HIGHMARK® Delaware

Highmark Blue Cross Blue Shield Delaware
ATTN: Underwriting Services, 1-8-10
PO Box 1991, Wilmington, DE 19899-1991
Fax: 877-731-4883

BLUE INDIVIDUAL
Application for Individual Coverage
Medically Underwritten—Subject to Approval

INSTRUCTIONS

- Complete this form and send to the address above.
- Form must be signed. An updated application will be required if the entire application process is not completed within 90 days of the date you signed this form.
- Incomplete applications will be returned. If additional information is needed from a physician, please allow four to six weeks to complete the process.
- Use a separate sheet of paper if more space is needed.
- To add a dependent or change coverage to a higher coverage level option, complete the entire application. To cancel a dependent or change to a lesser coverage level option, complete a *Change in Coverage* form.
- Make check or Money Order payable to Highmark Blue Cross Blue Shield Delaware.

IMPORTANT INFORMATION (Please read carefully.)

- **Do not cancel your current health care coverage until you have been informed of your approval.**
- Coverage is not guaranteed. Some or all persons on this application may be denied.
- The oldest applicant accepted will be the contract holder.
- **Please note:** Benefits include a 12-month preexisting waiting period. Individuals under age 19 will not be subject to a preexisting waiting period. If you have prior Blue Cross Blue Shield coverage (with no lapse), please submit your Certificate of Coverage to reduce this waiting period (with this application or send to the address above).

ELIGIBILITY

- A Delaware resident between the ages of 19 to 64;
- Not enrolled in or eligible for Medicare; and
- If a non-citizen resident of the U.S., must have resided in the U.S. for six consecutive months

I. APPLICANT INFORMATION. List all persons applying.

Last Name	First Name	M.I.	Date of Birth	Relationship	Social Security No.	Height	Weight
				Self: ☐ Male ☐ Female			
				☐ Spouse* ☐ Son ☐ Daughter			
				☐ Son ☐ Daughter			
				☐ Son ☐ Daughter			

Mailing Address: Number Street City State Zip Code

Home Phone: ( ) Business Phone: ( ) Are you married? ☐ Yes ☐ No

May we contact you by email? If yes, please provide your email address:

Employment information must be completed for you and your spouse, even if spouse is not applying for coverage.

Applicant's Employer: _____ Self-employed? ☐ Yes ☐ No Occupation:_____ ☐ Full-time ☐ Part-time

Spouse's Employer: _____ Self-employed? ☐ Yes ☐ No Occupation:_____ ☐ Full-time ☐ Part-time

If you are approved, please provide the date you would like your coverage to begin: Month: _____ ☐ 1st ☐ 15th

I am only interested in coverage if all persons on this application are approved: ☐ Yes ☐ No

HIGHMARK DE USE ONLY	Effective Date: _____ / _____ / _____			
GENERAL AGENT USE ONLY	Agent Name:	Agent No.:		
BROKER/PRODUCER USE ONLY	1). Did you review the completed application with the applicant(s)? ☐ Yes ☐ No	If No, please explain:	2). Are you aware of any undisclosed or misrepresented information on this application that would have an impact on Highmark DE's decision to approve or deny the applicant(s)? ☐ Yes ☐ No	If Yes, please explain:
Broker Name (Print):		Broker Signature:	Broker Number:	Date:

*Effective January 1, 2012, Highmark DE's definition of spouse includes civil union partners for all group and individual insured policies.

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II. COVERAGE LEVEL AND BILLING CYCLE. Check one option. Information shows single/family deductible amounts, and the level of coverage once the deductible is met.

