FOR AGENT USE ONLY (Please print legibly)

Agency Code _____ _____ _____ _____

Agent Number _____ _____ _____ _____

Agent Name _____

Simply Blue℠ or GoBlue℠

Individual Health Contract Application

A Reason for Application

☐ I am a new applicant, not currently a Blue Cross and Blue Shield of Minnesota (Blue Cross) member

☐ I have a Simply Blue or GoBlue contract and I am applying for a lower deductible — Blue Cross ID # _____

☐ I have other Blue Cross coverage and I am applying for Simply Blue or GoBlue — Blue Cross ID # _____

Application instructions

1. Please complete this entire application including all explanations as requested. Print clearly using black or blue ink. Incomplete applications will be returned to you to be completed. This may affect the date your coverage starts.
2. Sign and date this application. This application must be received at the home office of Blue Cross within 15 days of your signature date.
3. Submit this application with one month's premium to Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, MN 55164. If paying by check make it payable to Blue Cross and Blue Shield of Minnesota. Your payment will be refunded if this application is not approved.

General application information

- You must be a resident of Minnesota.
- You must be age 19 through age 64 to apply.
- **This is single coverage only; no dependents can be added to the contract.**
- **These plans provide benefits for prenatal care only and do not cover maternity-related services.**
- Your premium may be different if: there is a change to the effective date; your age has changed; you agree to a plan modification; rates change.
- This is an individual plan. If approved, coverage will be provided under an individual contract. Blue Cross does not issue individual coverage through any arrangement with an employer.

After you submit your application

- You may be contacted from Blue Cross for additional information. For example, Blue Cross may ask you to complete an authorization to release medical records from your clinic/hospital or call you for additional information.
- The application process generally takes 1 – 3 weeks unless there is a delay in receiving your medical records.
- You will be notified by mail if your application is approved or not approved.

How to contact us

- Please contact your agent for assistance or call 651-662-5050 or toll-free 1-800-262-0823 and one of our Blue Cross representatives will be happy to assist you.

Blue Cross® and Blue Shield® of Minnesota is a nonprofit independent licensee of the Blue Cross and Blue Shield Association.

F9738 (07/10)

B Applicant information

Name _____
FIRST LAST

Social Security Number _____ Occupation _____

Birth date _____ Sex ☐ Male ☐ Female Marital Status ☐ Single ☐ Married
mm dd yyyy

Applicant address _____ Email address _____
STREET including APT#

City _____ State _____ Zip _____

Preferred telephone number ( ) _____ Alternate telephone number ( ) _____

Tobacco use:

I have used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application ☐ Yes ☐ No

C Plan selection - I am applying for one of the following calendar year deductible plans with Accord network:

Simply Blue:	GoBlue:
☐ $3,000 deductible with 100% coinsurance	☐ $4,000 deductible with 100% coinsurance
☐ $6,000 deductible with 100% coinsurance	☐ $5,500 deductible with 100% coinsurance
☐ $9,000 deductible with 100% coinsurance	☐ $7,500 deductible with 100% coinsurance
Drug benefit (select one with the Simply Blue plan):	☐ $10,000 deductible with 100% coinsurance
☐ $5 generic copay ☐ $10 generic copay	

The deductibles, copays and out-of-pocket maximums are subject to annual adjustments on the annual renewal date. These adjustments are based on the medical care component of the Consumer Price Index (CPI) published by the U.S. Department of Labor.

COVERAGE FOR SUBSTANCE ABUSE IS INCLUDED IN THE CONTRACT. I WANT TO DECLINE COVERAGE FOR THIS BENEFIT, WHICH WILL RESULT IN A PREMIUM REDUCTION: ☐ Yes ☐ No

D Payment selection

Choose your preferred payment option: ☐ Monthly automatic withdrawal (Pay-O-Matic); or Bill me: ☐ Quarterly ☐ Semiannually ☐ Annually

A minimum of one month's premium must accompany this application. Amount paid with this application $ _____. If paying by check, please make your check payable to Blue Cross and Blue Shield of Minnesota.

E Effective date of coverage

Have you completed an application for a Blue Cross short-term InstaCare contract to precede this coverage? ☐ Yes ☐ No

If **Yes**, please leave the requested effective date blank. We cannot process this application if the termination date of the InstaCare contract is greater than 60 days beyond your signature date on this application.

