



Application for Enrollment

Individual Health Plans



An Independent Licensee of the Blue Cross and Blue Shield Association

azblue.com

How to apply

Blue Cross Blue Shield of Arizona offers the following guidelines and instructions to help you complete your application for health individual insurance coverage.

- Any applicant designated on this application must be under the age of 65 and not on Medicare. If you are a resident of Arizona and are interested in a Medicare Supplement plan, please call (602) 864-4899 or (877) 864-4899 and a representative can help you.

Applicants must be permanent Arizona residents.

- You can apply for coverage for yourself, your spouse and your unmarried children who are under the age of 30. If you only need insurance for your children, you can apply for child-only coverage for your child under the age of 19.
- Please be sure that you fill in all information requested on the application even if you currently have coverage with Blue Cross Blue Shield of Arizona.
- Blue Cross Blue Shield of Arizona (BCBSAZ) will review the medical history of all applicants provided on the application to determine if they are eligible for coverage. BCBSAZ requires you to provide medical history for all applicants for the last 10 years with the exception of a few questions that require you to provide information for any applicant that may have had a health/medical condition in their entire life. Please be sure to provide as much detail about each applicant's condition as possible. We need to know everything you know about each applicant's medical history.
- All persons named on this application who are age 18 or older MUST sign and date the signature page of the application. BCBSAZ must receive your application within 30 days from the date of all applicant signature(s).
- Please print your answers in ink but avoid the use of red ink. Do not use pencil or highlighters. Fill in all ovals completely; do not just mark with an "x". Do not print in any shaded areas.
- This application must be sent with a \$20.00 non-refundable fee, except no fee is required for child-only applications or from current BCBSAZ members. Please do not send the first month's premium with your application. If BCBSAZ accepts you for coverage, we will bill you. The application fee for a printed and mailed application is not refundable. However, no fee is required if you submit your application electronically by applying online at azblue.com or through the marketing Web site for your BCBSAZ broker.
- **For applicants who 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 pre-existing 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 to speak with a representative. Please note that you will lose your eligibility for Individual Portability Coverage if you become insured under any non-group policy. If you think you may not qualify for underwritten coverage, you can apply for portability coverage while BCBSAZ reviews your application for underwritten coverage.
- Do you have a Certificate of Eligibility for the Health Insurance Premium Tax Credit from the Arizona Department of Revenue? If yes, please enclose a copy of your Certificate with this application.

Please see next page to begin the application.

Before you continue.....

Please answer the following questions:

- Is any male or female applicant currently an expectant parent (excluding parents with pending adoptions)? YES NO
(If yes, any applicant who is expecting a child is not eligible for coverage at this time.)
- Is any applicant enrolled in Medicare? YES NO
(If yes, any applicant who is enrolled in Medicare or currently eligible for Medicare (65 or older) is not eligible for coverage at this time.)

The following conditions will result in a declination of coverage of the applicant. Please review this list carefully before proceeding. Is there an applicant who has one of the conditions listed below? YES NO If yes, please mark which applicant below.

- Alzheimer’s
- ESRD (End Stage Renal Disease)
- Multiple Sclerosis
- Schizophrenia
- Autoimmune Disorders
- Hemophilia
- Muscular Dystrophy
- Transplant recipient or candidate
- Crohn’s Disease
- HIV or AIDS
- Parkinson’s Disease
- Rheumatoid Arthritis
- Cystic Fibrosis

If yes to any of the above conditions, name the applicant(s) with the condition: _____

Applicants with certain conditions are non-insurable by BCBSAZ. This list is not meant to be an all-inclusive list of conditions or diseases that are non-insurable. Other conditions may be non-insurable based on the applicant’s medical information and BCBSAZ’s medical underwriting guidelines. Any applicant with any of these conditions is not eligible for coverage at this time.

