



BLUE CROSS and BLUE SHIELD OF MINNESOTA OPTIONS BLUE – HSA APPLICATION CHECKLIST

How to Apply:

- For faster service you may choose to apply online. To be set up for online enrollment please go to <http://www.mnhealthnetwork.com/applybcbsmn.htm>
- Complete the enclosed application or follow the above link to start an online application.
 - o **IMPORTANT:** Be sure to be very thorough when filling out the application. ALL questions that you answer yes to in section H, questions #1-3 MUST have corresponding answers in question #4 (i.e. reason for visit, results of physical or test, recovery date if applicable).

Effective Date:

- If you currently have coverage, choose an effective no more than 60 days in advance.
- If you do not have current coverage, you make leave this section blank. If you are approved for coverage, Blue Cross will issue coverage beginning the date that the application was received at the home office of Blue Cross.

Underwriting Review:

- You will want to expect about one month for the underwriting review, some application do go quicker and some do take longer – up to 60 days.
- It is possible that underwriting may require additional information from a clinic, doctor or hospital. Should your medical records be requested your provider may charge for this service! BCBSMN allows/pays up to \$30.

Monthly Premium:

- If you prefer to pay monthly, you must agree to the automatic checking withdraw (Pay-O-Matic program). Should you desire to pay monthly, please complete the enclosed Pay-O-Matic form and attach a voided check with the application.
- PLEASE send your first estimated premium with the application** (i.e. monthly, quarterly, semi-annual). Your check will be cashed upon receipt by BCBSMN. If you are not accepted, your premium will be refunded. **NOTE: Checks must be written from a personal account.**

Sending in the Application:

- Sign and date the application. **NOTE: The application MUST be received within 15 days of the signature date.**
- Return the application to us in the enclosed pre-paid envelope.
- So the we can provide you with application status updates, complete the following contact information:

Email Address: _____

Daytime Phone # _____

For a complete provider directory visit: <http://www.bluecrossmn.com/>

We will be happy to assist you wherever possible. Please contact us at 952.224.0123.

There is no guarantee the coverage will be offered. BCBSMN will either decline coverage, or offer coverage at the published rates... **Do not cancel your existing medical policy until you have verification of your acceptance.** Should you be declined coverage from any private health insurer, you would in most cases qualify for the Minnesota Comprehensive Health Association (MCHA) health coverage (<http://www.mchamn.com/> for more information).



FOR AGENT USE ONLY (Please print legibly)

Agency Code _____

Agent Number _____

Agent Name _____

Personal BlueSM or Options BlueSM 80/100

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, and I am applying for Personal Blue or Options Blue 80/100
- ___ I have a Personal Blue or Options Blue 80/100 contract and I am:
 - applying for a lower deductible; adding a dependent Blue Cross ID # _____
- ___ I have other Blue Cross coverage and I am applying for Personal Blue or Options Blue 80/100 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 your check 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.
- Applicants must be age 19 through age 64 years to apply.
- **Persons at least 90 days old and under the age of 19 are eligible only as dependents under an eligible parent/legal guardian applicant.**
- Maternity-related services are not covered for the first 18 months the contract is in effect.
- **The preexisting condition limitation does not apply to any covered person under 19 years of age.**
- Your premium may be different than quoted if: there is a change to the effective date; there is a change in the ages or number of individuals approved for coverage; you agree to a plan modification; rates change.
- 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 2 – 4 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.

Individual Application

B Applicant information

Applicant Name _____ Legal Marital Status ____ Single ____ Married
FIRST LAST

Applicant Social Security Number _____ Spouse/Same Sex Domestic Partner Social Security Number _____

Applicant address _____ Email address _____
Street including Apt#

City _____ State _____ Zip _____

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

Applicant occupation _____ Spouse/Same sex domestic partner occupation _____

Starting with Applicant, list each family member applying for coverage:

| First | Name | Last | Social Security Number | Relationship to Applicant | Birth Date mm/dd/yyyy | Sex M/F | Height | Present Weight | Weight one year ago |
|-------|------|------|------------------------|---------------------------|-----------------------|---------|---------|----------------|---------------------|
| | | | | Applicant | | | ft. in. | lbs. | lbs. |
| | | | | | | | ft. in. | lbs. | lbs. |
| | | | | | | | ft. in. | lbs. | lbs. |
| | | | | | | | ft. in. | lbs. | lbs. |
| | | | | | | | ft. in. | lbs. | lbs. |
| | | | | | | | ft. in. | lbs. | lbs. |

Additional family members on attached page

Tobacco use:

I (applicant/contractholder) have used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application. Yes No

My spouse/same sex domestic partner (if included or being added on this application) has used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application.

C 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.

D Coordination of Benefits

Will you or any family member on this application 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.

Individual Application

G 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 the signature date of this application.

If approved, coverage will be effective on:

- the date that coincides with the termination date of the InstaCare contract, if we have received this completed application before the termination date of the InstaCare and the InstaCare termination date is not greater than 60 days beyond the signature date of this application; or
- the first day of the month following our mailroom receipt date of the completed application. If possible, I would like my coverage to begin on the first day of the month of _____, provided this date is not greater than 60 days beyond the signature date of this application.

