

Application for Blue Shield Individual and Family Health Plans

Instructions for Completing Your Application...

You can use this application to apply for any Blue Shield health plan for individuals and families: **Access+ HMO, Deductible Plan or Preferred Savings**. Follow the six steps below and your application will be processed more quickly!

- **Before you start** – Separate the introductory pages from the rest of your application. Read all instructions on the application carefully. Make sure you do not skip any questions. Print clearly in blue or black ink. Do not use pencil.
- **Calculate your Blue Shield monthly rates**, using the rates included with your booklet.
- **Staple a personal check or money order to your application in an amount equal to one month's dues**, payable to Blue Shield of California.*
- **Important – Sign and date Part 8 of the application**. Signatures are required

for all applicants, including your spouse, and dependents age 18 and older.

- **To cover dependents** age 19 through 22, be sure to complete the last section of Part 2 on the application, regarding certification for students age 19 or older.
- **Return the application in the envelope provided within 30 days** of your date of signature. Blue Shield will notify you in writing if your application is approved.

Application Tips

- Provide an answer to every question, even if you are not sure it applies to you. This will speed the processing of your application.
- A complete physical examination is required for any family member age 55 or older. This examination must be within the last two years.
- Indicate your billing choice at the top of the application. (If you choose Easy\$Pay, complete the Easy\$Pay form included in this booklet.)

- If married: list the younger spouse as the applicant. It may lower your monthly dues.
- If applying for Access+ HMO: be sure to select a Personal Physician. Our online provider directories make it quick and easy, at www.mylifepath.com.
- Be sure to include your check or money order.*
- Remember – each applying family member age 18 or older must sign on in Part 8 of the application.

Have questions?

For help filling out your Blue Shield application, call your Blue Shield Agent. He or she will help you complete it correctly so it is processed as quickly as possible!

* **Please note:** cashing the dues check does not constitute approval for a health plan. Blue Shield will notify you in writing if your application is approved. Other rates may apply once the application is approved.

applying is easy

General Information

Eligibility for Individual and Family Plans (IFP)

If you are a California resident, are ineligible for Medicare and are not over the age of 65, you may apply for any Blue Shield Individual and Family plan. If your application is approved, you may be eligible to receive Access+ HMO benefits on the first of the month following Blue Shield's approval date, and on any day of the month, except for the 29th, 30th, or 31st of the month following Blue Shield's approval date for any IFP PPO plan. If you are married, your spouse (under age 65) and unmarried dependent children (under age 19, or under age 23 if a full-time student), are eligible to apply for dependent coverage.

If you apply for the Access+ HMO Plan, you and your eligible dependents must live or work in the Access+ HMO Plan Service Area (the geographic area served by the plan). You, and each family member covered by this plan, need to select a Personal Physician. The Personal Physician must be located sufficiently close to your home or work address to ensure reasonable access to care as determined by Blue Shield.

Eligibility for Guaranteed Issue Plans

If you are a California resident (regardless of age), are not eligible for Medicare, and you meet certain other conditions, you may apply for the \$1,500 or \$2,000 Deductible Guaranteed Issue Plan. You are required to fill out a Statement of Guaranteed Issue Eligibility for yourself and each dependent applying for guaranteed issue. See the section on How to Apply For Guarantee Issue for more detailed information.

Applying for Children's Coverage

When applying for coverage of children under age 19, you may include them as dependents on your family plan or apply for separate YouthCareSM plans for each child. YouthCare rates are per child and may cost you less overall. Call your Blue Shield Agent for help determining which option is best for you.

To apply for YouthCare rates, include each child's Social Security Number and mark the plan you've chosen for him or her in Part 2 of the application.

Deciding Whether to Apply for Guaranteed Issue Coverage

Following are a few facts that may help you decide whether to apply for guaranteed issue coverage:

- Blue Shield's guaranteed issue coverage is provided as an alternative for people who may not be eligible for underwritten plans because of a pre-existing condition.
- Guaranteed issue rates may be higher than those of Blue Shield's underwritten plans.
- Generally, people apply for guaranteed issue if they know or suspect that they are not eligible for an underwritten plan.
- If you're not sure whether you're eligible for an underwritten plan, you can apply for both guaranteed issue and an underwritten plan at the same time by completing all of the information on this application. If you complete the entire application, we will examine your application to see if you or any applying dependents are eligible for rates which are lower than the guaranteed issue rates, and will notify you of the rates for which you qualify. (Completing the entire application will not affect your eligibility for guaranteed issue.)

How to Apply for Guaranteed Issue

1. Complete the application for Blue Shield Individual and Family Health Plans:

- In Part 1 of the application, select either the \$1,500 or \$2,000 guaranteed issue Deductible Plan.
- If you are applying for guaranteed issue coverage for yourself only, or yourself and dependents who also meet the eligibility requirements; and you are NOT applying for CPIC *Life* Term Life Insurance, complete parts 1, 2, 3, 8 and 11 of the application and the Statement of Guaranteed Issue Eligibility.
- If you wish to also be considered for non-guaranteed issue coverage (an underwritten plan), complete the entire application. You must qualify for non-guaranteed issue coverage in order to be considered for any of the following:
 - Dependent coverage of a spouse or child who does not meet the requirements stated in the guaranteed issue eligibility checklist, above; or
 - CPIC *Life* Term Life Insurance; or
 - Lower rates than the guaranteed issue rates.

If you are declined for underwritten plan coverage and are eligible for guaranteed issue, you will automatically receive guaranteed issue coverage.

2. Obtain the following as proof of prior health coverage:

A copy of the Certificate(s) of Creditable Coverage issued by your prior health plan(s) indicating your 18 months or more of coverage. The 18 months include the number of months you were covered under COBRA as part of your most recent group coverage.

3. Submit to your Agent or Blue Shield:

- Your completed and signed Blue Shield Individual and Family Health Plan application;
- The Statement of Guaranteed Issue Eligibility, completed and signed; and
- Your certificate(s) of creditable coverage.

coverage

Blue Shield Flexible Billing Options

Dues must be paid in advance. Blue Shield offers three payment methods. Please select a billing method in the box at the top of the application.

