BLUECROSS BLUESHIELD OF MINNESOTA

AWARE CARE & HSA OPTIONS BLUE
APPLICATION CHECKLIST

Application Process:

How To Apply:

- ❒ Complete the application, being sure to answer all questions completely. **Important: for any/all yes answer to questions 19-26 must have complete corresponding information in section 27. Be sure to include reason for visit, results of physicals or test (i.e. results normal) any date of complete recovery if applicable.**
- ❒ If you currently have coverage, choose an effective date 30-60 days in advance. Underwriting review requires one month, typically. Should your medical records be requested from your doctor(s), a decision may take longer – up to 60 days. Your providers may charge for this service! BCBSM allows/pays up to $30 dollars. If you do not currently have coverage, choose the application date as the effective date**.** If accepted, your coverage will be placed in force either on the date BCBSM received your application or on any future date specified at question 16. You may specify a future effective date up to 60 days from signature date.
- ❒ **Send your first estimated premium with application (i.e. monthly, quarterly, semi-annual) your check will be cashed upon receipt by BCBSM. If you are not accepted your premium will be refunded. NOTE: Checks must be written from a personal account.**
- ❒ If you prefer to pay monthly, you must agree to the automatic checking withdraw or Pay-O-Matic program. Should you desire to pay monthly, please complete the Pay-O-Matic form and attach a voided check with the application.
- ❒ Sign and date the application. Applications must be received within 15 days of the signature date.
- ❒ Return the application to the address below. The application must be returned for application review and agent signature or the application may be returned.

  MN Health Insurance Network
  1020 E 146th St Suite 107
  Burnsville, MN 55337
- ❒ If coverage is issued, you will receive your ID card(s), contract and will be billed for future payments.
- ❒ If coverage is declined, BCBSM will refund your money.
- ❒ So that we can provide you application status updates complete the following contact information.

E-mail Address ____
Daytime Phone ____

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

We will be happy to assist you wherever possible. Please contact me at 952-432-2663 with any questions you might have.

For a complete provider directory see: http://www.bluecrossmn.com/

Application for an Individual Health Contract for Aware Care or Options Blue

BlueCross BlueShield of Minnesota

An independent licensee of the Blue Cross and Blue Shield Association

P.O. Box 64024, St. Paul, MN 55164

FOR COMPANY USE ONLY
Y 0 Effective Date
FOR AGENT USE ONLY (Please print legibly)
Agency code
Agent's number
Agent name ______

1. Applicant's or Contractholder's name

LAST FIRST MIDDLE

2. Applicant's or Contractholder's social security number ___ – ___ – ___ Spouse's social security number ___ – ___ – ___

3. Sex ☐ Male ☐ Female 4. Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

5. Applicant's address

STREET

CITY STATE ZIP

6. Home phone # ( )______ Applicant's work phone # ( )______ Spouse's work phone # ( )______

7. Are you a permanent resident of Minnesota currently residing in Minnesota? ☐ Yes ☐ No If no, please explain.

______

8. Payment mode (check one): ☐ Annual (12 months) ☐ Semiannual (6 months) ☐ Quarterly (3 months) ☐ Pay-O-Matic (1 month)

Amount paid with this application $______ Please make your check payable to Blue Cross and Blue Shield of Minnesota (BCBSM).
Payment must accompany application. We do not accept business checks for payment of coverage (See exception on page 4).

9. Applicant's occupation and employer (or employment status) ______

10. Spouse's occupation and employer (or employment status) ______

11. Starting with yourself, list each family member for whom application is being made.

Full name and Social Security #	Relationship to applicant	Birth date mo/day/yr	Sex	Height	Present weight	Weight one year ago
Name	Applicant			ft. in.	lbs.	lbs.
Name Social Security #				ft. in.	lbs.	lbs.
Name Social Security #				ft. in.	lbs.	lbs.
Name Social Security #				ft. in.	lbs.	lbs.
Name Social Security #				ft. in.	lbs.	lbs.

For any dependents age 19-24 listed in item 11, complete the following:

Name of dependent	Fulltime Student	Anticipated graduation date	School name
	☐ Yes ☐ No		
	☐ Yes ☐ No		

12. **Aware Care ONLY,** select your choice of calendar-year deductible:

☐ $300 ☐ $500 ☐ $750 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000 ☐ $10,000

If applying for a $5,000 deductible, you must select benefit percentage

☐ $5,000 – 80% benefit percentage ☐ $5,000 – 100% benefit percentage

13. **Options Blue ONLY,** select your choice of plan, deductible and preventive care:

☐ **Options Blue 80:**	☐ Low deductible	☐ Middle deductible	☐ High deductible
Preventive Option:	☐ 100% to a maximum of $300, then 80% after deductible		☐ 80% after deductible
☐ **Options Blue 100:**	☐ Low deductible	☐ Middle deductible	☐ High deductible
Preventive Option:	☐ 100% to a maximum of $300, then 100% after deductible		☐ 100% after deductible

The deductible and out-of-pocket maximum benefits are subject to annual adjustments on the annual renewal date. These adjustments are based on the Consumer Price Index (CPI) published by the Federal Department of Labor.

