Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: (818) 987-5000 fax: (818) 776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana, CA 91356

Please make your check payable to: Blue Cross of California

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: (818) 987-5000

Thank you for choosing...

Individual Enrollment Application

The following plans are offered by Blue Cross of California: PPO Share 2500/1500/1000/500, Select HMO, HMO Saver, Individual HMO, EPO and DentalSelect HMO plans. The following plans are offered by BC Life & Health Insurance Company (BCL&H): Basic PPO 1000/2500, PPO Saver, PPO Share 5000/1000/500, RightPlan PPO 40 plans, PPO 3500 (HSA-Compatible), 3500 Deductible PPO, Dental PPO and Term Life products. Blue Cross of California and BCL&H are Independent licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.

1. Application must be completed by the applicant in blue or black ink.
2. Any family member currently pregnant (whether or not listed on the application) or in the process of adoption is not eligible.

Applicant's Social Security or ID No.

1. *Applicant Information* (Please print)

Primary Applicant's Last Name First Name M.I.

Home Address (Must be complete: P.O. Box not acceptable)

City State ZIP Code

Reason for Application (Check one)

☐ New enrollment(s) ☐ Child only

☐ Add dependent(s) to ID No: _____

To change existing Blue Cross plan, please enter ID No: _____

For Summary Bill (existing), please enter ID No: _____

Primary Applicant's Social Security or ID No.	County Applicant Resides in *(Required)*	Home Phone No.
Mailing Address *(If different than above)* or P.O. Box Personal Mail Box (PMB) No.	Daytime Phone No.	FAX No.
City State ZIP Code	Marital Status ☐ Single ☐ Married	Spouse's Social Security or ID No.
E-mail Address	If possible, do you want e-mail notification? ☐ Yes ☐ No	Maiden Name of Applicant/Spouse

Has any person listed on this application resided (not traveled) outside the U.S. for the past three (3) consecutive months? ☐ Yes ☐ No
If yes, please explain:

Language Choice *(Optional)* ☐ English ☐ Spanish ☐ Korean ☐ Chinese

2. *Choice of Blue Cross Individual Coverage*

Do you wish to choose FamilyElect℠ for medical coverage? ☐ **Yes** ☐ **No**

If yes, proceed to Section 3 on the following page. Refer to the 4-digit codes in parentheses below to indicate medical coverage choices in Section 3B for each family member. **(NOTE: If choosing FamilyElect℠, all family members will be assigned the same original effective date.)**

If no, select ONE medical plan choice below.

If you are choosing **Dental** coverage or **Term Life Insurance**, please complete the appropriate sections on page 2.

MEDICAL COVERAGE

PPO Coverage

BC Life & Health Products

☐ BC Life Basic PPO 1000 (7900)
☐ BC Life Basic PPO 2500 (R418)
☐ BC Life PPO Saver (NM31)
☐ BC Life 3500 Deductible PPO (R420)
☐ BC Life PPO Share 1000 (1930)
☐ BC Life PPO Share 500 (1929)
☐ _____

☐ BC Life Basic PPO 1000 without Life (PE25)
☐ BC Life Basic PPO 2500 without Life (R419)
☐ BC Life PPO Saver without Life (PE27)
☐ BC Life Share 5000 (H062)
☐ BC Life RightPlan PPO 40-No Rx (P958)
☐ BC Life RightPlan PPO 40-Generic Rx (PE48)
☐ BC Life RightPlan PPO 40-Comprehensive Rx (PE49)
☐ BC Life PPO 3500 (HSA-Compatible) (TI60)

Blue Cross of California Products

☐ PPO Share 2500 (7891)
☐ PPO Share 1500 (7889)
☐ PPO Share 1000 (1393)
☐ PPO Share 500 (7895)
☐ EPO (HSA Compatible) (7892)

Alternative HMO Coverage

☐ Select HMO* (PE43) ☐ HMO Saver * (7896) ☐ Individual HMO* (7898)

*** If you have chosen Select HMO, HMO Saver or Individual HMO medical coverage, please complete Section 3A on the following page.**

If you do not qualify for an HMO plan, would you like to be considered for enrollment in PPO coverage at a higher premium rate?