If this application is not approved, no coverage will be effective for any individuals listed on this application.

H Health history (complete information is required for all persons listed on this application)

Answer all questions accurately and completely. Blue Cross relies on the information you provide on this application to determine whether you or any person age 19 or older 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, the issuance of a contract amendment, or rate adjustment. For eligible dependents under age 19, this information will be used in the underwriting process for rating purposes only.

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 if such tests 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. In the past five (5) years, have you or any family member listed on this application 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.

- | | | |
|---|--------------------------|--------------------------|
| 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 | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| B. GASTROINTESTINAL DISORDERS—Stomach, gallbladder, liver, intestinal bleeding or disorders, ulcers, hernia, hemorrhoids, chronic diarrhea, rectal disorders, or any treatment for obesity | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| D. BREAST DISORDERS—Disorders of the male or female breast, including complications from breast implants | <input type="checkbox"/> | <input type="checkbox"/> |
| E. RESPIRATORY DISORDERS—Asthma, emphysema, bronchitis, allergy or allergic reaction, lung, breathing disorder, or sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> |
| F. NERVOUS, EMOTIONAL, MENTAL, OR PERSONALITY DISORDERS—Depression, anxiety, adjustment disorders, autism, eating disorders, attention deficit disorders, hyperactivity, behavioral, or psychotic disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| G. ENDOCRINE OR GLANDULAR DISORDERS—Diabetes, thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement | <input type="checkbox"/> | <input type="checkbox"/> |

Individual Application

5. Have you or any family member listed on this application had a wellness/physical exam within the past 24 months? Yes No

If Yes:

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

6. Have you or any family member listed on this application taken any prescription medication within the past 24 months? Yes No

If Yes:

| Family Member Name | Drug Name and Dosage | Diagnosis | Dates Used | Doctor Name |
|--------------------|----------------------|-----------|------------|-------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

7. During the past 12 months, have you or any family member listed on this application 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:

| Family Member Name | Dates and Details |
|--------------------|-------------------|
| | |
| | |

8. Is any family member applying for coverage currently pregnant, currently an expectant father, or expecting a child through adoption within the next 12 months? Yes No

If Yes:

| Family Member Name | Expected Date of Birth or Adoption |
|--------------------|------------------------------------|
| | |

9. In the past five (5) years, have you or any family member listed on this application:
- 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? Yes No
- B. Been convicted of a DWI or DUI or had his/her driver's license suspended or revoked for driving while under the influence of alcohol or a controlled substance? Yes No
- C. Been medically advised by a health care professional to quit or reduce use of alcohol or drugs? Yes No

If you answered Yes to any questions 9A-9C, please complete this section. Give complete details.

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

10. Do you or any other family member listed on this application drink alcohol? Yes No

If Yes:

| Family Member Name | Average amount of alcohol used weekly |
|--------------------|---------------------------------------|
| | |
| | |

11. Have you or any other family member listed on this application 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:

| Family Member Name | Dates and Details |
|--------------------|-------------------|
| | |
| | |

12. Have you or any family member listed on this application ever been declined coverage, charged an increased rate, or had benefits excluded from coverage for any health coverage? Yes No

If Yes:

| Family Member Name | Dates and Details |
|--------------------|-------------------|
| | |
| | |

13. Do you or any family member listed on this application plan to travel in a foreign country in the next year? Yes No

If Yes:

| Family Member Name | Date of Departure | Destination | Date of Return |
|--------------------|-------------------|-------------|----------------|
| | | | |
| | | | |

14. Provide names of the physicians/health care professionals with the most complete knowledge of the medical history for you and all family members applying for coverage.

| Family Member Name | Provider Name | Provider Address |
|--------------------|---------------|------------------|
| | | |
| | | |
| | | |

Authorization and representation

I understand and agree that coverage, if approved, will commence in accordance with section G on page 4. 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. When I provide a check as payment, I authorize Blue Cross either to use information from my check to make a one-time electronic funds 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 funds 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.

Individual Application

In order to process this application, Blue Cross may collect personal information regarding me, or my family members listed on this application, 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 or my family members listed on this application. 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 and my family members 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 4 of this application.

Blue Cross primarily relies upon the information provided and full disclosure of the information listed on this application in the decision whether to accept the applicant and/or family members listed on this application 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, and/or family members listed on this application, currently have coverage or have 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 affiliated 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 (or my spouse/same sex domestic partner or family member's) health condition between the date of this application and the effective date of coverage. Failure to notify Blue Cross of any change in my (or my spouse/same sex domestic partner or family member's) health condition may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a rate adjustment.

Upon request, I agree to furnish additional information needed concerning eligibility of any family member applying for coverage.

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 on this application and that any false information, omissions or misstatements on 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, the issuance of a contract amendment, or a rate adjustment.

X _____ X _____ X _____ X _____
Date Applicant Signature Date Spouse/Same Sex Domestic Partner Signature
(if applying for coverage)

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 on 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