BlueCross BlueShield of Texas

P.O. Box 3236 Naperville, IL 60566-7236 888-697-0683

Special Offer Application for Individual Coverage

Prem: _____ Fee: _____
For Home Office Use

To help us process your application promptly, please remember to:
- Print all answers in black ink. Pencil will not be accepted.
- Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent child(ren) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line. Parent/guardian must sign if primary applicant is a minor.
- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid.

PART ONE

SECTION A — PERSON(S) APPLYING FOR COVERAGE (please print)

PRIMARY APPLICANT

First Name, Middle Initial, Last Name		Social Security #	Sex (M/F)	Age	Date of Birth (mo/day/yr)	Height (ft., in.)	Weight (lbs.)
					/ /		
Home Phone # ( )	Business Phone # ( )	Fax # (if available) ( )	Occupation/Duties			Spouse's Business # (if applying)	
Residence Street Address		City/State/ZIP				County	
Email (if available)		Best place and time to call (if necessary) for a phone interview. ☐ Home ☐ Business ☐ Morning ☐ Afternoon					

Spouse and dependent child(ren) you wish to cover (dependents must be under age 26).
If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)? ☐ Yes ☐ No

Name: First Middle Initial Last	Relation (spouse or child)	Sex	Height (ft., in.)	Weight (lbs.)	Date of Birth (mo/day/yr)	Social Security Number	Court Ordered for Dependents
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No

Is any dependent coverage required by court order? ☐ Yes ☐ No If "yes," was it effective within the last 30 days? ☐ Yes ☐ No
If "yes," to apply for court-mandated coverage for dependent children, contact Blue Cross and Blue Shield of Texas for the appropriate form.

SECTION B – COVERAGE APPLIED FOR (please choose only one plan)

PPO Select Blue Advantage
Deductible Plan: I ☐ $250 II ☐ $500 III ☐ $1,000 IV ☐ $1,500
V ☐ $2,500 VI ☐ $3,500 VII ☐ $5,000 VIII ☐ $10,000

PPO Select Choice
Deductible Plan: I ☐ $250 II ☐ $500 III ☐ $1,000 IV ☐ $1,500
V ☐ $2,500 VI ☐ $3,500 VII ☐ $5,000 VIII ☐ $10,000

PPO Select Saver
Deductible Plan: I ☐ $500 II ☐ $1,000 III ☐ $1,500 IV ☐ $2,500
V ☐ $3,500 VI ☐ $5,000 VII ☐ $10,000

SECTION C – PAYOR AND BILLING INFORMATION

Requested Effective Date (mo/day/yr) _____/_____/_____ (Note: Day cannot be 29th, 30th or 31st)

Premium Mode: ☐ Monthly Bank Draft (Submit Authorization form with application)
☐ Monthly Direct Bill ☐ Two Month Direct Bill ☐ Quarterly Direct Bill
☐ List Bill Monthly (Available for two or more applicants billed at the same address)

A $30.00 NONREFUNDABLE Application Fee must be submitted with completed application.
Please make check payable to Blue Cross and Blue Shield of Texas.

Application Fee	**$30.00**
Premium (if enclosed)	**$_____**
TOTAL enclosed	**$_____**

Payor of premium (if different than applicant)
Will your employer be contributing towards the premium for this policy? ☐ Yes ☐ No

Name:	Address/City/State/ZIP:	DOB:	SSN:

Applicant Name: _____ Social Security No. _____

Acknowledgements: The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows: 1. This application does not provide coverage of any kind unless approval is provided by Blue Cross and Blue Shield of Texas (the Company); and the application, if not previously approved or declined, will be considered withdrawn on the 60th day after its date. **2.** Medical expense coverage will not be available until the effective date of the health contract and payment, in full, of the first month's premium. **3.** The medical expense benefits applied for and if issued, shall not cover any illness, accident, or physical impairment which existed or occurred prior to the effective date of the Applicant's coverage until the Applicant shall have held coverage under the contract for a period of 12 months if PPO Select Saver or PPO Select Choice is selected, or 18 months if PPO Select Blue Advantage is selected. (This limitation does not apply to participants under 19 years of age for policies with an initial effective date on or after March 23, 2010.) **4.** No agent can accept risks or modify policies or requirement of the Company. **5.** The Company is not bound by any statement not written in this application. **6.** If a spouse is included for medical expense coverage, the premium will be calculated based on the age of each adult. **7.** An act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. You will be provided with at least 30 days' advance written notice before you or your dependent's coverage may be rescinded, retroactive to the effective date of coverage.

The undersigned Applicant further acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an Individual Policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by the Company in connection with the issuance of the Individual Policy, they should contact the agent.

Agreement: I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following underwriting approval and payment in full of the first months premium and receipt and acceptance by the Company of any required Amendatory Endorsement and/or Coverage Exclusion Rider, if applicable. The undersigned Applicant and agent acknowledge that the Applicant has read the completed application and that he/she realizes that any false statement material to the risk or misrepresentations therein may result in loss of coverage under the policy.

Medical Authorization: I authorize any medical professional,hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Signatures: I acknowledge receipt of the Required Outline of Coverage and I certify that:
1. Premiums are being paid by me as a personal expense. **2.** My employer is not contributing to any part of the premium, either directly or through reimbursement. **3.** Since my employer does not sponsor an employee health plan, neither my employer nor I deduct any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code.

The Disclosure Statement will be provided upon request. (Also available at www.bcbstx.com)

Important: Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant's Signature: _____ Date Signed: _____

Spouse's Signature (ONLY if to be insured): _____ Date Signed: _____

Parent/Guardian Signature (if Primary Applicant is a Minor): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the Required Outline of Coverage, and if requested, the Disclosure Statement.

Policy(ies) should be mailed to ☐ **Agent** ☐ **Agent**

☐ **Agent** ☐ **Agency** # _____ _____ % _____
BCBSTX Assigned Agent # percent Tax I.D.

Please PRINT Name _____

Address _____

City, State, Zip _____

Phone (___) _____ Fax (___) _____

Signature _____ Date _____

☐ **Agent** ☐ **Agency** # _____ _____ % _____
BCBSTX Assigned Agent # percent Tax I.D.

Please PRINT Name _____

Address _____

City, State, Zip _____

Phone (___) _____ Fax (___) _____

Signature _____ Date _____

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Primary Applicant's Signature: **X** _____

Print Your Name as You Signed It: _____ Date Signed: ____ / ____ / ____

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Changes in state or federal law, or regulations or interpretations thereof, may change the terms and conditions of coverage.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association