☐ **No, DO NOT enroll me** ☐ **Yes –** Specify any PPO coverage you wish to be enrolled: _____

HIPAA Enrollment

To determine eligibility for HIPAA guaranteed enrollment, please go to Section 5, questions D–D3.

If eligible, please enroll me in:
☐ BC Life HIPAA Basic PPO 1000 (PE02)
☐ HIPAA PPO Share 2500 (R415)
☐ BC Life HIPAA PPO Share 5000 (R417)
☐ HIPAA PPO Share 1500 (R416)

Applicant's Social Security or ID No.

DENTAL COVERAGE

☐ BC Life Dental PPO (7874)
☐ Dental Saver SelectHMO* (ZE6N)
☐ Dental SelectHMO* (ZE7N)
☐ Dental Premier SelectHMO* (ZE8N)

** For any of the Blue Cross Dental SelectHMO coverages, please indicate the Provider number:*

Provider Number

Please list applicants you wish to provide Dental coverage for:

Applicant Name	Birthdate	Applicant Name	Birthdate	Applicant Name	Birthdate
Self		Dependent			
Spouse					

3. Applicants for Medical Coverage

Please list ALL applicants (youngest to oldest) applying for coverage.
For RightPlan PPO 40, each member will be enrolled on his/her own policy. Use FamilyElect section 3B. If a family member's last name is different than yours, please explain: _____

MUST BE ACCURATE

3A. For HMO Use Only Choose a physician for each family member from the Provider Directory.

3B. FamilyElect Medical Coverage Choose Medical Plan code number(s) from Section 2

Relation	Last Name First M.I.	Social Security or ID No.	Birthdate	Age	Height	Weight	PMG/ IPA	Primary Care Physician (PCP)	Current Patient	3B.
10 ☐ Male 20 ☐ Female	Yourself		/ /						☐ Yes ☐ No	
30 ☐ Male 40 ☐ Female	Spouse*		/ /						☐ Yes ☐ No	
☐ Son ☐ Daughter			/ /						☐ Yes ☐ No	
☐ Son ☐ Daughter			/ /						☐ Yes ☐ No	
☐ Son ☐ Daughter			/ /						☐ Yes ☐ No	

3C. Dependent Information: Do you claim all children listed above who are between the ages of 19 through 22 as dependents on your Federal Income Tax? ☐ Yes ☐ No **If "NO", any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is not eligible as a dependent but may apply individually.** *Spouse includes domestic partner (when applicable). Domestic partner enrollment requires submission of a copy of a valid Declaration of Domestic Partnership filed with and stamped by the California Secretary of State.

4A. BC Life & Health Term Life Insurance

TERM LIFE COVERAGE

Applicants and/or any dependents that are approved will also qualify for BC Life & Health Insurance Term Coverage at an additional charge. Applicants under the age of one year are not eligible for life insurance.
DO NOT SUBMIT PREMIUM FOR LIFE INSURANCE.

Family Member Name	✓ Amount of Coverage $15,000* (30)	$30,000* (31)	$50,000* (32)	Beneficiary Name	Relationship	Beneficiary Address City / State / ZIP Code

If you have selected term life coverage, you are submitting this application and providing the information on this application to the life insurance department of BC Life & Health Insurance Company – Initial: _____

***NOTE:** The $50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $30,000.

If beneficiary is not listed and policy is issued, death benefits will be paid in accordance with the Beneficiary Provision on page 3 of the Policy.

I have discussed Life Insurance with my agent and decline to apply – Initial: _____

4B. If you have selected BC Life Basic PPO 1000 (7900) or BC Life PPO Saver (NM31), please provide the beneficiary name below:

Applicant's Social Security or ID No.

5. *Prior Insurance History and HIPAA Eligibility* –

Please answer ALL of the following questions.

Blue Cross credits prior coverage toward the preexisting period for those applicants who apply and are accepted for coverage and request an effective date within 63 days after termination of qualifying prior coverage as required by law. To obtain credit toward the preexisting period, please complete the following.