Coverage level:

☐ BlueIndividual EPO $30 - $1,200/$2,400 ☐ BlueAdvantage HSA PPO - $1,800/$3,600 ☐ BlueAdvantage HSA EPO - $2,000/$6,000

☐ BlueIndividual EPO $40 - $2,400/$4,800 ☐ BlueAdvantage HSA PPO - $3,000/$6,000 ☐ BlueAdvantage HSA EPO - $3,000/$9,000

Choose billing cycle: ☐ Monthly ☐ Quarterly (Direct Billing - January, April, July, October)

III. INSURANCE INFORMATION. CHECK ANSWER THAT BEST APPLIES.

1. ☐ I have no health insurance coverage now and am applying for new coverage.
   ☐ I am an existing Highmark DE Individual customer and want to change my coverage. (See choices below).
   ☐ Add a dependent ☐ Change coverage level
   ☐ I am currently enrolled with Highmark DE through a group or association. ID Number: _____
   ☐ I am currently enrolled with another carrier. Name of carrier:_____
   ☐ I am currently enrolled with another Blue Cross and Blue Shield plan. Name of plan: _____
   My current health care coverage will end on ____/____/____. If approved, will this policy replace current coverage? ☐ Yes ☐ No
2. Is anyone listed on this application eligible for Medicare? ☐ Yes ☐ No
   If "Yes," please provide the name(s) of family member(s): _____
3. Please list below anyone on this application who:
   • has not had any health insurance for the past 12 months:_____
   • previously applied for health insurance in the past three years and was denied for medical reasons: _____

IV. HEALTH STATEMENT.

Because this coverage is medically underwritten, we need your complete and accurate answers to all of the following health questions. Highmark DE has a duty to report insurance fraud to the Fraud Bureau of the Delaware Department of Insurance. For each family member applying, list all of the information below for the last visit with his/her physician.

Applicant Name	Date of Visit	Symptom or condition	Results of Visit – Provide Details	Complete Physician Name and Address

Has any person included on this application had any known indication, diagnosis or treatment within the last seven years of any of the conditions listed below? **Please check "Yes" or "No" for each question.** If "Yes," circle the appropriate condition. Answering "Yes" will not necessarily result in rejection of your application. Do not include any genetic information, such as family medical history or any information related to genetic testing, services or counseling.

	Yes	No	Relevant Person Applying
1. Any cancer, cysts, tumors or unusual growths?	☐	☐	_____
2. Any metabolic or endocrine conditions/disorders *(examples: diabetes, adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, chronic fatigue syndrome, AIDS or any immune disorder)*?	☐	☐	_____
3. Any alcohol, drug or substance abuse or dependency, or been advised to reduce alcohol or drug intake?	☐	☐	_____
4. Any disorder of the circulatory system or heart *(examples: aneurysm, chest pain, elevated cholesterol level, heart attack, heart murmur, high blood pressure, irregular heart beat, phlebitis, rheumatic fever, stroke or varicose veins)*?	☐	☐	_____
5. Any emotional or psychological disorders *(examples: adjustment disorder, anxiety, attention deficit disorder, depression, obsessive-compulsive disorder, schizophrenia or attempted suicide)*?	☐	☐	_____
6. Any disorder of the lungs or respiratory system *(examples: allergy, asthma, chronic obstructive pulmonary disease, emphysema or tuberculosis)*?	☐	☐	_____
7. Any disorder of the kidney or urinary system *(examples: cystitis, renal failure, kidney stones, nephritis, prostatitis or recurring bladder infections)*?	☐	☐	_____
8. Any disorder of the brain or nervous system *(examples: epilepsy, seizures, head trauma, migraines, multiple sclerosis or paralysis)*?	☐	☐	_____
9. Any disorder of the digestive system *(examples: cirrhosis, chronic constipation, colitis, esophagitis, gall bladder/stones, hemorrhoids, chronic acid reflux, hepatitis or ulcer)*?	☐	☐	_____
10. Any disorder of the muscles or skeletal system *(examples: arthritis, bursitis, carpal tunnel syndrome, gout, back or spine trouble, external deformity, osteomyelitis, osteoporosis, rheumatism, or scoliosis)*?	☐	☐	_____
11. Any disorder of the skin *(examples: collagen disorder, eczema or psoriasis)*?	☐	☐	_____
12. Any disorder of the blood *(examples: anemia, hemophilia, leukemia or sickle cell)*?	☐	☐	_____