NEW CUSTOMERS	EXISTING CUSTOMERS
How did you hear about us? <input type="radio"/> Internet <input type="radio"/> Newspaper <input type="radio"/> Billboard <input type="radio"/> Broker <input type="radio"/> Radio <input type="radio"/> Other (please specify) _____ <input type="radio"/> Personal Recommendation <input type="radio"/> TV _____	Please provide your member ID on the front of your card _____

To improve our service in the future, please indicate your preferred language. English Spanish

PLAN FOR WHICH YOU ARE APPLYING (DEDUCTIBLES ARE CALENDAR-YEAR: JANUARY—DECEMBER)						
BlueOptimum PPO	BlueValue PPO	BlueEssential PPO	BluePortfolio PPO	BluePreferred PPO	BluePreferred Basic PPO	<input type="radio"/> BlueSecure HMO <input type="radio"/> BlueSecure Plus HMO
<input type="radio"/> \$250	<input type="radio"/> \$250	<input type="radio"/> \$250	<input type="radio"/> \$1,750	<input type="radio"/> \$250	<input type="radio"/> \$1,500	
<input type="radio"/> \$500	<input type="radio"/> \$500	<input type="radio"/> \$500	<input type="radio"/> \$3,000	<input type="radio"/> \$500	<input type="radio"/> \$2,500	
<input type="radio"/> \$1,000	<input type="radio"/> \$1,000	<input type="radio"/> \$1,000	<input type="radio"/> \$5,500	<input type="radio"/> \$1,000	<input type="radio"/> \$3,500	
<input type="radio"/> \$2,000	<input type="radio"/> \$2,000	<input type="radio"/> \$2,000		<input type="radio"/> \$1,500	<input type="radio"/> \$5,000	
<input type="radio"/> \$3,000	<input type="radio"/> \$3,000	<input type="radio"/> \$3,000		<input type="radio"/> \$2,500	<input type="radio"/> \$7,500	
<input type="radio"/> \$5,000	<input type="radio"/> \$5,000	<input type="radio"/> \$5,000		<input type="radio"/> \$3,500	<input type="radio"/> \$10,000	
<input type="radio"/> \$7,500	<input type="radio"/> \$7,500	<input type="radio"/> \$7,500		<input type="radio"/> \$5,000		
<input type="radio"/> \$10,000	<input type="radio"/> \$10,000	<input type="radio"/> \$10,000		<input type="radio"/> \$7,500		
				<input type="radio"/> \$10,000		

EARLY ENROLLMENT OPTION

Blue Cross Blue Shield of Arizona medically underwrites all individuals listed on your application. Some medical conditions may require BCBSAZ to request medical records from an applicant’s physician which will require additional time to process your application. The early enrollment option allows you to enroll individuals who reach an approval status while BCBSAZ processes the remaining applicant(s). To take advantage of the early enrollment option, please check the box below. Otherwise, we will enroll all members only when all applicants reach a final status.

Check this box if you want the early enrollment option.

Contract Holder Information

THIS AREA IS TO BE FILLED IN BY THE APPLICANT NAMED AS CONTRACT HOLDER, OR IF APPLYING FOR CHILD-ONLY COVERAGE, NAME OF PARENT OR LEGAL GUARDIAN LIVING IN ARIZONA.

LAST NAME		SUFFIX	FIRST NAME			
PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)				SOCIAL SECURITY NUMBER		
MAILING ADDRESS (NUMBER AND STREET)					APT.	
CITY		STATE	ZIP CODE	HOME PHONE		
WORK PHONE		MOBILE PHONE		FAX		
E-MAIL ADDRESS						
IF APPLYING FOR CHILD-ONLY COVERAGE PLEASE CHECK THIS BOX HERE AND SKIP TO DEPENDENT LINE <input type="checkbox"/>						
DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE	MARITAL STATUS <input type="radio"/> SINGLE <input type="radio"/> MARRIED	DATE OF MARRIAGE (MM/DD/YYYY)	HEIGHT ft. in.		WEIGHT lbs.