1. Monthly billing

2. Quarterly billing

With options 1 and 2, your bill will tell you the date your payment is due. Payments should be sent to:

Blue Shield of California
P.O. Box 51827
Los Angeles, CA 90051-6127

3. Easy\$Pay Monthly Billing – a convenient, automatic way to pay your dues.

When you sign up for Easy\$Pay, your monthly payments to Blue Shield are handled automatically via electronic transfer from your checking or savings account.

To sign up for Easy\$Pay:

Simply complete the Easy\$Pay Authorization Form on the next page and return it with your application to Blue Shield. Staple a deposit slip or a blank check marked "VOID" to your Easy\$Pay Authorization Form (not your dues check). This will be used as a record of your account number, your bank's code, and other information we need to set up Easy\$Pay. If you prefer not to attach a voided check or deposit slip, you must provide the routing/transit number of your financial institution (see illustration).

Mary Jane Blue	3025
123 First St.	
Anytown, CA 99999	
Pay to _____	20
Order of _____	Dollars
Any Bank	
San Francisco Main Office	
P.O. Box 8944	
San Francisco, CA 94126	
Memo _____	
032056884 9 8707228001 0233	

VOID

_____ Bank Account Number
_____ Bank Routing/Transit Number

Easy\$Pay Authorization Form

<p>I AM: <input type="checkbox"/> A NEW EASY\$PAY APPLICANT <input type="checkbox"/> A CURRENT EASY\$PAY USER REPORTING A CHANGE IN MY BANK OR ACCOUNT NUMBER (REQUIRES 30-DAY NOTICE)</p> <p>TYPE OF ACCOUNT: <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS</p> <p>DEBIT DATE: <input type="checkbox"/> 1ST OF MONTH <input type="checkbox"/> 15TH OF MONTH (HMO AND DENTAL HMO SUBSCRIBERS MUST USE 1ST OF MONTH.)</p>			
BANK ROUTING/TRANSFER NUMBER			
BANK ACCOUNT NUMBER			
NAME OF FINANCIAL INSTITUTION			
NAME(S) ON BANK ACCOUNT			
BRANCH ADDRESS	CITY	STATE	ZIP CODE
BRANCH TELEPHONE NUMBER			
NAME OF SUBSCRIBER			
SUBSCRIBER'S DAYTIME PHONE NUMBER			
MAILING ADDRESS	CITY	STATE	ZIP CODE
<p>I authorize Blue Shield of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Shield of California dues, as well as for the dues of the following subscribers (my dependents):</p> <p>_____ - _____ - _____ - _____ _____ - _____ - _____ - _____</p> <p>BLUE SHIELD SUBSCRIBER NO. (OR SOC. SEC. NO.) BLUE SHIELD SUBSCRIBER NO. (OR SOC. SEC. NO.)</p>			
<p>I also authorize that financial institution to reduce the balance of my account by the amount of those debits (and/or corrections to previous debits). This authorization will remain in effect until I revoke the authorization indicated, at least 10 days before my account is to be debited.</p> <p>I understand that, if there are insufficient funds in my account when it is automatically debited, Blue Shield of California will debit for all dues owed in the next debit.</p> <p>I also understand that, if there are insufficient funds in my account two consecutive times, Blue Shield of California will convert my account to one that is billed to me monthly (rather than automatically debited from my account every month).</p> <p>Authorized Signature(s) – as it/they appear in the financial institution's records. If the account is listed as a joint account, both account holders must sign. If the holder of the bank account is not an individual, the one signing on behalf of a company/partnership/etc. must identify him/herself and his/her relationship to the company/partnership.</p>			
SIGNATURE		DATE	
PRINT NAME		RELATIONSHIP	
SIGNATURE		DATE	
PRINT NAME		RELATIONSHIP	



APPLICATION FOR BLUE SHIELD INDIVIDUAL AND FAMILY HEALTH PLANS

Application must be completed in ink pen or typed.

Lose your envelope? Call Blue Shield at (800) 431-2809 for the address of the Blue Shield office that will process your application.

MARKET CODE (PRODUCER USE ONLY)

BILLING OPTIONS: EASY\$ PAY (AUTOMATIC MONTHLY BILLING – COMPLETE REQUIRED FORM) MONTHLY BILLING QUARTERLY BILLING

PART 1 – APPLICANT INFORMATION – Please provide the following: (indicate the younger spouse as the applicant, if applying)

REASON FOR APPLICATION <input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> PLAN TRANSFER <input type="checkbox"/> ADD FAMILY MEMBER TO EXISTING COVERAGE <input type="checkbox"/> ADD TERM LIFE INSURANCE TO EXISTING COVERAGE	APPLICANT'S SOCIAL SECURITY NUMBER		FIRST NAME	MI	LAST NAME
	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARRIED: <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF BIRTH (MO/DAY/YR)	HEIGHT (FT. IN.)	WEIGHT (LBS.)
	ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME		PROVIDER #	MED. GROUP/IPA #	<input type="checkbox"/> CHECK IF CURRENT PATIENT
	EXISTING SUBSCRIBER #		REQUESTED EFFECTIVE DATE (SEE PART 8, ITEM 2 FOR INSTRUCTIONS)		

DO YOU WANT YOUR EFFECTIVE DATE TO COORDINATE WITH THE TERMINATION DATE OF YOUR CPIC LIFE SHORT TERM HEALTH INSURANCE? YES NO CPIC LIFE TERMINATION DATE ____/____/____

CHOOSE HEALTH PLAN (CHECK ONE BOX ONLY):