14. **PREVIOUS HEALTH INSURANCE INFORMATION -** If you are approved for coverage, **your contract will not cover preexisting conditions for the first 12 months**. You will not be subject to this exclusion to the extent you have already fully satisfied this type of requirement under prior continuous coverage. Please provide details of other coverages below.

Do you or any family member included on this application currently have any health insurance or had any health insurance within the past 63 days? . . . . ☐ Yes ☐ No

If YES, you must fully complete the following section by providing all health insurance information for the past 12 months for you and any family member included on this application:

Person Covered	Insurance company name, and policy number	Date Coverage Started	Date Coverage Ended	Was the previous coverage individual or group coverage?
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

15. **REASON FOR APPLICATION (complete one):**

☐ I am a new applicant presently not covered under a BCBSM contract.
☐ I presently have BCBSM coverage. I am covered under ID number ___ – ___ – ___
☐ I presently have Aware Care coverage and want to add my dependent(s) listed on the previous page. My contract identification (ID) number is ___ – ___ – ___

16. **REQUESTED EFFECTIVE DATE:** I agree that, if approved, coverage will be effective as of the date the complete application is received in the home office of BCBSM, or coverage will be effective on such later date as may be designated here, Month ___ Day ___ Year ___ provided this date is not more than 60 days beyond the date of this application. If this application is not approved, no coverage will be effective.

Have you completed an application for a 30-day or 60-day Insta-Care contract to precede this coverage? ☐ Yes ☐ No
If yes, please leave the requested effective date blank. If approved for coverage, BCBSM will assign an effective date that coincides with the termination date of the Insta-Care contract. We cannot process this application if the termination date of the Insta-Care contract is greater than 60 days beyond your signature date on this application.

17. **CHEMICAL DEPENDENCY COVERAGE:**
Coverage for chemical dependency is included in the contract. You may choose to delete chemical dependency coverage. Your premium will be slightly reduced if you delete chemical dependency coverage. Your decision to retain or delete chemical dependency coverage applies to all individuals applying for coverage under this contract.
Check this box if you want to **EXCLUDE** chemical dependency coverage . . . . ☐

18. **TOBACCO USE DESIGNATION AND DECLARATION:** **Yes** **No**
A. I have used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application. . . . . ☐ ☐
B. My spouse (if included on this application) has used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application. . . . . ☐ ☐

NOTE: Tobacco-free rates are available only to persons who have not used tobacco and/or smokeless tobacco in the preceding 24 months.

19. **HEALTH HISTORY (Complete information is required for all family members who are applying for coverage.)**

Have you or any other family member listed in this application ever had, 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.)

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 which 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.

	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, or rectal disorders	☐	☐
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 or allergic reaction, lung, or breathing disorder.	☐	☐
F. NERVOUS, EMOTIONAL, MENTAL, OR PERSONALITY DISORDERS—Depression, anxiety, adjustment disorders, 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	☐	☐
I. MUSCULOSKELETAL DISORDERS—Back disorders, scoliosis, temporomandibular joint disorder (TMJ), fibrositis, fibromyalgia, carpal tunnel syndrome, gout, arthritis, joint disorders, or amputation	☐	☐
J. CANCER, SARCOMA, 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)	☐	☐
20. Do you or any family member, including persons not applying for coverage, expect to add dependents to your coverage through birth or adoption within the next 12 months? If yes, expected date of birth or placement: ☐☐/☐☐/☐☐	☐	☐
21. Is any family member now pregnant or expecting a child through adoption, even if they are not applying on this application? If yes, expected date of birth or placement: ☐☐/☐☐/☐☐	☐	☐
22. Have you or any other family member listed in this application:		
A. Ever had an operation?	☐	☐
B. Been medically advised to have treatment or diagnostic testing, including dental work, that has not yet been performed?	☐	☐
C. Been hospitalized within the last 10 years?	☐	☐
D. Seen a doctor, chiropractor, psychologist, therapist, or any other health care professional within the past five (5) years?	☐	☐
E. Ever had any positive test for or any disease or disorder of the immune system?	☐	☐
F. Had a health-related screening or diagnostic test such as a blood test, mammogram, or x-ray during the last five (5) years?	☐	☐
G. Taken any prescription medication within the past 24 months? If yes, give type of medication and reason in number 27.	☐	☐
H. Ever been treated for or currently have a congenital abnormality?	☐	☐
23. Have you or any other family member listed in this application:		
A. In the past five (5) years, used drugs on a regular basis, other than drugs prescribed by an attending physician, or been treated for the abuse of any drugs or alcohol?	☐	☐
B. In the past five (5) years, have you or any other family member listed in this application been convicted of DWI or DUI? In the past five (5) years, have you or any other family member listed in this application had his/her driver's license suspended or revoked for driving while under the influence of alcohol or a controlled substance? If yes, give details, including names, dates, and driver's license numbers in number 27.	☐	☐
C. Ever been advised by a health care professional to quit or reduce use of alcohol or drugs? If yes, please provide details including individuals involved, dates, and driver's license number in number 27.	☐	☐
D. Do you or any other family member listed in this application drink alcohol? If yes, please explain in number 27 the average amount used weekly.	☐	☐
24. Do you or any other family members listed in this application have any condition that may necessitate medical, surgical, or hospital care? If yes, please explain in number 27	☐	☐
25. Have you or any family members listed in this application ever been declined coverage, charged an increased rate, or had benefits excluded from coverage for any health care or life insurance coverage?	☐	☐
26. Do you or any family member plan to travel in a foreign country in the next year? If yes, please explain (include destination, departure and return dates in number 27).	☐	☐