Dependent Information

SPOUSE AND/OR CHILDREN TO BE CONSIDERED FOR COVERAGE. IF THERE IS ALREADY A CONTRACT IN FORCE AND YOU ARE ADDING A DEPENDENT, LIST ONLY THOSE DEPENDENTS YOU ARE ADDING.

SPOUSE	SPOUSE'S LAST NAME		SUFFIX	FIRST NAME		
	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT lbs.
1	LAST NAME		SUFFIX	FIRST NAME		
	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT lbs.
	RELATIONSHIP TO CONTRACT HOLDER: <input type="radio"/> CHILD OR STEPCHILD <input type="radio"/> CHILD UNDER CONTRACT HOLDER'S GUARDIANSHIP* <input type="radio"/> OTHER					
	LAST NAME		SUFFIX	FIRST NAME		
2	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT lbs.
	RELATIONSHIP TO CONTRACT HOLDER: <input type="radio"/> CHILD OR STEPCHILD <input type="radio"/> CHILD UNDER CONTRACT HOLDER'S GUARDIANSHIP* <input type="radio"/> OTHER					
	LAST NAME		SUFFIX	FIRST NAME		
	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT lbs.
3	RELATIONSHIP TO CONTRACT HOLDER: <input type="radio"/> CHILD OR STEPCHILD <input type="radio"/> CHILD UNDER CONTRACT HOLDER'S GUARDIANSHIP* <input type="radio"/> OTHER					
	LAST NAME		SUFFIX	FIRST NAME		
	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT lbs.
	LAST NAME		SUFFIX	FIRST NAME		
4	PRIOR LAST NAME (I.E. MAIDEN NAME, ALIAS, ETC.)	SSN	DATE OF BIRTH (MM/DD/YYYY)	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE	HEIGHT ft. in.	WEIGHT lbs.
	RELATIONSHIP TO CONTRACT HOLDER: <input type="radio"/> CHILD OR STEPCHILD <input type="radio"/> CHILD UNDER CONTRACT HOLDER'S GUARDIANSHIP* <input type="radio"/> OTHER					
	LAST NAME		SUFFIX	FIRST NAME		
	LAST NAME		SUFFIX	FIRST NAME		

IF THERE ARE MORE THAN 4 DEPENDENTS PLEASE COMPLETE A SEPARATE SHEET OF PAPER AND CHECK HERE

*Please note that if child(ren) is/are under contract holder's guardianship then guardianship papers must accompany your application for those dependents.

SPACE BELOW: FOR BROKER USE ONLY

ASSOCIATION NAME	ASSN#	BROKER NAME, MAILING ADDRESS AND PHONE	BROKER #
		Michael Higgins P.O. Box 34754 Phx., AZ. 85067 602.405.8769	01437
APPLICATION FEE RECEIVED			

EFFECTIVE DATE—BCBSAZ DOES NOT ASSIGN EFFECTIVE DATES ON THE 29TH, 30TH, OR 31ST OF THE MONTH. APPLICATION APPROVALS MADE AFTER THE 26TH WILL HAVE AN EFFECTIVE DATE THE FIRST OF THE FOLLOWING MONTH.

EARLIEST EFFECTIVE DATE NOT BEFORE THE FOLLOWING DATE: (MM/DD/YYYY) ____/____/____ (use this option if you do not want the policy to be in effect before a certain date).

BILLING ADDRESS—IF YOU WOULD LIKE YOUR BILL TO GO TO A DIFFERENT ADDRESS THAN THE MAILING ADDRESS SUPPLIED EARLIER PLEASE INDICATE IT HERE, OTHERWISE LEAVE BLANK.