<input type="checkbox"/> ACCESS+ HMO PLAN	DEDUCTIBLE PLAN (PPO)	PREFERRED SAVINGS PLAN (PPO)		IF APPLYING FOR GI ONLY, COMPLETE PARTS 1, 2, 3, 8 AND 11 ONLY.
	<input type="checkbox"/> \$500 DEDUCTIBLE <input type="checkbox"/> \$1,500 DEDUCTIBLE <input type="checkbox"/> \$750 DEDUCTIBLE <input type="checkbox"/> \$2,000 DEDUCTIBLE	<input type="checkbox"/> \$1,700 DEDUCTIBLE (INDIVIDUAL) <input type="checkbox"/> \$2,400 DEDUCTIBLE (INDIVIDUAL)	<input type="checkbox"/> \$3,400 DEDUCTIBLE (TWO-PARTY/FAMILY) <input type="checkbox"/> \$4,800 DEDUCTIBLE (TWO-PARTY/FAMILY)	

APPLICANT DENTAL OPTION CHOICE (CHECK ONE BOX ONLY):	DENTAL HMO ONLY: DENTAL CENTER #:
<input type="checkbox"/> DENTAL HMO (DHMO) <input type="checkbox"/> DENTAL PPO (DPPO)	DENTAL HMO ONLY: DENTAL CENTER NAME:

APPLICANT'S BUSINESS PHONE NUMBER () ()	APPLICANT'S HOME PHONE NUMBER () ()	APPLICANT'S FAX NUMBER () ()	APPLICANT'S E-MAIL ADDRESS	COUNTY OF RESIDENCE
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HOME ADDRESS	CITY	STATE	ZIP CODE
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BILLING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
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MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
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APPLICANT'S OCCUPATION	ACCESS+ HMO ONLY: EMPLOYER AND EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE
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SPOUSE'S OCCUPATION	ACCESS+ HMO ONLY: EMPLOYER AND EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE
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IF YOU HAVE BEEN A BLUE SHIELD OF CALIFORNIA MEMBER, INDICATE PRIOR BLUE SHIELD #: _____ DATE CANCELLED (MO/DAY/YR) ____/____/____

TO HELP US SERVE YOU BETTER IN THE FUTURE, PLEASE INDICATE YOUR LANGUAGE PREFERENCE: ENGLISH SPANISH OTHER: _____

HOW WOULD YOU LIKE US TO CONTACT YOU? BLUE SHIELD WILL USE YOUR PREFERRED METHOD WHEN POSSIBLE. HOME TELEPHONE WORK TELEPHONE ELECTRONIC MAIL STANDARD MAIL
MAY BLUE SHIELD CONTACT YOU VIA EMAIL? YES NO

HAVE YOU BEEN A RESIDENT OF CALIFORNIA FOR THE PAST SIX MONTHS? YES NO IF NO, WHERE WAS YOUR LAST RESIDENCE? _____
IF NO, MEDICAL RECORDS DOCUMENTING A COMPLETE PHYSICAL EXAM BY A CALIFORNIA PHYSICIAN, WITHIN THE LAST SIX MONTHS, MAY BE REQUIRED.

PART 2 – DEPENDENT INFORMATION – List all family members you wish to cover. (Dependent children must be under age 19, or under age 23 if full-time students.)

Select an HMO Personal Physician for each family member from the Blue Shield HMO Physician and Hospital Network for your service area. For questions, call (800) 424-6521. For Dental HMO: select a Dental Center from the Dental HMO Dental Center Directory. For questions regarding your Dental Center selection, call (800) 431-2809.

RELATION	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT (FT.IN.)	WEIGHT (LBS.)	DENTAL
<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE								<input type="checkbox"/> HMO <input type="checkbox"/> PPO

ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME _____ PROVIDER # _____ MED.GROUP/IPA # _____ CHECK IF CURRENT PATIENT

DENTAL HMO ONLY: DENTAL CENTER # _____ DENTAL CENTER NAME _____

<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER								<input type="checkbox"/> HMO <input type="checkbox"/> PPO
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ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME _____ PROVIDER # _____ MED.GROUP/IPA # _____ CHECK IF CURRENT PATIENT

DENTAL HMO ONLY: DENTAL CENTER # _____ DENTAL CENTER NAME _____

PLEASE CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES
CHOOSE PLAN (CHECK 1 BOX ONLY): \$500 DEDUCTIBLE PLAN \$750 DEDUCTIBLE PLAN \$1,500 DEDUCTIBLE PLAN \$2,000 DEDUCTIBLE PLAN ACCESS+ HMO PLAN
 \$1,700 PREFERRED SAVINGS DEDUCTIBLE PLAN \$2,400 PREFERRED SAVINGS DEDUCTIBLE PLAN

<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER								<input type="checkbox"/> HMO <input type="checkbox"/> PPO
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ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME _____ PROVIDER # _____ MED.GROUP/IPA # _____ CHECK IF CURRENT PATIENT

DENTAL HMO ONLY: DENTAL CENTER # _____ DENTAL CENTER NAME _____

PLEASE CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES
CHOOSE PLAN (CHECK 1 BOX ONLY): \$500 DEDUCTIBLE PLAN \$750 DEDUCTIBLE PLAN \$1,500 DEDUCTIBLE PLAN \$2,000 DEDUCTIBLE PLAN ACCESS+ HMO PLAN
 \$1,700 PREFERRED SAVINGS DEDUCTIBLE PLAN \$2,400 PREFERRED SAVINGS DEDUCTIBLE PLAN

PART 2 – (CONTINUED)

RELATION	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT (FT.IN.)	WEIGHT (LBS.)	DENTAL
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER								<input type="checkbox"/> HMO <input type="checkbox"/> PPO

ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME _____ PROVIDER # _____ MED.GROUP/IPA# _____ CHECK IF CURRENT PATIENT

DENTAL HMO ONLY: DENTAL CENTER # _____ DENTAL CENTER _____

PLEASE CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES
 CHOOSE PLAN (CHECK 1 BOX ONLY): \$500 DEDUCTIBLE PLAN \$750 DEDUCTIBLE PLAN \$1,500 DEDUCTIBLE PLAN \$2,000 DEDUCTIBLE PLAN ACCESS+ HMO PLAN
 \$1,700 PREFERRED SAVINGS DEDUCTIBLE PLAN \$2,400 PREFERRED SAVINGS DEDUCTIBLE PLAN

**CERTIFICATION FOR STUDENTS AGE 19 OR OLDER (MUST BE UNDER AGE 23). I CERTIFY THAT MY DEPENDENT LISTED BELOW IS CURRENTLY ENROLLED AS A FULL-TIME STUDENT:
 IF YOU HAVE MORE THAN ONE DEPENDENT OVER AGE 18 WHO IS A FULL-TIME STUDENT, PLEASE ATTACH AN ADDITIONAL SHEET WITH THE REQUIRED INFORMATION AND CHECK HERE.**

NAME	HOURS/WEEK	UNITS	SCHOOL	ADDRESS

PART 3 – PRIOR MEDICAL COVERAGE – Please answer each question. If yes, please provide details in the space provided.

