MN

For the health of all.

FOR AGENT USE ONLY (Please print legibly)

Agency Code MHI

Agent Number 3341

Agent Name Kevin Knutson

Simply Blue℠, GoBlue℠ or Healthy Blue®

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 GoBlue or Healthy Blue contract and I am applying for a lower deductible Blue Cross ID # _____

☐ I have a Simply Blue 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 Simply Blue, GoBlue or Healthy Blue Blue Cross ID # _____

* You can only add a dependent to a Simply Blue contract that was issued with an effective date of July 1, 2012 or later. If your Simply Blue contract was issued with an effective date **prior** to July 1, 2012, you cannot add a dependent to your current contract (you and your dependent will need to apply for the Simply Blue family plan).

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. The application can be mailed to Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, MN 55164.

General application information

- You must be a resident of Minnesota.
- Applicants must be age 19 through age 64 years to apply.
- **NOTE: GoBlue and Healthy Blue are single coverage only plans. Simply Blue is a single or family plan.**
- Persons at least 90 days old and under the age of 19 are eligible only as dependents under an eligible parent/legal guardian applicant.
- These plans provide benefits for prenatal care only and do not cover maternity-related services.
- 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 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.
- If approved, you will receive your contract, ID cards, and first bill or automatic withdrawal notification within two (2) weeks of approval.
- A request to change the effective date of coverage will only be considered if you provide evidence of other active health coverage and the requested effective date change is within 60 days of the application signature date. The effective date of coverage will always be on the first day of a month unless we are coordinating this coverage with the termination of an InstaCare contract.

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.

F9738R02a (03/12)

B Applicant information

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

Applicant address _____
Street including Apt#

City _____ State _____ Zip _____ County _____

Preferred telephone number (_____) _____ Alternate telephone number (_____) _____
Telephone type: ☐ home ☐ cell ☐ work Telephone type: ☐ home ☐ cell ☐ work

Preferred Email address _____ Alternate Email address _____

Applicant occupation _____ Spouse/Same sex domestic partner occupation _____

For Simply Blue, starting with applicant, list each family member applying for coverage.
For GoBlue or Healthy Blue, which are single coverage plans, list the applicant.

Name 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.
						ft. in.	lbs.	lbs.

__ Additional family members on attached page

C Tobacco use

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

D Payment selection

Choose your preferred payment option, the two (2) options will be: ☐ Monthly automatic withdrawal; **or** ☐ Bill me monthly

E 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

 (Continued on page 3)

F Plan selection - I am applying for one of the following calendar year deductible plans:

Simply Blue	GoBlue	Healthy Blue
Single/family coverage	Single coverage	Single coverage
Select deductible level: ☐ $3,000 / person - $6,000 / family ☐ $6,000 / person - $12,000 / family ☐ $9,000 / person - $18,000 / family	Select deductible level: ☐ $4,000 ☐ $6,000 ☐ $10,000	Select deductible level: ☐ $1,000 Inpatient / $4,500 Outpatient ☐ $2,500 inpatient / $6,000 Outpatient
Drug benefit (select one) ☐ Drug option 1 ☐ Drug option 2		

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.

G Provider Network Selection. Select one Network:

☐ Aware
☐ Blue Performance Enhanced
☐ Blue Performance Regional

More information about Provider Networks can be found at www.bluecrossmn.com. Health history may be required if you request to move to a different network at a later date.

H Substance abuse and Mental health coverage

This plan covers substance abuse and mental health coverage. Do you want to keep the substance abuse and mental health coverage? (Your decision will apply to all dependents covered by the plan. Removing this coverage will reduce your monthly premium.)

☐ Keep coverage
☐ Remove coverage

When adding a spouse/same sex domestic partner or dependents to your current contract, the mental health and substance abuse coverage will not change.

I Current / previous health insurance - The preexisting condition limitation does not apply to any covered person under 19 years of age.

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 maintained 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 you and any family member included on this application. Make sure to include information for other Blue Cross coverage.

Person(s) Covered	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?

(Continued on page 4)

J 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.

K 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.**

		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, allergic reaction, lung, breathing disorder, sleep apnea	☐	☐
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	☐	☐

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1. (Continued):

	Yes	No
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)	☐	☐

	Yes	No
2. Have you or any family member listed on this application **EVER** been treated for or diagnosed as having cancer?	☐	☐

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

	Yes	No
A. Had a medical operation within the last five (5) years?	☐	☐
B. Been hospitalized within the last five (5) 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. Been treated within the last five (5) years for or currently have a congenital abnormality?	☐	☐

4. **If you answered Yes to any questions in 1-3, please provide complete details here.** Add an additional page if you need more space.

Ques. no. & letter	Family Member Name	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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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	Start Date	End Date if ongoing, state ongoing	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: 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? 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

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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. In the past five (5) years, 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 premium, 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

L Authorization and representation

I understand and agree that coverage, if approved, will begin as specified in section J on page 4. If this application is approved, 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 check 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.

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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 I 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 I am continually insured with the insurer. I am entitled to receive a copy of any release I 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 premium 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 premium adjustment.

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

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

MN

For the health of all.

Application Submission Instructions:
Electronic: Scan the signed application and email to enroll2012@bluecrossmn.com or fax to 651-662-6439.
Paper: Sign and mail to Blue Cross and Blue Shield of Minnesota, PO Box 64024, St Paul MN 55164-9561