C/O (IF APPLICABLE)		ADDRESS (NUMBER & STREET)	
APT./SUITE	CITY	STATE	ZIP+FOUR

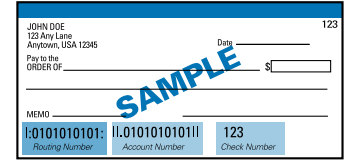
BILLING DATE—YOU HAVE THE OPTION TO BE BILLED ON EITHER THE 1ST OR 15TH OF THE MONTH. PLEASE INDICATE BELOW WHICH CYCLE YOU WOULD LIKE.

PREMIUM BILLING: 1st of the month 15th of the month METHOD OF PAYMENT: Monthly Sure Pay Electronic Bank Draft (please complete section below)
 Monthly Paper Bill Quarterly Paper Bill

SURE PAY AUTHORIZATION

COMPLETE THIS SECTION IF YOU SELECTED THE MONTHLY SURE PAY OPTION AS YOUR METHOD OF PAYMENT. IF THE FIRST DEDUCTION IS DELAYED THE INITIAL AMOUNT MAY BE MORE THAN ONE MONTHLY PREMIUM.

PLEASE DEBIT MY: CHECKING ACCOUNT SAVINGS ACCOUNT



ROUTING TRANSIT NUMBER	ACCOUNT NUMBER
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Important: Remember to sign the authorization below.

I authorize Blue Cross Blue Shield of Arizona 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 Blue Cross Blue Shield of Arizona telling them to discontinue my Sure Pay service. I agree to allow them 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. I understand that any applicable refund of monies will be released 30 days after the last draft date.

Authorized Signature on Account X _____ Date: (MM/DD/YYYY) ____/____/____

Evidence of Insurability

Blue Cross and Blue Shield of Arizona (BCBSAZ) needs to know everything you know about each applicant's medical history. The following questions cover many general medical conditions but are not intended to be all-inclusive. If injury or illness was greater than ten (10) years ago, but the applicant is still receiving treatment or follow-up, this too must be disclosed on the application. When the application is complete, it should disclose all medical conditions whether or not listed below.

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/cancelled 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. Please include any treatment from any health care provider including but not limited to a chiropractor, physical therapist, osteopath or medical doctor. If more than one applicant has a condition within a question, please attach a separate sheet of paper and provide the same criteria for the additional applicants for that question.

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.

<p>1 Has any applicant been diagnosed with or treated in the past 10 years for a head or brain disease, condition or injury?</p> <p><i>For Example:</i> Carotid Artery Disease, Cerebral Aneurysm, Concussion/Head Injury, Craniocynostosis, Hydrocephalus, Migraine/Cluster Headaches, Plagiocephaly, Stroke (Cerebrovascular Accident), Transient Ischemic Attack (TIA), <i>or any other head or brain disease, condition or injury not listed.</i></p> <p>If yes, please circle condition(s) above or if not listed write it in below. Indicate applicant(s) with the condition(s) and supply information to the right:</p> <p><input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4</p> <p>Condition(s) (if not circled above): _____</p> <p>Treating physician: _____</p>	<p><input type="radio"/> YES <input type="radio"/> NO</p> <p>If yes, please provide: Onset Date (MM/YY): ____/____ End Date (MM/YY): ____/____</p> <p>Ongoing Symptoms: <input type="radio"/> YES <input type="radio"/> NO</p> <p>Tell us more about your treatments and/or surgeries: _____ _____ _____</p>
<p>2 Has any applicant been diagnosed with or treated in the past 10 years for an eye, ear, nose or throat condition or disease?</p> <p><i>For Example:</i> Allergies, Cataracts, Corneal Ulcers, Corneal Scars, Degeneration (such as lattice degeneration, macular degeneration, retinal degeneration), Deviated Septum, Retinal Detachment, Eye deviations (such as lazy eye or crossed eyes), Glaucoma, Hearing Loss, Mastoiditis, Meniere's Disease, Nasal Polyps, Nodules, Sinusitis, Vocal Cord Polyps <i>or any other eye, ear, nose or throat disease, condition or injury not listed.</i></p> <p>If yes, please circle condition(s) above or if not listed write it in below. Indicate applicant(s) with the condition(s) and supply information to the right:</p> <p><input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4</p> <p>Condition(s) (if not circled above): _____</p> <p>Treating physician: _____</p>	<p><input type="radio"/> YES <input type="radio"/> NO</p> <p>If yes, please provide: Onset Date (MM/YY): ____/____ End Date (MM/YY): ____/____</p> <p>Ongoing Symptoms: <input type="radio"/> YES <input type="radio"/> NO</p> <p>Tell us more about your treatments and/or surgeries: _____ _____ _____</p>