A. Has any applicant been a member of Blue Cross of California ☐ or any other health plan ☐ within the last 5 years? ..... ☐ Yes ☐ No

B. Has any applicant had coverage in the last 63 days? ..... ☐ Yes ☐ No

If you answered "Yes" to A or B above, please provide the following information for each applicant:

Applicant Name	Insurer Name	Certificate/Policyholder No.	
Plan Name	State	Most recent coverage start date	End Date
Applicant Name	Insurer Name	Certificate/Policyholder No.	
Plan Name	State	Most recent coverage start date	End Date
Applicant Name	Insurer Name	Certificate/Policyholder No.	
Plan Name	State	Most recent coverage start date	End Date

I certify that my coverage terminated/will terminate on (date):

Do you agree to discontinue your current coverage if this application is accepted? ..... ☐ Yes ☐ No

If No, please explain:

C. Has any applicant ever been eligible for or received benefits from any of the following?

(Check all that apply): ☐ Medicaid ☐ Medi-Cal ☐ Medicare ☐ California State Disability Insurance ☐ Workers' Compensation ☐ Employer-sponsored health plan

If Yes, please explain:	Start Date *(Mo/Day/Yr)*	End Date *(Mo/Day/Yr)*

D. HIPAA Coverage – If I do not qualify for the Individual Plans, I would like to be considered for coverage under HIPAA. HIPAA does require eligibility. I understand that no underwriting is required and rates may be higher than for the Individual Plans. If I qualify, please offer the HIPAA coverage and send complete details regarding my options and rates. ..... ☐ Yes ☐ No

If yes, please provide the following information:

Name of Applicant(s) requesting HIPAA Coverage

1. Are you currently covered by or eligible for Medicaid, Medicare, or any other employer-sponsored health insurance benefits, or do you have other health coverage? ..... ☐ Yes ☐ No

   If yes, you are not eligible for HIPAA coverage.

2. Have you had a minimum of 18 months of continuous health coverage <u>most recently</u> under an employer-sponsored group health plan, ("employer" includes a governmental entity or church), that ended within the last 63 days for a reason other than fraud or non-payment of premium? ☐ Yes ☐ No

   If yes, you will be asked to provide documentation of such coverage, preferably the Certificate of Coverage from your former employer or carrier OR a letter from the employer giving us the following:

Name of Applicant	Start Date *(Mo/Day/Yr)*	End Date *(Mo/Day/Yr)*
Name of insurance carrier(s):	Phone No.	

   If no, you are not eligible for HIPAA coverage.

3. Were you eligible for COBRA or Cal-COBRA? ..... ☐ Yes ☐ No

   If yes, please provide the following:

Start Date *(Mo/Day/Yr)*	End Date *(Mo/Day/Yr)*

   If no, please explain:

   If COBRA or Cal-COBRA is not exhausted, you are not eligible for HIPAA coverage.

6. *Health History* – Include information on ALL family members you wish to enroll.
HIPAA law guarantees coverage. Applicants for only HIPAA do not need to complete.

Applicant's Social Security or ID No.

***6A. Health History Questionnaire* – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.**
Give COMPLETE details of any "Yes" answers in Section 6C on the following page.

Has any person listed on this application, in the last **10 years**, had any signs or symptoms, seen a health care provider, had treatment recommended including prescription medications, received treatment, or been hospitalized for any of the following conditions as stated in questions 1 through 14?

1. Brain/Nervous – such as: frequent and/or severe headaches, migraines, seizures, epilepsy, dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, sleep apnea, narcolepsy, used a sleep monitoring device. ☐ Yes ☐ No

2. Heart/Circulatory – such as: chest pain, angina, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, valve replacement, pacemaker, defibrillator; or blood clot, phlebitis, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, Raynaud's. ☐ Yes ☐ No

3. Lungs/Respiratory – such as: allergies, infections, sinusitis, asthma, bronchitis, emphysema, pneumonia, tuberculosis, difficulty breathing, shortness of breath, chronic cough, spitting/coughing up blood. ☐ Yes ☐ No

4. Digestive – such as: tonsillitis, infections of the mouth/throat, jaw/chewing problems, gastric reflux, ulcers, hernia, colitis, intestinal problems, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, gallbladder, pancreatitis, liver disease, cirrhosis, hepatitis, jaundice, unexplained weight loss. ☐ Yes ☐ No