If approved, coverage will be effective as of:

- the date that coincides with the termination date of the InstaCare contract if you have applied for InstaCare and we have received this completed application by that date; or
- the day the completed application is received by mail in the home office of Blue Cross; or
- the day after the completed application is received in the home office of Blue Cross if delivered to the lobby or submitted electronically; or
- a later effective date as requested here _____. (This date cannot be more than 60 days beyond the signature date.)
  mm/dd/yyyy

If this application is not approved, no coverage will be effective.

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F Current / previous health insurance

If you are approved for coverage, **your contract will not cover preexisting conditions for the first 12 months**. Conditions are considered to be preexisting if medical advice, diagnosis, care or treatment was recommended or received up to six (6) months immediately preceding the enrollment date of your coverage. You will not be subject to this exclusion to the extent you have already satisfied this type of requirement under prior continuous qualifying creditable coverage. Please provide details of other coverages below.

Do you currently have any health insurance or have you had any health insurance within the past 63 days? ☐ Yes ☐ No

If Yes, you must complete the following section. Provide health insurance information for the past 12 months for yourself. Make sure to include information for other Blue Cross coverages.

Insurance Company Name and Policy Number	Date Coverage Started mm/dd/yyyy	Date Coverage Ended (If active, state active) mm/dd/yyyy	Was the previous coverage individual or group coverage?

G Coordination of Benefits

Will you have other health or medical coverage, including Medicare, once this policy is in force? ☐ Yes ☐ No

If the response is Yes, you may be contacted for more information.

H Health history (complete information is required)

Answer all questions accurately and completely. Blue Cross relies on the information you provide on this application to determine whether you are eligible for coverage. Any false information, omissions or misstatements you provide in this application which affect the risk assumed by Blue Cross may result in the denial of a claim, rescission of the contract, or the issuance of a contract amendment.

DO NOT PROVIDE ANY GENETIC INFORMATION, INCLUDING FAMILY MEDICAL HISTORY INFORMATION.

You do not have to disclose tests to detect the presence of human immune deficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), or other bloodborne pathogens which were administered to you at the time you were: (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) an emergency medical personnel who was tested as a result of performing emergency medical services while employed; (3) corrections employees or inmates; or (4) patients or employees of a secured facility. The term emergency medical personnel includes individuals employed to provide out-of-hospital medical emergency services, licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as employees or volunteers of an ambulance service who provide emergency medical services; a member of an organized first responder squad that is formally recognized by a political subdivision in Minnesota; crime lab personnel; other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law; and any individual who, in the process of executing a citizen's arrest, may have experienced a significant exposure.

1. Your Height: _____ ft. _____ in. Current Weight: _____ lbs. Weight One (1) Year Ago: _____ lbs.

2. **In the past five (5) years, have you been treated for or diagnosed as having diseases or disorders related to the following conditions? Check each item either "Yes" or "No" and circle conditions.**

	Yes	No
A. HEART OR CIRCULATORY DISORDERS—Chest pain, rheumatic fever, heart murmur, stroke, high blood pressure, anemia, bleeding disorders, varicose veins, myocardial infarction or heart disease	☐	☐
B. GASTROINTESTINAL DISORDERS—Stomach, gallbladder, liver, intestinal bleeding or disorders, ulcers, hernia, hemorrhoids, chronic diarrhea, rectal disorders, or any treatment for obesity	☐	☐
C. GENITOURINARY DISORDERS—Kidney, urinary tract disorders, sexually transmitted diseases, infertility, disorders of the male reproductive system including prostate gland, disorders of the female reproductive system including menstrual disorders and abnormal pap smears	☐	☐
D. BREAST DISORDERS—Disorders of the male or female breast, including complications from breast implants	☐	☐
E. RESPIRATORY DISORDERS—Asthma, emphysema, bronchitis, allergy or allergic reaction, lung, breathing disorder, or sleep apnea	☐	☐

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2. (Continued)