3 Has any applicant been diagnosed with or treated in the past 10 years for a **breast or skin** condition or disease?

For Example: Breast Cancer, Fibroadenoma/Lump, Fibrocystic Breast, Psoriasis, Basal Cell Carcinoma, Squamous Cell Carcinoma, Melanoma *or any other breast or skin condition or disease not listed.*

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

4 Has any applicant been diagnosed with or treated in the past 10 years for a **lung** condition or disease?

For Example: Asthma, Bronchitis, Lung Cancer, Cystic Fibrosis, Emphysema / Chronic Obstructive Pulmonary Disease (COPD), Pleurisy, Pneumonia, Sleep Apnea, Tuberculosis, Valley Fever *or any other lung condition or disease not listed.*

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

5 Has any applicant been diagnosed with or treated in the past 10 years for a **heart** condition or disease?

For Example: Angina (chest pain) or Heart Attack and/or Coronary Artery Disease (CAD), Arrhythmia, Congestive Heart Failure, Heart Valve Problems, Heart Pacemaker, Elevated Blood Pressure (Hypertension), Arteriosclerosis, Peripheral Vascular Disease, Phlebitis (blood clots), Varicose Veins *or any other heart condition or disease not listed.*

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

6 Has any applicant been diagnosed with or treated in the past 10 years for a **back** condition, disease, or injury?

For Example: Sprain/Strain/Back Pain, Spinal Injury, Fracture, Sciatica, Curvature, Herniated Disc/Disc Bulge, Degenerative Disk Disease *or any other back condition, disease, or injury not listed.*

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

7 Has any applicant been diagnosed with or treated in the past 10 years for a **stomach, esophagus, intestinal, or abdominal** condition or disease?

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO
Tell us more about your treatments and/or surgeries:

For Example: Celiac Disease, Colitis, Diverticular Disease, Esophagitis/Gastroesophageal Reflux (GERD), Gall Stones, Hernia, Irritable Bowel Syndrome (IBS), Pancreatitis, Polyps, Cirrhosis, Crohn’s Disease, Enlarged/Fatty Liver, Gall Bladder Diseases, Hepatitis, Hiatal Hernia, Obesity, Peptic Ulcer, Rectocele **or any other stomach, esophagus, intestinal or abdominal condition or disease not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

8 Has any applicant been diagnosed with or treated in the past 10 years for a **diabetic, endocrine or hormonal** condition or disease?

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO
Tell us more about your treatments and/or surgeries:

For Example: Adrenal Disorders, Diabetes, Pituitary Disorders or any other **diabetic, endocrine or hormonal condition or disease not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

9 Has any applicant been diagnosed with or treated in the past 10 years for a **kidney, bladder or urinary tract** condition or disease?

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO
Tell us more about your treatments and/or surgeries:

For Example: Chronic Renal Disease / End Stage Renal Disease (ESRD), Congenital Anomalies, Fallen Bladder (Cystocele), Hematuria (blood in urine), Incontinence, Kidney Stones, Bladder Stones, Pyelonephritis (kidney infection), Urinary Reflux (VUR) **or any other kidney, bladder or urinary tract condition or disease not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

10 Has any applicant been diagnosed with or treated in the past 10 years for a **reproductive** condition or disease?

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO
Tell us more about your treatments and/or surgeries:

For Example: Sexually Transmitted Diseases, Abnormal Menstruation/Bleeding, Abnormal PAP Smear, Testicular Hernia/Torsion, Undescended Testicles, Endometriosis, Fibroids, Irregular Menstrual Cycle/No Menstruation, Ovarian Cysts, Pelvic Inflammatory Disease (PID), Polycystic Ovarian Disease, Prolapsed Uterus **or any other reproductive condition or disease not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

11 Has any applicant been diagnosed with or treated in the past 10 years for a **bone or joint** injury, condition or disease?