1A. Did you or any applying family member have other health coverage (insurance) within the last 63 days? YES NO

1B. IF YOU ANSWERED YES TO 1A COMPLETE THE FOLLOWING:

TYPE OF COVERAGE	EFFECTIVE DATE	CANCEL DATE:	HEALTH PLAN CARRIER OR COBRA ADMINISTRATOR
APPLICANT _____ <input type="checkbox"/> GROUP <input type="checkbox"/> COBRA <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> OTHER	____/____/____	____/____/____	_____
SPOUSE _____ <input type="checkbox"/> GROUP <input type="checkbox"/> COBRA <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> OTHER	____/____/____	____/____/____	_____
OTHER: _____ OTHER: _____			

2. If you are applying for a plan other than Access+ HMO and your prior plan terminated within the last 63 days of the Blue Shield receipt date of this application, please fill out question 6 in Part 8, regarding prior coverage.

PART 4 – MEDICAL HISTORY – Please answer ALL questions.

Have you or any applying family member ever received any professional advice or treatment for or had any symptoms pertaining to any of the following?
 All questions must be checked (✓) "Yes" or "No," even if you're not sure a question is applicable to you.
 Full details of any "Yes" answers must be given in Parts 5, 6, & 7.

	YES	NO
1. Brain or nervous system – such as: dizziness, headache, seizure disorder, loss of consciousness, epilepsy, paralysis, muscular dystrophy, multiple sclerosis, stroke, cerebral palsy, mental retardation, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
2. Cardiovascular system – such as: heart or valve problems, coronary artery disease, heart attack, heart murmur, pericarditis, mitral valve prolapse, mitral regurgitation, rheumatic fever, palpitations, high blood pressure, shortness of breath, chest pains, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
3. Circulatory system – such as: varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder, anemia, or enlarged lymph nodes, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
4. Respiratory tract – such as: asthma, reactive airway disease, bronchitis, hayfever, allergies, sinusitis, lung/chest problems of any kind, emphysema, tuberculosis, spitting or coughing up blood, shortness of breath, pneumonia, cystic fibrosis, pulmonary fibrosis, chronic obstructive pulmonary disease, sleep apnea, etc.? IF ASTHMA OR ALLERGIES: FREQUENCY (CIRCLE ONE): DAILY, WEEKLY, MONTHLY, SEASONAL SEVERITY (CIRCLE ONE): MILD, MODERATE, SEVERE, OTHER	<input type="checkbox"/>	<input type="checkbox"/>
5. Digestive system – such as: mouth, tongue, esophagus or stomach problems, ulcer, gall bladder disorder, liver disease, cirrhosis, jaundice, ascites, pancreatitis, colon, intestinal or rectal problems, colitis, chronic diarrhea, hemorrhoids, hernia, weight or eating problems, hepatitis, etc.? IF HEPATITIS, TYPE (S): A, B, C, OTHER	<input type="checkbox"/>	<input type="checkbox"/>
6. Urinary tract – such as: renal colic, gravel or stone, urethra, bladder, ureter or kidney problems, infections, stricture, pyelonephritis, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
7. Male reproductive system – such as: prostate problems, impotency, male breast problems, gynecomastia, infections, herpes, syphilis, gonorrhea, or other venereal disease, etc. or is either the applicant or spouse, whether or not listed on the application, currently being treated for infertility?	<input type="checkbox"/>	<input type="checkbox"/>
8. A. Female reproductive system – such as: breast problems, breast implants, adhesions, abnormal bleeding, amenorrhea, endometriosis, fibroid tumors, abnormal Pap test, problems of the ovaries, uterus and associated female organs, in-vitro fertilization, infections, genital warts, herpes, syphilis, or other venereal disease, etc. or is either the applicant or spouse, whether or not listed on the application, currently being treated for infertility? TYPE OF IMPLANTS (CIRCLE ONE): SALINE OR SILICONE	<input type="checkbox"/>	<input type="checkbox"/>
B. Does any female applicant between the ages of 12-60 menstruate? IF YES, LIST THE NAMES OF FAMILY MEMBER(S) AND DATES OF LAST MENSTRUAL PERIOD: _____/____/____; _____/____/____; _____/____/____ IF NO, LIST THE NAMES OF FAMILY MEMBER(S) AND REASON: _____/____/____; _____/____/____; _____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
9. Is either the applicant, spouse, or dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
10. If you are a male listed on this application, are you expecting a child with anyone, even if the birth mother is not listed on the application?	<input type="checkbox"/>	<input type="checkbox"/>
11. Musculo-Skeletal system – such as: neck, spine/back sprain, pain, injury, sciatica, herniated or bulging disc(s), or problems: curvature of the spine, scoliosis; any pain, injuries, or problems of the joints, bones, or muscles; arthritis; rheumatoid arthritis, temporo-mandibular joint syndrome (TMJ), Lyme disease, fractures/residual hardware, dislocations, bunions, hammertoe, carpal tunnel syndrome, physically handicapped, polio, amputations, etc.? IF CHIROPRACTIC TREATMENT, PLEASE EXPLAIN REASON FOR TREATMENT: _____ FREQUENCY (CIRCLE ONE): DAILY, WEEKLY, MONTHLY, OTHER	<input type="checkbox"/>	<input type="checkbox"/>
12. Skin conditions – such as: skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
13. Metabolic system – such as: diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders, such as: lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID or Pentamidine therapy, etc.? (CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING COVERAGE.)	<input type="checkbox"/>	<input type="checkbox"/>