5. Urinary – such as: kidney, bladder, urinary tract infections, stones, urinary incontinence, blood in urine. ☐ Yes ☐ No

6. Male Reproductive System –

a) Such as: prostate, infertility, low sperm count, impotence, sexual dysfunction, penile or scrotal implant, sexually transmitted disease, herpes, genital warts, undescended testes. ☐ Yes ☐ No

b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not listed on this application? ☐ Yes ☐ No

7. Female Reproductive –

a) Such as: breast disorder/cyst, lump, breast implants, fibroid tumors, endometriosis, pelvic pain, menstruation disorders, abnormal/absent menstrual bleeding, uterine fibroids, ovarian cysts, infertility, miscarriages, sexually transmitted disease, herpes, genital warts. ☐ Yes ☐ No

b) Does any proposed female member menstruate? ☐ Yes ☐ No
If yes, indicate if: ☐ Applicant/spouse ☐ Dependent(s)
Dependent name(s): _____

c) Has it been more than 40 days since her/their last menstrual period? ☐ Yes ☐ No
Name(s): _____ ☐ Applicant/spouse ☐ Dependent
If yes, explain: _____

d) Has any female applicant had a pelvic exam/Pap smear? ☐ Yes ☐ No
If yes, complete 7e below.

e) Date and result of last pelvic exam/Pap smear for each female over age 16.
Name: _____ Mo/Day/Yr: ____ ☐ Normal ☐ Abnormal
Name: _____ Mo/Day/Yr: ____ ☐ Normal ☐ Abnormal
Name: _____ Mo/Day/Yr: ____ ☐ Normal ☐ Abnormal

f) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy? ☐ Yes ☐ No

8. Musculoskeletal – such as: bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/joint, amputation, physical handicap, polio, arthritis, gout, sprain/strain, prosthesis, joint replacement, hardware, internal fixations (i.e., pins, plates, screws), fractures, TMJ. ☐ Yes ☐ No

9. Endocrine/Metabolic –

a) Such as: diabetes, thyroid, anemia, adrenal disorders, pituitary disorders, lupus, AIDS/ARC, immune disorders not including the result for an HIV test, scleroderma, Epstein-Barr/chronic fatigue syndrome. ☐ Yes ☐ No

b) Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? ☐ Yes ☐ No

c) Is any applicant currently on the waiting list and/or registered to donate an organ or bone marrow **(excluding DMV donor card)?** ☐ Yes ☐ No

10. Has any applicant ever had cancer, tumor/growth, leukemia, cyst? ☐ Yes ☐ No
If yes, specify: ☐ Cancer ☐ Tumor/growth ☐ Leukemia ☐ Cyst

11. Skin Disorder/Problems – such as: cancer, melanoma, pre-cancerous lesion, psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, acne, fungal infections, eczema, dermatitis, herpes, scars/keloids, or revisions of cosmetic or reconstructive surgery, infections. ☐ Yes ☐ No

12. Eyes, Ears, Nose and Throat – Disorders such as: any infections, crossed eyes, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, problems with tonsils or adenoids, sleep apnea? ☐ Yes ☐ No

13. Nervous, Mental, Emotional, Behavioral – such as: eating disorder, anorexia/bulimia, depression, anxiety, alcohol or substance abuse/dependency, counseling, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive or panic disorder. ☐ Yes ☐ No

14. Congenital Abnormalities, Birth Defects – such as: cleft lip/palate, club foot, webbed fingers or toes, mental retardation, developmental delay, Down's syndrome, heart/lung problems, skull/facial deformities, birthmark. ☐ Yes ☐ No

15. Has any applicant taken any prescribed medications in the **last 12 months?** ☐ Yes ☐ No
If yes, complete 6E on page 6.

16. Has any applicant consulted a provider for any condition or symptom(s) in the **last 12 months**, for which a diagnosis has not been established? ☐ Yes ☐ No

17. Has any applicant been advised to see a dentist or oral surgeon in the **last 12 months (excluding normal checkups)?** ☐ Yes ☐ No

18. Has any applicant been a patient in a hospital, clinic, surgicenter, sanatorium, or other medical facility as an inpatient or outpatient (excluding childbirth) in the last 10 years? ☐ Yes ☐ No
If yes, complete 6C on page 6.

