Do not staple or tear.

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.

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 H I L L S T

- 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.

An Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross Blue Shield of Arizona Individual Application

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

BluePreferred PPO	BluePreferred Basic PPO	BluePreferred Saver PPO	BlueSelect HMO	BlueClassic Indemnity	BlueClassic Saver Indemnity
◯ $250 ◯ $500 ◯ $1,000 ◯ $2,500 ◯ $5,000	◯ $2,500 ◯ $5,000 ◯ $10,000	◯ $1,500/100% ◯ $2,600/100% ◯ $5,000/100%	◯ PLAN 2 ◯ PLAN 3	◯ $250 ◯ $500 ◯ $750 ◯ $1,250 ◯ $2,500 ◯ $5,000	◯ $5,000

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 - 31st, 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
HOPE 4 ALL INC
4734 E 27TH ST
TUCSON, AZ 85711-6411 (520) 318-4800

BROKER # 06859

◯

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

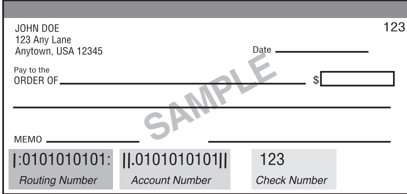
IF YOU WANT YOUR BILL MAILED TO A DIFFERENT ADDRESS, COMPLETE THIS SECTION

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

OPTIONAL: INDICATE TERM LIFE INSURANCE FOR WHICH YOU ARE APPLYING. PLEASE COMPLETE THE ATTACHED LIFE INSURANCE AUTHORIZATION FORM, IF YOU ARE APPLYING FOR TERM LIFE INSURANCE UNDERWRITTEN BY FORT DEARBORN LIFE INSURANCE COMPANY.

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

BROKER STATEMENT

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

BROKER SIGNATURE X____

Fort Dearborn Life Insurance Company is an independent company and is not affiliated in any way with BCBSAZ. Life and disability plans 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.)

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.

10 Are any medications being taken by any applicant?
List all medications being taken (regularly or as needed). Use extra paper if needed, and check here ☐

YES ◯ NO ◯

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?**
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?
	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 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

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 Blue Preferred, BluePreferred Saver, BluePreferred Basic BlueClassic or BlueClassic Saver 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 a BlueSelect plan

There is no pre-existing condition waiting period. BlueSelect does 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.

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. A standard commission is a percentage of the premium paid by the subscriber. 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. The commission rate varies by the number of months a contract is in effect. Certain brokers with a high volume of BCBSAZ individual contracts and sales of new contracts receive a different standard commission rate. Your broker is required under the agreement with BCBSAZ to give you information on his/her commission rate with BCBSAZ. Licensed Inside Sales Representatives receive a flat-rate, one-time payment for sales of BCBSAZ individual products. Additional information about broker commissions and BCBSAZ employee sales compensation 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.

For questions about this application, Please call your broker.

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.

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 Signatures(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.
- ☐ **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: HOPE 4 ALL INC
4734 E 27TH ST
TUCSON, AZ 85711-6411 (520) 318-4800

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Instructions for Completing Confidential Information Release Form

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 us.
- 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 About Whom the Above Information Relates: Enter the name of whose information should be disclosed. This will normally be your name.

Entities Receiving Information: Tell us with whom you want us to share your information.

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

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 your information)

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, Arizona 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 About Whom the Above Information Relates: ____________________

Entities Receiving Information: I authorize BCBSAZ to disclose the above information to:

Name: ____________________

Company Name: ____________________

Address: ____________________

City, State, Zip code ____________________

Purpose of Use/Disclosure: I authorize BCBSAZ to use and/or disclose the above information for the following purpose:

☐ To assist with obtaining a health care policy ☐ To assist with claims processing and/or payments
☐ For any requested reason ☐ Other Purpose of Use/Disclosure ____________________

____

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, C105, BCBSAZ, 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

____________________ ____________________
Group Name (if applicable) Group Number (if applicable)

____________________ ____________________
Personal Representative's Name* Relationship to Individual

____________________ ____________________
Personal Representative's Signature Date

*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.

Life Insurance Authorization Form

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

An Independent Licensee of the Blue Cross and Blue Shield Association

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.

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