Blue Shield of California

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 Part 2, Number 6 on the application.
- **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

Confidentiality of Personal and Health Information

Blue Shield of California protects the confidentiality of your personal and health information, including your medical records, claims and personal information. Blue Shield of California will not disclose your personal and health information without your consent, except as permitted by law.

A STATEMENT DESCRIBING BLUE SHIELD'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. TO REQUEST A COPY OF THIS STATEMENT, CALL **(800) 431-2809**.

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 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 YouthCare℠ 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, 4 and 8 of the application and the Statement of Guaranteed Issue Eligibilty.
- 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
123 First St.
Anytown, CA 99999

3025

20___

Pay to
Order of

VOID

Dollars

Any Bank
San Francisco Main Office
P.O. Box 8944
San Francisco, CA 94126

Memo ______________

032056884 9   8707228001 0233

Bank Account Number

Bank Routing/Transit Number

Easy$Pay Authorization Form

I AM: ☐ A NEW EASY$PAY APPLICANT

☐ A CURRENT EASY$PAY USER REPORTING A CHANGE IN MY BANK OR ACCOUNT NUMBER (REQUIRES 30-DAY NOTICE)

TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS

DEBIT DATE: ☐ 1ST OF MONTH ☐ 15TH OF MONTH

(HMO AND DENTAL HMO SUBSCRIBERS MUST USE 1ST OF MONTH.)

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

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):

_____ _____ _____ – _____ _____ – _____ _____ _____ _____ BLUE SHIELD SUBSCRIBER NO. (OR SOC. SEC. NO.)

_____ _____ _____ – _____ _____ – _____ _____ _____ _____ BLUE SHIELD SUBSCRIBER NO. (OR SOC. SEC. NO.)

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.

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.

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).

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.

SIGNATURE DATE

PRINT NAME RELATIONSHIP

SIGNATURE DATE

PRINT NAME RELATIONSHIP

Blue Shield of California
An Independent Member of the Blue Shield Association

APPLICATION FOR BLUE SHIELD INDIVIDUAL AND FAMILY HEALTH PLANS

Application must be completed in ink pen or typed. For instructions, turn the page.
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 — Please provide the following: (indicate the younger spouse as the applicant, if applying)

☐ NEW APPLICATION	APPLICANT'S SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___	FIRST NAME	MI	LAST NAME
☐ PLAN TRANSFER	EXISTING SUBSCRIBER NUMBER	FIRST NAME	MI	LAST NAME
☐ ADD FAMILY MEMBER TO EXISTING COVERAGE	EXISTING SUBSCRIBER NUMBER	☐ ADD TERM LIFE INSURANCE TO EXISTING COVERAGE	EXISTING SUBSCRIBER NUMBER	

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):

☐ ACCESS+ HMO PLAN	DEDUCTIBLE PLAN	PREFERRED SAVINGS PLAN	PLEASE CONSIDER MY APPLICATION FOR A GUARANTEED ISSUE PLAN:
	☐ $500 DEDUCTIBLE ☐ $1,500 DEDUCTIBLE ☐ $750 DEDUCTIBLE ☐ $2,000 DEDUCTIBLE	☐ $1,700 DEDUCTIBLE (INDIVIDUAL) ☐ $3,400 DEDUCTIBLE (TWO-PARTY/FAMILY) ☐ $2,400 DEDUCTIBLE (INDIVIDUAL) ☐ $4,800 DEDUCTIBLE (TWO-PARTY/FAMILY)	☐ $1,500 DEDUCTIBLE ☐ $2,000 DEDUCTIBLE

OPTIONAL — CHOOSE DENTAL PLAN (CHECK ONE BOX ONLY): ☐ DENTAL HMO (DHMO) ☐ DENTAL PPO (DPPO)

MARRIED	SPOUSE'S SOCIAL SECURITY NUMBER	APPLICANT'S BUSINESS PHONE NUMBER	APPLICANT'S HOME PHONE NUMBER	APPLICANT'S FAX NUMBER	COUNTY OF RESIDENCE
☐ Y ☐ N	___ ___ ___ - ___ ___ - ___ ___ ___ ___	( )	( )	( )	