	Yes	No	Relevant Person Applying
13. Any breast or gynecological disorders *(examples: endometriosis, infertility, irregular menstruation, or breast condition)*?	☐	☐	
14. Any venereal disease *(examples: gonorrhea, herpes or syphilis)*?	☐	☐	
15. Any disorders of the eye, ear, nose or throat *(examples: allergy, deafness, cataracts)*?	☐	☐	
16. Any of the following conditions or procedures: Alzheimer's disease, cystic fibrosis, Hodgkin's disease, muscular dystrophy, myasthenia gravis, palsy, Parkinson's disease or polio?	☐	☐	
17. Any congenital conditions?	☐	☐	
18. Any premature births, caesarean deliveries, or miscarriages?	☐	☐	
19. Is any person named on this application currently pregnant, expecting a baby or in the process of adoption or surrogacy? If "Yes," please fill in expected delivery or adoption date below	☐	☐	
Expected delivery or adoption date: _____ / _____ / _____			
20. Any motor vehicle accident involvement in the last three years?	☐	☐	
21. Is any applicant an organ transplant recipient or currently on a transplant waiting list?	☐	☐	
22. Any abnormal test or physical exam results, or is any applicant currently awaiting test results?	☐	☐	
23. Any advice by a physician to undergo additional testing or treatment that has not yet been sought?	☐	☐	
24. Any scheduled surgery or hospital admission within the next six months?	☐	☐	
Please list the condition: _____			
Date of scheduled surgery or hospital admission: _____ / _____ / _____			
Attending physician: _____			
25. Any tobacco use (smoked, snuffed or chewed tobacco) at any time during the past 24 months?	☐	☐	
26. Any health issue not previously mentioned on this application for which advice, diagnosis, care or treatment (including medical, surgical, hospital, emergency, or urgent care) was sought?	☐	☐	
27. Any health issue not previously mentioned on this application for which advice, diagnosis, care or treatment was not sought?	☐	☐	

- If you answered "Yes," to any of the questions above, please enter details below. (If more space is required, use a separate piece of paper.)
- All questions must be answered "Yes" or "No," or your application will be returned.
- Failure to disclose conditions may result in voiding of coverage and denial of benefits.

Applicant Name	Question No.	Illness or condition	Last Treatment	Operation	Complete Attending Physician Name and Address
			Month Year /	☐ Yes ☐ No	
			Month Year /	☐ Yes ☐ No	
			Month Year /	☐ Yes ☐ No	
			Month Year /	☐ Yes ☐ No	

- Has anyone included in this application been prescribed medications in the last 12 months? (If "Yes," please complete the information below). ☐ Yes ☐ No

Applicant Name	Drug and Daily Dosage	Illness or condition

V. AUTHORIZATION TO PROVIDE HEALTH INFORMATION TO BROKER

If you are submitting this application through a broker, complete this section to indicate if you authorize Highmark DE to discuss this application, including related health information, with that broker. Please note: This authorization applies to all applicants signing below.

_____ Yes, I do want Highmark DE to discuss this application with my broker. Please write your broker's name in the blank below.

_____ No, I do not want Highmark DE to discuss this application with my broker.

I authorize Highmark BCBSD Inc. to release my Protected Health Information (PHI) to _____ (name of your broker) for any and all purposes related to this application for coverage, including discussion of Highmark DE's decision to accept or reject the application. My signature below authorizes the disclosure of all PHI in Highmark DE's possession, specifically including the following: HIV/AIDS, Substance Abuse, Behavioral Health and Genetic Testing. I understand that I may revoke this authorization at any time by notifying Highmark DE in writing. My revocation will not affect any action that Highmark DE took before receiving my notice. I understand that if the person I have authorized to receive my PHI is not subject to federal health information privacy laws, the information will no longer be protected by those laws and may be re-disclosed. I understand that giving this authorization is not a condition of eligibility for benefits, enrollment in a health plan or payment of claims.

VI. TERMS OF AGREEMENT

I hereby apply on behalf of myself, my spouse and my dependent children (if listed on this application) for a Highmark Blue Cross Blue Shield Delaware (Highmark DE) health insurance contract.