19. In the last 10 years, has any applicant had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing, surgery or treatment? ☐ Yes ☐ No

20. In the last 10 years, has any applicant seen, received treatment from or consulted any doctor, or any other person providing health care services for any other condition or symptom(s) not listed on this application? ☐ Yes ☐ No
If yes, complete 6C on page 6.

Applicant's Social Security or ID No.

6B. *Other Health Questions*

A. During the past 12 months, has any applicant smoked cigarettes, cigars, or pipes, or used chewing tobacco? ☐ Yes ☐ No

Applicant Name: ____________________

Applicant Name: ____________________

B. Has any applicant used marijuana, cocaine, heroin, methamphetamines, LSD, or any other illegal or controlled drugs, or substances in the last 10 years, or been diagnosed as chemically or alcohol dependent? ☐ Yes ☐ No

Applicant Name: ____________________

Substance: ____________ Date discontinued: ________

Applicant Name: ____________________

Substance: ____________ Date discontinued: ________

C. Has any applicant consumed any alcoholic beverages in the last 6 months? ☐ Yes ☐ No

(Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.)

Applicant Name:__________ Type: __________

Amount: __________ per: ☐ Day ☐ Week ☐ Month

Applicant Name:__________ Type: __________

Amount: __________ per: ☐ Day ☐ Week ☐ Month

D. Has any applicant been advised by a health care professional to reduce alcohol intake within the past 10 years? ☐ Yes ☐ No

Applicant Name:__________ Date discontinued:__________

Applicant Name:__________ Date discontinued:__________

6C. *Professional Services*

Give COMPLETE details in all sections below of any "Yes" answers to the questions in Section 6A.

Question #	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty ☐ Pediatric ☐ Cardiac ☐ Internal Medicine ☐ Family ☐ Other ________	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* / **Results**			City / State / ZIP Code	FAX No. *(Optional)* ( )

Question #	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty ☐ Pediatric ☐ Cardiac ☐ Internal Medicine ☐ Family ☐ Other ________	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* / **Results**			City / State / ZIP Code	FAX No. *(Optional)* ( )

Question #	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty ☐ Pediatric ☐ Cardiac ☐ Internal Medicine ☐ Family ☐ Other ________	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* / **Results**			City / State / ZIP Code	FAX No. *(Optional)* ( )

Question #	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty ☐ Pediatric ☐ Cardiac ☐ Internal Medicine ☐ Family ☐ Other ________	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* / **Results**			City / State / ZIP Code	FAX No. *(Optional)* ( )

Applicant's Social Security No. or ID No.

6D. Last Doctor Visit (for any reason including checkup) **– Provide information for ALL family members you wish to cover.**

Family Member	Date of Visit	Reason for Visit	Results		Name, Phone No. & FAX No. *(FAX # optional)* of Physician or Hospital Complete Address / City / State / Zip Code
			Normal ✓	Abnormal Findings *(Explain)*	
					Name: _____ Phone: _____ FAX: _____ Address: _____ City_____ State ____ Zip __
					Name: _____ Phone: _____ FAX: _____ Address: _____ City_____ State ____ Zip __
					Name: _____ Phone: _____ FAX: _____ Address: _____ City_____ State ____ Zip __
					Name: _____ Phone: _____ FAX: _____ Address: _____ City_____ State ____ Zip __

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. **No. of sheets attached**

6E. Prescription Medications **– List all medications taken within the last 12 months by any family member listed on this application.**

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____

Statement of Accountability **– To be completed when the applicant cannot complete the application.**

I, _____ , personally read and completed this Individual Enrollment Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Application Conditions and Agreement."

_____ _____

Signature of Translator *(Required)* Today's Date *(Required)*

7. Application Understandings, Conditions and Agreement

IMPORTANT: It is important that you carefully read and fully understand the following.
All Applicants age 18 and over must personally read, agree to and sign the following. If an Applicant does not read English, the translator must sign and submit a Statement of Accountability for translating this entire application (see above).