RESIDENCE OF APPLICANT	CITY	STATE	ZIP CODE
BILLING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
E-MAIL ADDRESS	IF YOU HAVE BEEN A BLUE SHIELD OF CALIFORNIA MEMBER INDICATE: PRIOR BLUE SHIELD NUMBER:		DATE CANCELLED (MO/DAY/YR) _____/_____/_____

APPLICANT'S OCCUPATION	EMPLOYER AND EMPLOYER'S ADDRESS (ACCESS+ HMO ONLY)	CITY	STATE	ZIP CODE
SPOUSE'S OCCUPATION	EMPLOYER AND EMPLOYER'S ADDRESS (ACCESS+ HMO ONLY)	CITY	STATE	ZIP CODE

TO HELP US SERVE YOU BETTER IN THE FUTURE. PLEASE INDICATE YOUR LANGUAGE PREFERENCE: ☐ ENGLISH ☐ SPANISH ☐ CHINESE ☐ 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

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 — List applicant and all family members you wish to cover. (Dependent children must be under age 19, or under age 23 if full-time students.)

If you are applying for Access+ HMO, you must select an HMO Personal Physician for yourself and each family member from the Blue Shield HMO Physician and Hospital Network for your service area. You may choose the same or a different Personal Physician for each family member. Be sure to include each Personal Physician's provider number listed in the directory. (If you do not select a Personal Physician, Blue Shield will select one for you. If you have questions regarding your Personal Physician selection, call **(800) 424-6521**.) For Dental HMO: You must select a Dental Center from the Dental HMO Dental Center Directory. Be sure to include the Dental Center number listed in the directory. (If you have any questions regarding your Dental Center selection, call **(800) 431-2809**.)

1	☐ MALE ☐ FEMALE	YOUR FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH (MO/DAY/YR) _____/_____/_____	HEIGHT (FT. IN.)	WEIGHT (LBS.)
	ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME		MI	LAST	PROVIDER#	MED. GROUP/IPA #	☐ CHECK IF CURRENT PATIENT
	DENTAL HMO ONLY: DENTAL CENTER NUMBER			DENTAL HMO ONLY: DENTAL CENTER NAME			
2	☐ HUSBAND ☐ WIFE	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH (MO/DAY/YR) _____/_____/_____	HEIGHT (FT. IN.)	WEIGHT (LBS.)
	ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME		MI	LAST	PROVIDER#	MED. GROUP/IPA #	☐ CHECK IF CURRENT PATIENT
	DENTAL HMO ONLY: DENTAL CENTER NUMBER			DENTAL HMO ONLY: DENTAL CENTER NAME			
3	☐ SON ☐ DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH (MO/DAY/YR) _____/_____/_____	HEIGHT (FT. IN.)	WEIGHT (LBS.)
	ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME		MI	LAST	PROVIDER#	MED. GROUP/IPA #	☐ CHECK IF CURRENT PATIENT

PLEASE CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES. ☐
CHILD'S SOCIAL SECURITY NUMBER:
___ ___ ___ - ___ ___ - ___ ___ ___ ___

CHOOSE PLAN (CHECK ONE BOX ONLY):
DEDUCTIBLE PLAN: ☐ $500 DEDUCTIBLE ☐ $750 DEDUCTIBLE ☐ $1,500 DEDUCTIBLE ☐ $2,000 DEDUCTIBLE
ACCESS+ HMO ☐ **PREFERRED SAVINGS:** ☐ $1,700 DEDUCTIBLE ☐ $2,400 DEDUCTIBLE

OPTIONAL – CHOOSE DENTAL PLAN: ☐ **DENTAL HMO (DHMO)** ☐ **DENTAL PPO (DPPO)** | DENTAL HMO ONLY: DENTAL CENTER NAME AND NUMBER

® Registered Mark of Blue Shield Association

PART 2 — (CONTINUED)

4

☐ SON ☐ DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH (MO/DAY/YR) ____/____/____	HEIGHT (FT. IN.)	WEIGHT (LBS.)
ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME		MI	LAST	PROVIDER#	MED. GROUP/IPA #	☐ CHECK IF CURRENT PATIENT