PART 4 – MEDICAL HISTORY – (continued)

	YES	NO
14. Diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing – such as: any infections, crossed eyes, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, problems with tonsils or adenoids, sleep apnea, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
15. Cancer/malignancy, leukemia, Hodgkin's, tumor/cyst, lymphoma, etc? TYPE: _____	<input type="checkbox"/>	<input type="checkbox"/>
16. Alcoholism, drug dependency or substance abuse? TYPE: _____	<input type="checkbox"/>	<input type="checkbox"/>
17. Presently a member of a support group? TYPE: _____ HOW LONG: _____	<input type="checkbox"/>	<input type="checkbox"/>
18. Congenital abnormalities, birth defects – such as: Down's Syndrome, cerebral palsy, cleft lip or palate, clubfoot, developmental delay, or other neurological or physical abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you or any applying family member ever received any counseling or treatment for symptoms of depression, manic depression, anxiety, panic attacks, nervousness, mental or emotional disorders, schizophrenia, behavior problems, hyperactivity, attention deficit disorder, eating disorders, bulimia, anorexia, alcohol or substance abuse, or for any other reason? IF IN COUNSELING, PLEASE EXPLAIN REASON FOR COUNSELING: _____ FREQUENCY (CIRCLE ONE): DAILY, WEEKLY, MONTHLY, OTHER	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you or any applying family member ever been an inpatient or outpatient in a hospital, surgical center, sanitarium, or other medical facility, including an emergency room, or had surgery, including angioplasty, cosmetic/reconstructive, bypass, or transplant surgery?	<input type="checkbox"/>	<input type="checkbox"/>
21. Have you or any applying family member ever had abnormal laboratory results, blood work, x-rays, EKG, nerve condition, blood flow studies, MRI, CT, PET or other scan(s)?	<input type="checkbox"/>	<input type="checkbox"/>
22. Do you or any applying family member have a prosthesis, implant, or retained hardware? TYPE: _____	<input type="checkbox"/>	<input type="checkbox"/>
23. Do you or any applying family member have any symptoms and/or health problems that have not yet been evaluated by a physician, or have any diagnoses, symptoms or problems not mentioned elsewhere on this application, or have any complications or residuals remaining following any treatment?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you or any applying family member ever smoked cigarettes? FAMILY MEMBER: _____ PACKS PER DAY: _____ HOW MANY YEARS: _____ WHEN DID YOU/THEY STOP? _____	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you or any applying family member drink alcoholic beverages? FAMILY MEMBER: _____ DRINKS PER WEEK: _____ HOW MANY YEARS: _____ WHEN DID YOU/THEY STOP? _____	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you or any applying family member ever had any application for health or life insurance revoked, declined, deferred, postponed, or restricted in any way? FAMILY MEMBER: _____ DATE: ____/____/____ PLEASE EXPLAIN: _____	<input type="checkbox"/>	<input type="checkbox"/>
27. Have you or any applying family member ever requested or received a pension, benefits or payment because of any injury, sickness, disability or workers compensation? FAMILY MEMBER: _____ DATE: ____/____/____ PLEASE EXPLAIN: _____	<input type="checkbox"/>	<input type="checkbox"/>
28. In the last 12 months: have you or any applying family member taken or been ordered to take prescription medication(s)? If yes, please fill out Part 7 of this application.	<input type="checkbox"/>	<input type="checkbox"/>

PART 5 – MEDICAL CONDITION DETAILS – If you answered "YES" to any of questions 1–28 in PART 4, give details below.

If additional space is necessary to provide complete information, please attach an additional sheet of paper. Be sure to identify the family member, the section and the question number, as appropriate, include all information requested in Part 5 and **sign and date every attachment**. Check here for attachment.

FAMILY MEMBER NAME AND NAME USED ON DOCTOR'S RECORDS		DIAGNOSIS AND PRESENT STATUS	DATES OF TREATMENT, HOSPITALIZATION	
LIST QUESTION NUMBER	NAME	DIAGNOSIS AND TREATMENT	BEGAN: ____ / ____ (MO/YR)	
			ENDED: ____ / ____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRESENT STATUS:		
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO ER VISITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATES:	
FULL NAME AND ADDRESS OF EVERY PHYSICIAN, CLINIC OR HOSPITAL (INCLUDE ZIP CODE). FOR PHYSICIANS WHO BELONG TO A MEDICAL GROUP, PLEASE LIST THE MEDICAL GROUP AS WELL.				
	NAME:	PHONE NUMBER: ()	MEDICAL GROUP	
	ADDRESS:	STE #	CITY	STATE ZIP
LIST QUESTION NUMBER	NAME	DIAGNOSIS AND TREATMENT	BEGAN: ____ / ____ (MO/YR)	
			ENDED: ____ / ____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRESENT STATUS:		
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO ER VISITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATES:	
FULL NAME AND ADDRESS OF EVERY PHYSICIAN, CLINIC OR HOSPITAL (INCLUDE ZIP CODE). FOR PHYSICIANS WHO BELONG TO A MEDICAL GROUP, PLEASE LIST THE MEDICAL GROUP AS WELL.				
	NAME:	PHONE NUMBER: ()	MEDICAL GROUP	
	ADDRESS:	STE #	CITY	STATE ZIP

PART 5 – MEDICAL CONDITION DETAILS – (CONTINUED)