I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I have the authority to act for myself, my spouse and all of my dependent children; including those who have reached the age of 18.
2. The contract will be effective only for those applicants approved by Highmark DE.
3. If Highmark DE accepts this application, I will receive a copy of the contract and an identification card. The contract will state plan benefits for insureds and define the conditions under which the benefits will be available. If I am a new member, the carrier holding my ID card will specify the effective date of my coverage.
4. Highmark DE has a 12-month waiting period before preexisting conditions will be covered under this contract. Individuals under age 19 will not be subject to a preexisting waiting period. Highmark DE will apply this waiting period to any physical or mental condition of a covered person (a) for which medical advice, diagnosis, care or treatment was received within the 12 months prior to this contract being effective, or (b) that manifested symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis or treatment within the 12 months prior to this contract being effective.
5. The contract, application and any attached amendments shall constitute the entire agreement and shall supersede any previous agreements.
6. I will pay the premiums to Highmark DE when due.
7. In the event there is an error made in any payment of benefits, I agree to refund to Highmark DE the amount of any overpayment of benefits to which I am not entitled.
8. I will notify Highmark DE in writing if there have been any changes to the health of any person listed on this application, that occur prior to acceptance of this application by Highmark DE.
9. All statements made on this application are complete, true, and correctly stated to the best of my knowledge. I intend for Highmark DE to rely on these representations in deciding to issue the contract, and for them to be part of this contract.
10. Failure to enter accurate and complete medical information in writing, as well as failure to update that information prior to the acceptance of the application by Highmark DE, may be a material or fraudulent misrepresentation. If so, Highmark DE may void or cancel your contract, deny benefits for the affected individual or condition, and report fraud to the Delaware Department of Insurance.
11. I authorize any medical professional, hospital, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, health plan, or other medical or medical-related facility, governmental agency or other person or firm, to disclose to Highmark DE or Highmark DE's authorized representative information (including copies of records) concerning advice, care or treatment provided to me and/or my dependents. That information may include, without limitation, information relating to HIV/AIDS, mental health, or abuse of drugs or alcohol. In addition, I authorize Highmark DE to use its own records for information. I understand that such information will be used by Highmark DE to evaluate my application for health coverage, to decide whether or not to offer me coverage, and to determine whether I am eligible for benefits. I understand information obtained with my authorization may be re-disclosed by Highmark DE as permitted or required by law and that upon such re-disclosure, it may no longer be protected by federal privacy laws. I understand that I, or any authorized representative, will receive a copy of this authorization upon request. This authorization is valid for two years from the date signed unless (a) revoked by me in writing, which I may do at any time, or (b) Highmark DE declines this application. Any revocation will not affect the activities of Highmark DE prior to the date such revocation is received by Highmark DE.

IF I HAVE A HEALTH SAVINGS ACCOUNT (HSA), I UNDERSTAND AND AGREE TO THE FOLLOWING ADDITIONAL STATEMENTS

12. If Highmark DE accepts this application, I accept complete and sole responsibility, and Highmark DE has no responsibility for payment of any tax obligations I may incur should any individuals I cover under a Highmark DE health insurance contract not meet the definition of spouse or dependent child under the Internal Revenue Code and IRS published rulings. Such tax obligations include, but are not limited to, federal, state and local income tax obligations, and any interest and penalties that may result from such tax obligations.
13. If Highmark DE accepts this application, the Highmark DE health insurance policy that will be issued to me is intended to qualify as a high-deductible health plan (HDHP) under Section 223 of the Internal Revenue Code and IRS published rulings. I should obtain professional legal advice before I establish or contribute to a Health Savings Account (HSA) now and in the future.

I have carefully read this application and agree to the terms and conditions specified. All applicants have signed below, except for dependent children under the age of 18.

Signature (DO NOT PRINT)	Printed Name	Date
Signature of Spouse or Child Age 18 or Older (DO NOT PRINT)	Printed Name of Spouse of Child Age 18 or Older	Date
Signature of Child Age 18 or Older (DO NOT PRINT)	Printed Name of Child Age 18 or Older	Date