	Yes	No
F. NERVOUS, EMOTIONAL, MENTAL, OR PERSONALITY DISORDERS—Depression, anxiety, adjustment disorders, autism, eating disorders, attention deficit disorders, hyperactivity, behavioral, or psychotic disorders	☐	☐
G. ENDOCRINE OR GLANDULAR DISORDERS—Diabetes, thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement	☐	☐
H. NEUROLOGICAL OR NEUROMUSCULAR DISORDERS—Headache or migraine, head injury, seizure disorder, multiple sclerosis, cerebral palsy, paralysis, or chronic fatigue syndrome	☐	☐
I. MUSCULOSKELETAL DISORDERS—Back disorders, scoliosis, temporomandibular joint disorder (TMJ), fibrositis, osteoporosis, fibromyalgia, carpal tunnel syndrome, gout, arthritis, joint disorders, or amputation	☐	☐
J. TUMOR, CYST, OR POLYP	☐	☐
K. SKIN DISORDERS—Acne, rash, warts, or growth	☐	☐
L. COLLAGEN DISEASE—Lupus, scleroderma, or rheumatoid arthritis	☐	☐
M. GENERAL FATIGUE OR MALAISE, MONONUCLEOSIS, OR EPSTEIN-BARR SYNDROME	☐	☐
N. EYES, EARS, NOSE, THROAT DISORDERS—Impairment of sight, cataracts, eye muscle, otitis media, earache, hearing impairment, nasal or sinus disorders, tonsillitis, or adenoiditis	☐	☐
O. IMMUNE DISORDERS—Congenital or acquired disease or disorder of the immune system, including AIDS or an ARC (AIDS Related Complex)	☐	☐
3. Have you **EVER** had, been treated for or diagnosed as having cancer?	☐	☐
4. Female applicant: Are you pregnant?	☐	☐

5. Have you:

	Yes	No
A. Had a medical operation within the last five (5) years?	☐	☐
B. Been hospitalized within the last 10 years?	☐	☐
C. Seen a doctor, chiropractor, psychologist, therapist, or any other health care professional for any reason other than a wellness/physical exam within the past five (5) years?	☐	☐
D. Received speech, physical, behavioral, or occupational therapy within the past five (5) years?	☐	☐
E. Been diagnosed with or received a positive test for any disease or disorder of the immune system within the past five (5) years?	☐	☐
F. Had a health-related screening or diagnostic test such as a blood test, mammogram, x-ray/imaging, CT or MRI scan during the last five (5) years?	☐	☐
G. Ever been treated for or currently have a congenital abnormality?	☐	☐

6. **If you answered Yes to any questions in 2-5, please provide complete details here.** Add an additional page if you need more space.

Ques. no. & letter	Date of Onset	Diagnosis and Treatment including results of diagnostic tests	Days in hospital	Date of complete recovery (If ongoing, state ongoing)	Doctor, Clinic or Hospital Name and City

☐ Check box if you are adding an additional page

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7. In the past five (5) years, have you: Yes No

A. Used drugs on a regular basis, other than drugs prescribed by a physician, or been treated for the abuse of any drugs or alcohol? ☐ ☐

B. Been convicted of a DWI or DUI or had your driver's license suspended or revoked for driving while under the influence of alcohol or a controlled substance? ☐ ☐

C. Been medically advised by a health care professional to quit or reduce use of alcohol or drugs? ☐ ☐

If you answered Yes to any questions (7A-7C), please provide details here.

Ques. no. & letter	Dates and details regarding drug and/or alcohol use, DWI or DUI, and any treatment including medical facility name	Driver's License Number

8. Do you drink alcohol? Yes ☐ No ☐

If **Yes,** what is the average amount of alcohol used weekly?

9. Have you had a wellness/physical exam within the past 24 months? Yes ☐ No ☐

If **Yes:**

Date of Physical	Doctor or Clinic Name	Were all physical results normal including lab test(s)? **YES** or **NO**	If **NO**, list all abnormal findings, treatment received and outcome

10. Have you taken any prescription medication within the past 24 months? Yes ☐ No ☐

If **Yes:**

Drug Name and Dosage	Diagnosis	Dates Used	Doctor Name

11. During the past 12 months, have you experienced back or neck pain, joint or muscle pain, headaches, stomach or abdominal pain, chest pain, shortness of breath or chronic cough, dizziness or fainting episodes, fever, swollen glands or lump, blood in stool or urine, or an injury for which a physician has not been consulted? Yes ☐ No ☐