FAMILY MEMBER NAME AND NAME USED ON DOCTOR'S RECORDS		DIAGNOSIS AND PRESENT STATUS	DATES OF TREATMENT, HOSPITALIZATION	
LIST QUESTION NUMBER	NAME	DIAGNOSIS AND TREATMENT	BEGAN: ___/___/___ (MO/YR)	
			ENDED: ___/___/___ (MO/YR)	
	DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRESENT STATUS:		
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO ER VISITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATES:	
FULL NAME AND ADDRESS OF EVERY PHYSICIAN, CLINIC OR HOSPITAL (INCLUDE ZIP CODE). FOR PHYSICIANS WHO BELONG TO A MEDICAL GROUP, PLEASE LIST THE MEDICAL GROUP AS WELL.				
	NAME:	PHONE NUMBER: ()	MEDICAL GROUP	
	ADDRESS:	STE # CITY	STATE	ZIP
LIST QUESTION NUMBER	NAME	DIAGNOSIS AND TREATMENT	BEGAN: ___/___/___ (MO/YR)	
			ENDED: ___/___/___ (MO/YR)	
	DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRESENT STATUS:		
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO ER VISITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATES:	
FULL NAME AND ADDRESS OF EVERY PHYSICIAN, CLINIC OR HOSPITAL (INCLUDE ZIP CODE). FOR PHYSICIANS WHO BELONG TO A MEDICAL GROUP, PLEASE LIST THE MEDICAL GROUP AS WELL.				
	NAME:	PHONE NUMBER: ()	MEDICAL GROUP	
	ADDRESS:	STE # CITY	STATE	ZIP

PART 6 – LIST YOUR LAST PHYSICIAN VISIT

Please provide details regarding the last physician visit you or any applying family member has had, regardless of the date (includes check-ups).
A complete physical examination is required for any family member age 55 years or older. This examination must be within the last two years.
Medical records will be requested for children under one year of age.

NAME OF FAMILY MEMBER	DATE OF VISIT : ___/___/___	REASON FOR EXAM/CHECK-UP	FINDINGS AND PRESENT STATUS		
PHYSICIAN NAME		PHONE NUMBER	MEDICAL GROUP	PHYSICIAN SPECIALTY	
ADDRESS		STE # CITY	STATE	ZIP	
NAME OF FAMILY MEMBER	DATE OF VISIT : ___/___/___	REASON FOR EXAM/CHECK-UP	FINDINGS AND PRESENT STATUS		
PHYSICIAN NAME		PHONE NUMBER	MEDICAL GROUP	PHYSICIAN SPECIALTY	
ADDRESS		STE # CITY	STATE	ZIP	
NAME OF FAMILY MEMBER	DATE OF VISIT : ___/___/___	REASON FOR EXAM/CHECK-UP	FINDINGS AND PRESENT STATUS		
PHYSICIAN NAME		PHONE NUMBER	MEDICAL GROUP	PHYSICIAN SPECIALTY	
ADDRESS		STE # CITY	STATE	ZIP	

PART 7 – CURRENT OR RECENT PRESCRIPTION MEDICATIONS

If you answered "YES" to question 28 in PART 4, please provide the details of the current and previous medications.

NAME OF FAMILY MEMBER		DATES FROM : ___/___/___	TO : ___/___/___
MEDICATION	DOSAGE	CONDITION	FREQUENCY
PHYSICIAN NAME	PHONE NUMBER	MEDICAL GROUP	PHYSICIAN SPECIALTY
ADDRESS	STE # CITY	STATE	ZIP
NAME OF FAMILY MEMBER		DATES FROM : ___/___/___	TO : ___/___/___
MEDICATION	DOSAGE	CONDITION	FREQUENCY
PHYSICIAN NAME	PHONE NUMBER	MEDICAL GROUP	PHYSICIAN SPECIALTY
ADDRESS	STE # CITY	STATE	ZIP
NAME OF FAMILY MEMBER		DATES FROM : ___/___/___	TO : ___/___/___
MEDICATION	DOSAGE	CONDITION	FREQUENCY
PHYSICIAN NAME	PHONE NUMBER	MEDICAL GROUP	PHYSICIAN SPECIALTY
ADDRESS	STE # CITY	STATE	ZIP

DON'T FORGET – YOUR SIGNATURE AND TODAY'S DATE IS REQUIRED IN PART 8 OF THIS APPLICATION

PART 8 – DISCLOSURE STATEMENTS – Please read these conditions of membership and authorization and sign below

- Attached is my personal check or money order in an amount equal to one month's dues.** Cashing of my check by Blue Shield does not constitute approval. It will be refunded if my application is not approved. (If you are also applying for CPIC *Life* short term health insurance, you are not required to submit one month's dues with your Blue Shield application. *Submit your Blue Shield application and a copy of your CPIC Life application to Blue Shield. Your original CPIC Life application and full CPIC Life short term health insurance payment should be submitted directly to CPIC Life.*)
- To specify an effective date for **Preferred Savings Plan, or Deductible Plan** coverage, indicate a date that is between 30 and 90 days from your signature date not including the 29th, 30th or 31st of the month. If you do not specify an effective date in Part One of this application, Blue Shield will assign one. **Access+ HMO** effective dates are always on the first of the month. (If you are requesting **Dental HMO** coverage, you must request a health plan effective date on the first of the month. If you are also applying for **CPIC Life short term health insurance**, specify a health plan effective date that coincides with the last day of your CPIC *Life* short term health insurance. Attach a copy of your CPIC *Life* short term health insurance application.) If Blue Shield cannot honor your requested effective date or is unable to issue coverage before your requested date, coverage will begin as soon as possible. **Blue Shield is a prepaid dues plan.** No benefits will be accessible unless dues are paid in full prior to or on the first day of the billing period. **Charges incurred before your effective date of coverage are never covered.**
- To find Blue Shield providers by name, location, specialty, and language, go to our Web site: **www.mylifepath.com**. You can use the Web site to print out a listing of Blue Shield providers in your area. This directory is for information purposes only and is not to be considered a total representation of Blue Shield's Provider Network.
- If my application is approved, Blue Shield will inform me in writing of my effective date of coverage. Then, after Blue Shield receives my full dues, I will be covered as of that effective date. This application, including the Statement(s) of Health, will become part of my agreement with Blue Shield. My agent cannot approve my application or change any terms or conditions of my coverage. I understand Blue Shield has the right to decline my application.
- The Deductible Plan, and Preferred Savings Plan pay substantially lower benefits when non-Preferred Providers are used. In most cases, the Access+ HMO Plan pays benefits only for services received through the Personal Physician. Refer to the Summary of Benefits brochure for more information.
- Certificate of coverage** – If you are applying for a plan other than Access+ HMO, did you have a prior health plan that covered any of the conditions checked yes in Part 4? **Yes** **No** If that plan terminated within 63 days of the Blue Shield receipt date of this application, please check here and submit a certificate of creditable coverage from your previous health carrier. If your application is approved, we will apply your prior creditable coverage to reduce any waiting period on your pre-existing condition exclusion with this plan. See the Summary of Benefits booklet for more on pre-existing conditions. You can call Blue Shield at **(800) 431-2809** for assistance obtaining a certificate.
- Parent or Legal Guardian*** (if the applicant is a minor): I will assume all responsibility for dues payments and for managing the provision of benefits under the plan applied for by my child. Individuals authorized to make changes to my minor child's contract include:
 - A.** Parent or legal guardian only: _____ (name) or,
 - B.** My designee _____ (include name and relationship) or,
 - C.** Qualified Medical Child Support Order designee _____ (include name and relationship).
 I further request that all changes to this contract be made only upon Blue Shield's receipt of such written request.
(*Court documents must be attached authorizing guardianship if the responsible adult is not the parent.)
- Applicants with a Spouse also applying for coverage:** If you are applying for coverage and your coverage is approved, please specify whether or not you authorize your spouse, if also covered, to make inquiries or changes on your behalf to your contract. **Yes** **No.** This authorization may be discontinued at any time upon Blue Shield's receipt of such written request.
- Authorization for Disclosure of Personal Information** – I authorize any "provider of care," insurer, or health plan to disclose to Blue Shield of California and CPIC *Life* Insurance Company (if applicable), or their representatives, including my Blue Shield agent or broker, all "medical information" (as these terms are defined in the California Civil Code) regarding me or any applying family member, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for evaluating this application, determining eligibility for benefits, and/or for quality assurance and peer review. This authorization will remain valid for the term of coverage for the Blue Shield health service contract/CPIC *Life* policy. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