PLEASE CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES. ☐
CHILD'S SOCIAL SECURITY NUMBER:
_____ _____ _____ - _____ _____ - _____ _____ _____ _____

CHOOSE PLAN (CHECK ONE BOX ONLY):
DEDUCTIBLE PLAN: ☐ $500 DEDUCTIBLE ☐ $750 DEDUCTIBLE ☐ $1,500 DEDUCTIBLE ☐ $2,000 DEDUCTIBLE
ACCESS+ HMO ☐ PREFERRED SAVINGS: ☐ $1,700 DEDUCTIBLE ☐ $2,400 DEDUCTIBLE

OPTIONAL – CHOOSE DENTAL PLAN: ☐ DENTAL HMO (DHMO) ☐ DENTAL PPO (DPPO) | DENTAL HMO ONLY: DENTAL CENTER NAME AND NUMBER

5

☐ SON ☐ DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH (MO/DAY/YR) ____/____/____	HEIGHT (FT. IN.)	WEIGHT (LBS.)
ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME		MI	LAST	PROVIDER#	MED. GROUP/IPA #	☐ CHECK IF CURRENT PATIENT

PLEASE CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES. ☐
CHILD'S SOCIAL SECURITY NUMBER:
_____ _____ _____ - _____ _____ - _____ _____ _____ _____

CHOOSE PLAN (CHECK ONE BOX ONLY):
DEDUCTIBLE PLAN: ☐ $500 DEDUCTIBLE ☐ $750 DEDUCTIBLE ☐ $1,500 DEDUCTIBLE ☐ $2,000 DEDUCTIBLE
ACCESS+ HMO ☐ PREFERRED SAVINGS: ☐ $1,700 DEDUCTIBLE ☐ $2,400 DEDUCTIBLE

OPTIONAL – CHOOSE DENTAL PLAN: ☐ DENTAL HMO (DHMO) ☐ DENTAL PPO (DPPO) | DENTAL HMO ONLY: DENTAL CENTER NAME AND NUMBER

6

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 — 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.
If "Yes," circle the condition(s) applicable and provide the information requested in the appropriate Part: 5, 6, or 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.?		
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.?		
3. Circulatory system – such as: varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder, anemia, or enlarged lymph nodes, etc.?		
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, PLEASE EXPLAIN: FREQUENCY: ____________ SEVERITY: ____________		
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: ____________		
6. Urinary tract – such as: renal colic, gravel or stone, urethra, bladder, ureter or kidney problems, infections, stricture, pyelonephritis, etc.?		
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?		
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 ltreated for infertility? TYPE OF IMPLANTS (CIRCLE ONE): SALINE OR SILICONE		
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: ______/______; ______/______; ______/______		
9. A. Is either the applicant, spouse, or dependent, whether or not listed on the application, currently pregnant?		
B. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on the application?		
10. 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: ____________		
11. Skin conditions – such as: skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns, etc.?		
12. 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.)		
13. 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.?		

PART 3 — Medical History — (continued)

	YES	NO
14. Cancer/malignancy, leukemia, Hodgkin's, tumor/cyst, lymphoma, etc? TYPE: ________		
15. Alcoholism, drug dependency or substance abuse? TYPE: ________		
16. Presently a member of a support group? TYPE: ________ HOW LONG: ________		
17. Congenital abnormalities, birth defects – such as: Down's Syndrome, cerebral palsy, cleft lip or palate, clubfoot, developmental delay, or other neurological or physical abnormalities?		
18. 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: ________		
19. 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?		
20. 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)?		
21. Do you or any applying family member have a prosthesis, implant, or retained hardware? TYPE: ________		
22. 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?		
23. Have you or any applying family member ever smoked cigarettes? FAMILY MEMBER: ________ PACKS PER DAY: ________ HOW MANY YEARS: ________ WHEN DID YOU/THEY STOP? ________		
24. Do you or any applying family member drink alcoholic beverages? FAMILY MEMBER: ________ DRINKS PER WEEK: ________ HOW MANY YEARS: ________ WHEN DID YOU/THEY STOP? ________		
25. 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: ________		
26. Have you or any applying family member ever requested or received a pension, benefits or payment because of any injury, sickness or disability? FAMILY MEMBER: ________ DATE:____/____/____ PLEASE EXPLAIN: ________		
27. Have you or any applying family member seen a physician or health care provider for any reason within the last two (2) years? **If yes, or if any applicant is five years old or younger or 55 years old or older, please fill out part 6 of this application.**		
28. In the last 12 months: have you or any applying family member taken or been ordered to take prescription medication(s) other than: antibiotics solely for seasonal flu or cold infection OR birth control pills solely for the prevention of conception OR female hormones solely for replacement therapy? **If yes, please fill out Part 7 of this application.**		