For Example: Amputation/Prosthesis, Arthritis, Bursitis, Tendonitis, Epicondylitis (Tennis Elbow), Degenerative Joint Disease, Osteoporosis, Carpal Tunnel Syndrome, Fractures, Knee Injury, Rotator Cuff **or any other bone or joint injury, condition or disease not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

12 Has any applicant been diagnosed with or treated in the past 10 years for a **neurologic, neuromuscular or musculoskeletal** condition or disease?

For Example: Chronic Fatigue Syndrome (CFS), Epilepsy/Seizure Disorder, Fibromyalgia, Lupus, Multiple Sclerosis, Muscular Dystrophy, ALS (Lou Gehrig's), Parkinson's Disease, Tourette's Syndrome, Cerebral Palsy, Scleroderma **or any other neuromuscular condition or disease not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

13 Has any applicant been diagnosed with or treated in the past 10 years for a **blood** condition or disease?

For Example: Anemia, Hemophilia, Leukemia (Acute & Chronic) **or any other blood condition or disease not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

14 Has any applicant been diagnosed with or treated in the past 10 years for a **mental** disorder, disease or condition?

For Example: Obsessive Compulsive Disorder (OCD), Post Traumatic Stress, Panic Disorders, Hypochondriasis, Bi-Polar (manic depressive), Schizophrenia, Paranoia **or any other mental disorder, disease or condition not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

15 Has any applicant been diagnosed with or treated in the past 10 years for a **emotional** or **behavioral** disorder, disease or condition?

For Example: Anxiety, Attention Deficit Disorders (ADD/ADHD), Depression, Eating Disorders (anorexia / bulimia), General Counseling, Marital or Family counseling **or any other emotional or behavioral disorder, disease or condition not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

16 Has any applicant been diagnosed with or treated in the past 10 years for **substance abuse?**

For Example: Alcohol Abuse/Dependence, Drug Abuse/Dependence **or any other substance abuse or dependence not listed.**

If yes, please circle condition(s) above or if not listed write it in below.
Indicate applicant(s) with the condition(s) and supply information to the right:

- Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Condition(s) (if not circled above): _____

Treating physician: _____

YES NO

If yes, please provide:
Onset Date (MM/YY):
____/____
End Date (MM/YY):
____/____

Ongoing Symptoms:
 YES NO

Tell us more about your treatments and/or surgeries:

General Medical Questions

It is important that you have disclosed all known medical information so that BCBSAZ may properly underwrite your application for insurance. In order to help determine if anything was overlooked as the body systems were reviewed, the following questions are designed to help prompt your recollection.