THIS SECTION MUST BE COMPLETED BEFORE YOUR APPLICATION CAN BE PROCESSED. ALL APPLICANTS AGE 18 AND OLDER MUST SIGN AND DATE THIS APPLICATION. KEEP A COPY OF THIS APPLICATION FOR YOUR RECORDS.

I HAVE READ THE SUMMARY OF BENEFITS AND THE ABOVE CONDITIONS. I UNDERSTAND AND AGREE TO THEM. I ALONE AM RESPONSIBLE FOR THE ACCURACY AND COMPLETENESS OF THIS APPLICATION FOR BLUE SHIELD HEALTH COVERAGE, DENTAL COVERAGE (IF APPLICABLE), AND CPIC *LIFE* TERM LIFE INSURANCE (IF APPLICABLE). I UNDERSTAND THAT NEITHER I NOR MY FAMILY WILL BE ELIGIBLE FOR COVERAGE IF ANY INFORMATION IS FALSE OR INCOMPLETE, AND THAT COVERAGE MAY BE REVOKED BASED ON SUCH FINDING.

APPLICANT'S SOCIAL SECURITY NUMBER _____ - _____ - _____	OTHER NAME UNDER WHICH APPLICANT OR FAMILY MEMBER HAS RECEIVED CARE _____	
TODAY'S DATE (REQUIRED) ____/____/____	SIGNATURE OF APPLICANT (OR LEGAL GUARDIAN) X_____	PRINT NAME (AND RELATIONSHIP IF APPLICANT IS A MINOR) _____
TODAY'S DATE (REQUIRED) ____/____/____	SIGNATURE OF APPLICANT'S SPOUSE (IF APPLYING) X_____	PRINT NAME _____
TODAY'S DATE (REQUIRED) ____/____/____	SIGNATURE OF FAMILY MEMBER AGE 18 AND OVER (IF APPLYING) X_____	PRINT NAME _____
TODAY'S DATE (REQUIRED) ____/____/____	SIGNATURE OF FAMILY MEMBER AGE 18 AND OVER (IF APPLYING) X_____	PRINT NAME _____

PLEASE MAKE SURE YOU FILL OUT PART 11 IF YOU ARE APPLYING FOR GI COVERAGE

PART 9 — CPIC LIFE INSURANCE — If you want CPIC Life Term Life Insurance, please complete the following.

If you, the primary applicant, are approved for Blue Shield health coverage, you **may qualify** for CPIC Life Term Life Insurance at an additional charge. Applicants under the age of one year are not eligible for life insurance. Additional beneficiaries can be attached.

1. INDICATE THE TERM LIFE INSURANCE AMOUNT DESIRED: \$10,000 \$25,000 \$50,000 (NOT AVAILABLE TO APPLICANTS UNDER AGE 19)

2. DESIGNATE YOUR BENEFICIARY BELOW.

BENEFICIARY _____	RELATIONSHIP (AND AGE, IF A MINOR) _____	CITY/STATE _____	ZIP _____
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IF A BENEFICIARY IS NOT INDICATED, AND THE POLICY IS ISSUED, DEATH BENEFITS WILL BE PAID IN ACCORDANCE WITH THE SUCCESSION OF INTEREST OF BENEFICIARIES PROVISION ON PAGE 4 OF THE POLICY.

TODAY'S DATE (REQUIRED) _____ SIGNATURE OF APPLICANT OR GUARDIAN (IF APPLICANT IS UNDER 18) _____ PRINT NAME _____

_____/_____/_____ X _____

PART 10 — PRODUCER INFORMATION — Must be completed by Producer.