PART 4 — PRIOR MEDICAL COVERAGE – Please answer each question. If yes, please provide details in the space provided.

1. Did you or any applying family member have other health coverage (insurance) within the last 63 days?

FAMILY MEMBER: ☐ YES ☐ NO	TYPE OF COVERAGE	EFFECTIVE DATE	CANCEL DATE:	HEALTH PLAN CARRIER:
PRIMARY ________	☐ GROUP ☐ COBRA ☐ INDIVIDUAL ☐ OTHER	____/____/____	____/____/____	________
SPOUSE ________	☐ GROUP ☐ COBRA ☐ INDIVIDUAL ☐ OTHER	____/____/____	____/____/____	________
OTHER: ________	OTHER: ________			

2. 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 3? 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 preexisting conditions. You can call Blue Shield at **(800) 431-2809** for assistance obtaining a certificate.

PART 5 — MEDICAL CONDITION DETAILS — If you answered "YES" to any of questions 1–22 in PART 3, 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. ☐

QUESTION NUMBER	FAMILY MEMBER NAME AND NAME USED ON DOCTOR'S RECORDS	DIAGNOSIS AND PRESENT STATUS		DATES OF TREATMENT, HOSPITALIZATION	
	NAME	DIAGNOSIS AND TREATMENT		BEGAN: ____ /____ (MO/YR) ENDED: ____ /____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? ☐ YES ☐ NO	PRESENT STATUS			
	MEDICAL RECORD NO.	HOSPITALIZED? ☐ YES ☐ NO ER VISITS? ☐ YES ☐ 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
	NAME	DIAGNOSIS AND TREATMENT		BEGAN: ____ /____ (MO/YR) ENDED: ____ /____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? ☐ YES ☐ NO	PRESENT STATUS			
	MEDICAL RECORD NO.	HOSPITALIZED? ☐ YES ☐ NO ER VISITS? ☐ YES ☐ 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)

QUESTION NUMBER	FAMILY MEMBER NAME AND NAME USED ON DOCTOR'S RECORDS		DIAGNOSIS AND PRESENT STATUS	DATES OF TREATMENT, HOSPITALIZATION	
	NAME		DIAGNOSIS AND TREATMENT	**BEGAN**: ____ /____ (MO/YR) **ENDED**: ____ /____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? ☐ YES ☐ NO		PRESENT STATUS		
	MEDICAL RECORD NO.		HOSPITALIZED? ☐ YES ☐ NO ER VISITS? ☐ YES ☐ 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
	NAME		DIAGNOSIS AND TREATMENT	**BEGAN**: ____ /____ (MO/YR) **ENDED**: ____ /____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? ☐ YES ☐ NO		PRESENT STATUS		
	MEDICAL RECORD NO.		HOSPITALIZED? ☐ YES ☐ NO ER VISITS? ☐ YES ☐ 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.