<p>1 Has any applicant in the last three years had an abnormal x-ray or other radiographic test? (i.e. MRI, CAT Scan, PET Scan)</p> <p>If yes, please indicate applicant(s) and describe to the right:</p> <p><input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4</p>	<p><input type="radio"/> YES <input type="radio"/> NO</p> <p>Please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>2 Has any applicant in the last three years been advised that he/she had any abnormal lab values, whether or not treatment was recommended?</p> <p>For Example: Blood Sugar, Cholesterol/Triglycerides, Liver Function Tests, PSA <i>or any other abnormal lab value not listed.</i></p> <p>If yes, please indicate applicant(s) and describe to the right:</p> <p><input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4</p>	<p><input type="radio"/> YES <input type="radio"/> NO</p> <p>Please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>3 Has any applicant been advised to have diagnostic studies or surgery (inpatient or outpatient), whether planned, scheduled, pending or simply recommended?</p> <p>For Example but not limited to: placement of ear tubes, biopsies, bone spur, skin growths, scopes, cysts, etc.</p> <p>If yes, please indicate applicant(s) and describe to the right:</p> <p><input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4</p>	<p><input type="radio"/> YES <input type="radio"/> NO</p> <p>Please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>4 Has surgery (other than cosmetic) been performed within the last 10 years on any applicant?</p> <p>If yes, please indicate applicant(s) and describe to the right:</p> <p><input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4</p>	<p><input type="radio"/> YES <input type="radio"/> NO</p> <p>Please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>5 Is any applicant currently in the process of a medical work-up for symptoms not yet diagnosed or resolved?</p> <p>For Example, but not limited to: Scans (MRI, CAT, EKG, bone), cardiac evaluation, scopes, laboratory testing, x-rays, etc.</p> <p>If yes, please indicate applicant(s) and describe to the right:</p> <p><input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4</p>	<p><input type="radio"/> YES <input type="radio"/> NO</p> <p>Please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>6 Has any applicant EVER been made aware of, evaluated for, advised of, tested for (other than routine screening), diagnosed with or treated for cancer or malignant neoplasms, other than what has already been disclosed on the application so far?</p> <p>If yes, please indicate applicant(s) and describe to the right:</p> <p><input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4</p>	<p><input type="radio"/> YES <input type="radio"/> NO</p> <p>Please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p>

7 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 **yes**, please indicate applicant(s) and describe to the right:

Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Please describe:

8 Has any applicant been convicted of or plead "No Contest" to a **DUI/DWI** in the last three years? YES NO

If **yes**, please indicate applicant and # of times:

Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Number of times in past five years: _____

9 Are there any additional **medications** (including injections) currently prescribed or recommended for any applicant other than what you've previously listed? YES NO

If yes, fill in the details in the table below:

APPLICANT	NAME OF DRUG	REASON FOR TAKING	DATE OF LAST USE MM/YYYY
<input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4			
<input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4			
<input type="radio"/> Contract holder <input type="radio"/> Spouse <input type="radio"/> Dependent 1 <input type="radio"/> Dependent 2 <input type="radio"/> Dependent 3 <input type="radio"/> Dependent 4			

10 Are there any applicants with **additional conditions or injuries** not otherwise specified on this application? YES NO

If **yes**, please indicate applicant(s) and describe to the right:

Contract holder Spouse Dependent 1 Dependent 2 Dependent 3 Dependent 4

Please describe:

**Until this application is effective, do not cancel any insurance you may have.
 Please make sure all applicants sign page 13 of this application.**

Please read this application carefully. Upon acceptance, this application and the acknowledgments below become part of your contract with BCBSAZ.