1. DID YOU COMPLETE THIS APPLICATION? YES NO

2. IF YES, DID YOU ASK EACH QUESTION IN THIS APPLICATION EXACTLY AS SET FORTH? YES NO

3. ARE THE ANSWERS RECORDED EXACTLY AS GIVEN TO YOU? YES NO, ATTACH EXPLANATION.

4. DID YOU SEE THE APPLICANT? YES NO

5. ARE YOU AWARE OF ANY INFORMATION NOT DISCLOSED IN THIS APPLICATION OF HEALTH, WHICH MAY HAVE A BEARING ON THIS RISK?
 YES, ATTACH EXPLANATION NO

6. DO YOU WANT THE SERVICE AGREEMENT SENT DIRECTLY TO THE SUBSCRIBER? YES NO

PRODUCER NUMBER: _X_ _X_ _X_ _X_ _X_ _____	TELEPHONE NUMBER: () _____	FAX NUMBER: () _____
PRODUCER NAME: _____	EMAIL ADDRESS: _____	
PRODUCER ADDRESS: _____		
SUPER PRODUCER NAME: _____	SUPER PRODUCER NUMBER _____	

TODAY'S DATE (REQUIRED) _____ PRODUCER SIGNATURE (REQUIRED) _____ PRINT NAME _____

_____/_____/_____ X _____

PART 11 — STATEMENT OF GUARANTEED ISSUE ELIGIBILITY

If you have a pre-existing condition and are concerned about obtaining health care coverage, Blue Shield offers an alternative that you may want to consider. The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. If you meet every condition below, you are eligible for guaranteed issue in accordance with HIPAA, and Blue Shield will automatically accept your application for the **\$1,500 or \$2,000 Deductible Plan**, without underwriting. If you are applying for coverage on behalf of any dependents who are not eligible for guaranteed issue, their coverage will be subject to medical underwriting, except for children who were enrolled under any prior creditable coverage within 30 days of the birth or placement for adoption. A dependent child who is 18 years of age or younger or a dependent spouse applying for guaranteed issue must complete a separate Statement of Guaranteed Issue Eligibility (Blue Shield will accept copies of the Statement of Guaranteed Issue Eligibility). For additional applications or current guaranteed issue rates, please contact your Blue Shield agent or call Blue Shield at **(800) 431-2809**. PLEASE CHECK HERE IF YOU'RE NOT INTERESTED IN A GUARANTEED ISSUE PLAN.

STATEMENT OF GUARANTEED ISSUE ELIGIBILITY & CHECKLIST

Please answer "yes" or "no" to each of the following statements.

1. I HAVE HAD A TOTAL OF AT LEAST 18 MONTHS OF HEALTH CARE COVERAGE (INCLUDING COBRA OR CAL-COBRA, IF APPLICABLE) WITHOUT MORE THAN A 63-DAY BREAK IN COVERAGE (EXCLUDING ANY EMPLOYER-IMPOSED WAITING PERIODS). YES NO

2. MY MOST RECENT COVERAGE WAS THROUGH AN EMPLOYER-SPONSORED HEALTH PLAN (COBRA AND CAL-COBRA ARE CONSIDERED EMPLOYER-SPONSORED COVERAGE). YES NO

3. I ACCEPTED COBRA OR CAL-COBRA COVERAGE AND EXHAUSTED ALL OF ITS BENEFITS, OR WAS NOT ELIGIBLE FOR COBRA OR CAL-COBRA. YES NO
IF YES, PLEASE LIST THE DATE THAT COBRA OR CAL-COBRA WAS EXHAUSTED: ____/____/____ IF NO, PLEASE EXPLAIN: _____

IF YOU ANSWERED "YES" TO EACH STATEMENT 1 THROUGH 3, PLEASE PROCEED TO NUMBERS 4 AND 5.
IF YOU ANSWERED "NO" TO ANY OF THE ABOVE STATEMENTS, DO NOT PROCEED. YOU ARE NOT ELIGIBLE FOR GUARANTEED ISSUE.

4. I AM CURRENTLY ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH PLAN, MEDICARE OR MEDICAID. YES NO

5. MY MOST RECENT COVERAGE WAS TERMINATED BECAUSE OF NONPAYMENT OF DUES OR FRAUD. YES NO

IF YOU ANSWERED "NO" TO STATEMENTS 4 AND 5 AND "YES" TO STATEMENTS 1 THROUGH 3, THEN YOU ARE ELIGIBLE FOR GUARANTEED ISSUE.

GUARANTEED ISSUE COVERAGE OPTIONS YOU MUST SELECT ONE OF THE BOXES BELOW TO PROCESS YOUR APPLICATION.

A. IF YOU KNOW THAT YOU WILL NOT QUALIFY FOR COVERAGE, OR DO NOT WANT TO APPLY FOR AN UNDERWRITTEN PLAN, CHECK THIS BOX:
 ISSUE THE GUARANTEED ISSUE PLAN ONLY. SINCE I HAVE CHOSEN THIS OPTION, I UNDERSTAND THAT I WILL NOT BE CONSIDERED FOR AN UNDERWRITTEN PLAN.

B. IF YOU ARE APPLYING FOR BOTH GUARANTEED ISSUE AND AN UNDERWRITTEN PLAN, SELECT ONE OF THE FOLLOWING:
 GUARANTEED ISSUE COVERAGE AT THE EARLIEST EFFECTIVE DATE, SO THAT I AM COVERED DURING THE UNDERWRITING PROCESS OF THE INDIVIDUAL PLAN. (I UNDERSTAND THAT IF MY APPLICATION FOR THE UNDERWRITTEN PLAN IS APPROVED, I WILL AUTOMATICALLY BE TRANSFERRED TO THE UNDERWRITTEN PLAN. IF IT IS NOT APPROVED, I WILL CONTINUE TO RECEIVE GUARANTEED ISSUE.
 ISSUE THE GUARANTEED ISSUE PLAN ONLY IF I AM NOT APPROVED FOR THE UNDERWRITTEN PLAN. (I UNDERSTAND THAT I WILL NOT HAVE ANY COVERAGE UNTIL MY APPLICATION FOR THE UNDERWRITTEN PLAN IS PROCESSED AND EITHER APPROVED OR DECLINED.)

BY SIGNING THIS STATEMENT I VERIFY THAT I HAVE READ AND UNDERSTOOD THE ELIGIBILITY CONDITIONS LISTED ABOVE AND THAT ALL OF THE INFORMATION IS TRUE AND CORRECT.

TODAY'S DATE (REQUIRED) _____ SIGNATURE OF APPLICANT OR LEGAL GUARDIAN _____ PRINT NAME _____

_____/_____/_____ _____