financial institution to charge such withdrawals to my account. A draft shall be drawn each month on or about the premium due date of the policy/contract. As the account holder, by signing below, I also certify, in the event that this draft is being drawn from a company checking account, that I am authorized to approve this transaction, that the company is not paying any portion of the premium for this subscriber, either directly, or through reimbursement, and that the employer/company is not deducting any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code. I understand that both the financial institution and BCBSTX reserve the right to terminate this payment program and/or my participation therein. I also understand that I may discontinue this payment program, (except on individual temporary contracts) at any time with at least 10 days advance notice to BCBSTX by telephone prior to a scheduled withdrawal date.

As policyholder, I am authorizing my insurance premium due be paid as described in this agreement and agree that if any withdrawal is dishonored, the premium payment for such withdrawal will be considered in default. I also authorize, as policyholder, the disclosure of my policy identification/group numbers and any other necessary personal information on the financial institution's statements to identify to the account holder named for whom withdrawals are being made.

Please complete the following • Print or Type information

___ Yes, I elect to have my insurance premium paid monthly thru the Automatic Premium Payment Program.

Policyholder: Name _____

Group Number _____ Subscriber Number _____

Daytime Phone Number _____

Address _____

Accountholder: Name(s) _____

Daytime Phone Number _____ *As shown on Account Records*

Home Address _____

Full Name of Financial Institution _____

Account Number _____

I have read and accept the above agreement.

Policyholder Signature _____

Accountholder Signature(s) (if different from the Policyholder) _____

As accepted by Financial Institution