7. *Application Understandings, Conditions and Agreement* (Continued)

Applicant's Social Security or ID No.

PPO Plan Applicants only

I, the undersigned, understand that under the Blue Cross plan in which I am enrolling, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use a network hospital or physician.

Effective Date (PPO Applicants only)

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED.

☐ If Blue Cross approves my application, please assign an effective date of _____.
The effective date must be after the signature date but not greater than 75 days from the signature date on this application.

☐ If Blue Cross approves my application, please assign an effective date of the first day after Blue Cross approval.
Please note: If you are adding a dependent or changing coverage, your effective date will always be the first of the **month following approval.**

HMO Applicants only: I understand I will only receive benefits for services by, or authorized by, the HMO facility I selected on this application.
☐ If Blue Cross approves my application, please assign an effective date of the first day after Blue Cross approval.

☐ If Blue Cross approves my application, please assign an effective date of _____.

If you have simultaneously applied for a BCL&H Short Term Plan, the effective date of this coverage will begin the day of termination of that Short Term Plan.

High Deductible EPO for Health Savings Account Applicants only

I understand that the High Deductible Plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an HSA. To do so, I must contact a qualified financial institution. Also, I understand that I should contact my tax advisor.

HIPAA enrollees only: Your effective date is determined by the delivery or postmark date of your premium to Blue Cross. If your payment is delivered or postmarked in the first fifteen days of the month, your effective date is the first of that month. If your payment is delivered or postmarked after the fifteenth day of the month, coverage is effective the first day of the following month.

Eligible/Ineligible Applicants: Blue Cross will enroll all eligible family members unless otherwise instructed.

☐ I, the Applicant, request that Blue Cross not enroll any eligible applicants unless ALL family members qualify.

All Applicants

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

CURRENT HEALTH COVERAGE: If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 60 to 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.

***Agreement* (all applicants)**

By applying for coverage, I, the undersigned, agree to the following:

1. Blue Cross may decline my application. No coverage comes into effect until Blue Cross approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Blue Cross at its discretion (except for HIPAA).
2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Blue Cross nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Blue Cross.
3. The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or the terms of any Blue Cross coverage.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
5. In no event shall Blue Cross or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the money submitted with this application if this application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Blue Cross.
6. I understand Blue Cross may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if I intentionally provided incomplete or false material information Blue Cross may revoke my coverage. This means Blue Cross will cancel membership as if it never existed. Also, after approval for membership, if material information is discovered by Blue Cross that was not provided to the Plan prior to the effective date of the policy, Blue Cross may deny coverage.

All of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if they provide false or incomplete information and that Blue Cross may revoke coverage if it discovers that in applying for coverage I intentionally provided incomplete or false material information to Blue Cross.

I understand that if my coverage is revoked I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I will be required to pay for any services that were covered while a member and that Blue Cross will refund all amounts paid by me except amounts owed to Blue Cross.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Blue Cross and me. I and any enrolled family members agree to abide by the terms of that contract.

Requirement for Binding Arbitration

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes against Blue Cross, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: **"It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."** Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

***Signatures (Required)* – IMPORTANT: All applicants over age 18 must sign and date.**

Applicant/Parent or Legal Guardian	Today's Date	Applicant's Spouse	Today's Date
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date

ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION, IF APPLICABLE, HERE. DO NOT TAPE.

Applicant's Social Security or ID No.

8. Payment Method **Premium payment required. First payment will be credited to approved applicants only.** By sending your check to us, you authorize Blue Cross of California to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

8A. Checking Account Automatic Premium Payment

☐ **Monthly checking account deduction premium payments**

Name of Bank or Financial Institution: _____

Account No.: | | | | | | | | | | | | | | | | | Bank Routing No.: | | | | | | | | | |

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment Authorization – As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. **You will incur a $25 service charge for any withdrawal not honored**.