27. **IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS (19–26), PLEASE COMPLETE THIS SECTION. GIVE COMPLETE DETAILS. ADD AN ADDITIONAL PAGE IF YOU NEED MORE SPACE.**

Ques. no. & letter	Person's name	Date of onset	Diagnosis, treatment, or **reason for physical check-up including all results of physical examinations and diagnostic tests**	Days in hospital	Date of complete recovery	Doctor's name and complete address

28 . **PLEASE LIST THE NAMES AND ADDRESSES OF THE PHYSICIANS OR HEALTH CARE PROFESSIONALS WITH THE MOST COMPLETE KNOWLEDGE OF THE MEDICAL HISTORY FOR YOU AND ALL FAMILY MEMBERS APPLYING FOR COVERAGE.**

Name of family member	Provider's name	Provider's address	City	State and zip code

29. **TO BE SIGNED BY APPLICANT (AND SPOUSE IF APPLYING FOR COVERAGE):**

I have read the preceding statements and answers and declare them to be true and complete. I understand and agree that coverage, if approved, will commence in accordance with question 16. I am enclosing a check for the initial payment. **For administrative convenience, BCBSM will deposit in a bank any cash or check I submit with this application, but such deposit shall not constitute an approval of this application or issuance of coverage.** If this application is rejected, a refund check will be mailed to me.

I agree to notify BCBSM of any change in my (or my spouse's or children's) health condition between the date of this application and the effective date of coverage. Failure to notify BCBSM of any change in my (or my spouse's or children's) health condition may result in denial of claim(s) and/or rescission of the contract or the issuance of a contract rider.

I UNDERSTAND AND AGREE THAT BCBSM WILL ACT IN RELIANCE UPON THE INFORMATION I HAVE PROVIDED HEREIN AND THAT ANY MISSTATEMENTS IN THIS APPLICATION WHICH MATERIALLY AFFECT EITHER THE ACCEPTANCE OF RISK OR HAZARD ASSUMED BY BCBSM MAY RESULT IN DENIAL OF A CLAIM(S), OR RESCISSION OF THE CONTRACT AS APPLIED FOR HEREIN. I ALSO UNDERSTAND AND AGREE THAT PAYMENT OF A CLAIM DOES NOT PRECLUDE THE RIGHT OF THE COMPANY TO DENY FUTURE CLAIMS OR TAKE ANY ACTION IT DETERMINES APPROPRIATE.

Upon request, I agree to furnish additional information needed concerning eligibility of any dependents.

X ____________ Date **X** ____________ Applicant's Signature **X** ____________ Date **X** ____________ Spouse's Signature (if applying for coverage)

PLEASE ANSWER ALL QUESTIONS, OTHERWISE YOUR APPLICATION OR EFFECTIVE DATE MAY BE DELAYED. YOUR PAYMENT MUST ACCOMPANY THIS APPLICATION.

EXCEPTION FOR BUSINESS CHECKS

We do not accept business checks or Pay-O-Matic electronic payments from employers with two (2) or more individuals working 20 hours or more per week.

The only exception is if the business does not have two (2) or more individuals working 20 hours or more per week. If this exception applies to your application, you must sign and date the following statement:

I am paying for this coverage with a business check or Pay-O-Matic electronic payment. I confirm this business does not have two (2) or more individuals working 20 hours or more per week.

X ____________ Date **X** ____________ Applicant's Signature

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 in this application are complete and accurate as given.

X ____________ Agent's signature (   ) ____________ Agent's phone number ____________ Date