Acknowledgments

1. I have carefully read this application form and the information I provided. I understand and agree that it will be part of the contract with Blue Cross Blue Shield of Arizona (BCBSAZ) for any applicant accepted for coverage.
2. I understand and agree that:
 - The information I've provided is material to BCBSAZ's decision to offer health care coverage;
 - BCBSAZ will rely on the accuracy of the information to determine each applicant's eligibility for coverage;
 - BCBSAZ may rescind the contract and declare it null and void as of the effective date of coverage, if BCBSAZ discovers a material misrepresentation or omission after issuing coverage.
3. I understand and agree that each applicant must fully cooperate with BCBSAZ to investigate any health conditions or claims, and to provide any other relevant information BCBSAZ may need to process this application and perform its business functions.
4. I authorize any physician, practitioner, hospital, clinic or other health related provider or facility to furnish BCBSAZ and its representatives with my health information, including information related to drug use, alcoholism, mental illness, HIV, AIDS and genetic testing. I agree to be 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 process claims. My information may, in certain circumstances, be disclosed to third parties without my permission if permitted by law.
5. I understand that:
 - 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.
 - BCBSAZ generally pays a commission to the broker of record or permitted assignee until this contract is terminated or the contract holder terminates his/her relationship with the broker or the broker becomes ineligible.
 - BCBSAZ broker contracts require the broker to give me information on the broker's commission rate with BCBSAZ. I can also get more detailed information about broker commission and compensation paid to BCBSAZ licensed inside sales representatives for sales of BCBSAZ individual products at azblue.com or by calling BCBSAZ at (602) 864-4021.
6. I understand and agree that coverage will be effective on the date assigned by BCBSAZ, and subject to waiting periods, limitations, medical waivers and other provisions, regardless of any prior coverage I may have, including the following:
 - For a PPO plan: Services for pre-existing conditions are not covered until 11 consecutive months after my 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 my contract effective date, or a condition which was documented in my medical records during that same 12 month period. A condition exists when an individual had signs or symptoms, whether or not a specific injury, illness or disease was diagnosed.
 - For an HMO plan: There is no waiting period for coverage of pre-existing conditions, however there is a waiting period of 12 months from the effective date of the contract for coverage of routine maternity services.
7. I apply for enrollment on behalf of any child(ren) named on this application. I understand that if BCBSAZ accepts this application, I will be the contract holder on behalf of the named child(ren).
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 provided by court order or law. If equal access is not allowed, I have provided BCBSAZ with a copy of any such court order or law.

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.

Signatures

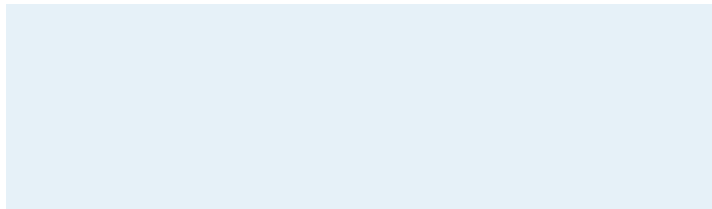
All persons named on this application age 18 and older **MUST** sign and date this form, acknowledging their understanding of and their agreement to the conditions listed above. A copy of the Acknowledgments is available to you or your authorized representative upon request.

SIGNATURE	TODAY'S DATE (MM/DD/YYYY)	RELATIONSHIP (for child-only contracts)
X _____	_____	<input type="radio"/> Parent <input type="radio"/> Legal Guardian
X _____	_____	<input type="radio"/> Parent <input type="radio"/> Legal Guardian
X _____	_____	
X _____	_____	

If you are the legal guardian, please attach a copy of the guardianship papers.

If you would like Blue Cross Blue Shield of Arizona (BCBSAZ) to share personal information with additional people not listed on this application please complete a Confidential Information Release form at the end of this application.

Please return all pages of this application to:



Instructions for Completing Confidential Information Release Form



An Independent Licensee of the Blue Cross and Blue Shield Association

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 applicant 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 BCBSAZ.
- 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 Whose Information May Be Released: Enter the name of the person whose information should be disclosed. This will normally be your name.

Who May Receive the Indicated Information: Tell us with who you are authorizing to receive your information.

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

Authority to Update My Records: Tell us if the person you indicate is authorized by you to update our records if you move to a different address, change banks or change bank accounts.

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 and/or update 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, AZ 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 Whose Information May Be Released: _____

Who May Receive the Indicated Information:

Name: _____
Company Name: _____
Address: _____
City, State, Zip Code _____

Purpose of Use/Disclosure:

- To assist with obtaining a health care policy
- To assist with claims processing and/or payments
- Other Purpose of Use/Disclosure: _____

Authority to Update My Records: I also authorize _____ to be able to:

- To change my mailing address information
- Update my SurePay/Banking information

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, Mail Stop C302, 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 (MM/DD/YYYY)

Group Name (if applicable)

Group Number (if applicable)

Personal Representative's Name*

Relationship to Individual

Personal Representative's Signature

Date (MM/DD/YYYY)

*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.**