Authorized Signature *(As it appears in the financial institution's records)*	Date
X	

8B. Credit Card **FAX to: (800) 327-9255**

☐ **Initial premium (For new member's Medical and Dental fees only)** ☐ **Monthly premiums**

Monthly Credit Card Authorization - As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. Credit Card: ☐ VISA ☐ MasterCard ☐ Discover

Card No.: | | | | | | | | | | | | | | | | Exp.: _____ Cardholder's Zip Code | | | | | – | | | | |

Cardholder's Name *(As it appears on the credit card)* PRINT	Authorized Signature *(As it appears on the credit card)*	Date
X	**X**	

8C. Billing (To be used if an automatic payment option is NOT selected from 8A or 8B above.)

☐ **Bi-monthly** (Submit 2 months premium) ☐ **Quarterly** (Submit 3 months premium)

TO BE COMPLETED BY YOUR BLUE CROSS-APPOINTED AGENT

1. Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk? ..... ☐ Yes ☐ No
   If yes, please attach explanation.
2. Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? ..... ☐ Yes ☐ No
   If no, please explain: _____
3. I verify that this application was completed by the applicant unless the Statement of Accountability was completed.

Signature of Agent *(Required)*	Date *(Required)*
X	

4. **Breakdown of funds collected:**
   Total Medical funds $ _____
   Total Dental funds $ _____
   Total funds collected $ _____
5. Was the Term Life Insurance option selected? *(If yes, first Term Life Insurance payment will be billed.)* ..... ☐ Yes ☐ No

Name of Agent (Print Name)		Agent's Street Address Suite No./Personal Mail Box (PMB) No.	
Oleg Skurskiy		18375 Ventura Blvd. # 226	
Agent ID No. BCLNGNPVMZ	Sub-Agent ID No.	City/State/ZIP Code Tarzana, CA 91356	Location No.
Phone No. (818) 987-5000	FAX No. (818) 776-9865	E-mail Address oleg@askoleg.com	

Mail Service Agreement to: ☐ Agent ☐ Primary Applicant

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the primary applicant.

Mailing address:

Agent: Please mail this application to the following address:

Blue Cross of California • P.O. Box 9041 • Oxnard, CA 93031-9041

Authorization for Use of Protected Health Information

By signing below:

I authorize Blue Cross of California, or an agent, subsidiary or affiliate that has a business associate contract with Blue Cross of California, to obtain any medical records (but not including psychotherapy notes) from any physicians, hospitals and/or other health care providers concerning my care and the care of any family member listed on my Application or Change of Coverage Form.

I also authorize any physicians, hospitals and/or other health care providers to furnish any medical records (but not including psychotherapy notes) concerning my care and the care of any family member listed on my Application or Change of Coverage Form to Blue Cross of California, or an agent, subsidiary or affiliate that has a business associate contract with Blue Cross of California. This information is needed to determine eligibility for the coverage requested for myself and/or any family members listed on my Application or Change of Coverage Form.

I understand that the entities indicated above can request medical records for up to the past 10 years and this information will be used to determine whether I and my listed family members are eligible for enrollment in the coverage requested.

I understand that this form must be signed and returned with my completed Application if I am initially applying for enrollment in a medically underwritten health plan offered by Blue Cross of California or its affiliate, BC Life & Health Insurance Company, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage. This Authorization will expire when determination is completed regarding my/our eligibility for coverage.

I understand that I may revoke this Authorization at any time while Blue Cross of California is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Blue Cross of California. An Authorization Revocation Form is available by writing to: Blue Cross of California, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I/we will not be considered by Blue Cross of California for enrollment in one of its medically underwritten health plans. If I revoke this Authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made.

Printed name of Applicant/Member	Signature of Applicant/Member or his/her Personal Representative	Date
Printed name of Spouse or Dependent Child age 18 or over listed on Application	Signature of Spouse/Dependent Child* or his/her Personal Representative	Date
Printed name of Dependent Child age 18 or over listed on Application	Signature of Dependent Child* or his/her Personal Representative	Date

**If listed on your Application or Change Form, your spouse and each dependent child age 18 or over must sign above.*

If this Authorization is signed by a personal representative on behalf of the Applicant/Member, Spouse and/or Dependent Child(ren), the representative must complete the following:

Printed name of Personal Representative	Relationship to Applicant/Member, Spouse and/or Dependent Child(ren)	Date

A photocopy of this form will be as valid as the original.
You have the right to receive a copy of this Authorization upon request.