If **Yes,** give dates and details:

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12. Have you been advised by a health care professional to have an evaluation, testing or treatment for a medical, dental, or mental health condition that has not yet been performed? Yes ☐ No ☐

If **Yes,** give dates and details:

13. Have you ever been declined coverage, charged an increased rate, or had benefits excluded from coverage for any health coverage? Yes ☐ No ☐

If **Yes,** give dates and details:

14. Do you plan to travel in a foreign country in the next year? Yes ☐ No ☐

If **Yes**:

Date of Departure	Destination	Date of Return

15. Provide names of the physicians/health care professionals with the most complete knowledge of your medical history:

	Provider Address

Authorization and representation

I understand and agree that coverage, if approved, will commence in accordance with section E on page 2. I have included payment with this application. For administrative convenience, Blue Cross will deposit in a bank any payment I submit with this application, but such deposit shall not constitute an approval of this application or issuance of coverage. If this application is rejected, any money submitted will be refunded to me. When I provide a check as payment, I authorize Blue Cross either to use information from my check to make a one-time electronic fund transfer from my account or to process the payment as a check transaction. When Blue Cross uses information from my check to make an electronic fund transfer, funds may be withdrawn from my account as soon as the same day Blue Cross receives my payment and I will not receive my check back from my financial institution.

I understand if Blue Cross approves this application, coverage will be provided under an individual contract. I understand that Blue Cross does not issue individual coverage through any arrangement with an employer. Blue Cross is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

In order to process this application, Blue Cross may collect personal information regarding my health history and motor vehicle driving records from persons other than myself. The information collected by Blue Cross or Blue Cross authorized agents may in certain circumstances be disclosed to third parties without authorization. I have the right to see my personal records that are maintained by Blue Cross and to correct personal information Blue Cross has collected about me. Upon my request, Blue Cross will furnish a more detailed notice of Blue Cross information practices. The sole purpose for collecting this information is to underwrite this application for coverage.

I agree to authorize and request any hospital, clinic, institution, physician, pharmacy and pharmacy related service organizations or other persons to furnish Blue Cross full details of diagnosis, treatment, medical history, pharmaceutical records and any other information and conclusions about me listed on this application. Blue Cross needs this information to underwrite this application. Blue Cross keeps this information confidential, but may release it if you authorize release, or if state or federal law permits or requires release without authorization. For purposes of obtaining information in connection with this application, reinstatement, or change in policy benefits, this release is valid as long as the applicant is continually insured with the insurer. You are entitled to receive a copy of any release you sign. Blue Cross will not request the release of information about bloodborne pathogen tests that were administered to individuals described on page 3 of this application.

(Continued on page 7)

Blue Cross primarily relies upon the information provided and full disclosure of the information listed in this application in the decision whether to accept the applicant for coverage. The approval or disapproval of this application may or may not include review of actual medical records, which I agree to obtain upon Blue Cross' request. Therefore, I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the application, even if the applicant currently has coverage or had prior coverage with Blue Cross. Blue Cross may also review its records relating to my enrollment in current or prior coverage through Blue Cross or one of its affilitated companies.

I understand and agree that payment of a claim does not preclude the right of Blue Cross to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

I agree to notify Blue Cross immediately of any change in my health condition between the date of this application and the effective date of coverage. Failure to notify Blue Cross of any change in my health condition may result in the denial of a claim(s), rescission of the contract or the issuance of a contract amendment.

I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand and agree Blue Cross will act in reliance upon the information I have provided in this application and that any false information, omissions or misstatements in this application which materially affect either the acceptance of risk or hazard assumed by Blue Cross may result in the denial of a claim(s), rescission of the contract or the issuance of a contract amendment.

X _____ X _____

Date Applicant Signature

J Agent

IF APPLICATION COMPLETED BY AGENT, COMPLETE AND SIGN BELOW

If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded in this application are complete and accurate as provided by the applicant.

X _____ ( ) _____ _____

Agent Signature Agent Telephone Number Date

BlueCross BlueShield of Minnesota

An independent licensee of the Blue Cross and Blue Shield Association