If you answered "YES" to question 27 in PART 3, or if the applicant is five years old or younger, please provide the details of the physician visits.
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		
FULL NAME, ADDRESS, MEDICAL GROUP AND SPECIALTY OF PHYSICIAN NAME		PHONE NUMBER		MEDICAL GROUP		SPECIALTY
ADDRESS		STE#	CITY		STATE	ZIP
NAME OF FAMILY MEMBER	DATE OF VISIT : _____/_____/_____	REASON FOR EXAM/CHECK-UP		FINDINGS AND PRESENT STATUS		
FULL NAME, ADDRESS, MEDICAL GROUP AND SPECIALTY OF PHYSICIAN NAME		PHONE NUMBER		MEDICAL GROUP		SPECIALTY
ADDRESS		STE#	CITY		STATE	ZIP
NAME OF FAMILY MEMBER	DATE OF VISIT : _____/_____/_____	REASON FOR EXAM/CHECK-UP		FINDINGS AND PRESENT STATUS		
FULL NAME, ADDRESS, MEDICAL GROUP AND SPECIALTY OF PHYSICIAN NAME		PHONE NUMBER		MEDICAL GROUP		SPECIALTY
ADDRESS		STE#	CITY		STATE	ZIP
NAME OF FAMILY MEMBER	DATE OF VISIT : _____/_____/_____	REASON FOR EXAM/CHECK-UP		FINDINGS AND PRESENT STATUS		
FULL NAME, ADDRESS, MEDICAL GROUP AND SPECIALTY OF PHYSICIAN NAME		PHONE NUMBER		MEDICAL GROUP		SPECIALTY
ADDRESS		STE#	CITY		STATE	ZIP

PART 7 —CURRENT OR RECENT PRESCRIPTION MEDICATIONS.

If you answered "YES" to question 28 in PART 3, please provide the details of the current and previous medications.

NAME OF FAMILY MEMBER			DATES FROM :_____/_____/_____		TO :_____/_____/_____
NAME OF MEDICATION AND CONDITION FOR WHICH MEDICATION WAS PRESCRIBED MEDICATION	DOSAGE		CONDITION		FREQUENCY
FULL NAME, ADDRESS, MEDICAL GROUP AND SPECIALTY OF PHYSICIAN NAME	PHONE NUMBER		MEDICAL GROUP		SPECIALTY
ADDRESS	STE#	CITY		STATE	ZIP
NAME OF FAMILY MEMBER			DATES FROM :_____/_____/_____		TO :_____/_____/_____
NAME OF MEDICATION AND CONDITION FOR WHICH MEDICATION WAS PRESCRIBED MEDICATION	DOSAGE		CONDITION		FREQUENCY
FULL NAME, ADDRESS, MEDICAL GROUP AND SPECIALTY OF PHYSICIAN NAME	PHONE NUMBER		MEDICAL GROUP		SPECIALTY
ADDRESS	STE#	CITY		STATE	ZIP

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

PART 7 — CURRENT OR RECENT PRESCRIPTION MEDICATIONS. (CONTINUED)

NAME OF FAMILY MEMBER			DATES FROM :_____/_____/_____	TO :_____/_____/_____
NAME OF MEDICATION AND CONDITION FOR WHICH MEDICATION WAS PRESCRIBED MEDICATION	DOSAGE		CONDITION	FREQUENCY
FULL NAME, ADDRESS, MEDICAL GROUP AND SPECIALTY OF PHYSICIAN NAME	PHONE NUMBER		MEDICAL GROUP	SPECIALTY
ADDRESS	STE#	CITY	STATE	ZIP
NAME OF FAMILY MEMBER			DATES FROM :_____/_____/_____	TO :_____/_____/_____
NAME OF MEDICATION AND CONDITION FOR WHICH MEDICATION WAS PRESCRIBED MEDICATION	DOSAGE		CONDITION	FREQUENCY
FULL NAME, ADDRESS, MEDICAL GROUP AND SPECIALTY OF PHYSICIAN NAME	PHONE NUMBER		MEDICAL GROUP	SPECIALTY
ADDRESS	STE#	CITY	STATE	ZIP

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

1. 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.*)*
2. 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.**
3. 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.
4. 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.
5. 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.
6. **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 or, **B.** my designee ____ (include relationship) or,
   C. Qualified Medical Child Support Order designee ____ (include relationship).
   I further request that all changes to this contract be made only upon Blue Shield's receipt of such written request.
   Please indicate: □ **A** □ **B or** □ **C.** (Court documents must be attached authorizing guardianship if the responsible adult is not the parent.)
7. **Applicants with a Spouse:** 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.
8. **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	PRINT NAME
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 ______________________

CPIC Life®
A Blue Shield of California Subsidiary

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.

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

IF YOU WANT LIFE INSURANCE COVERAGE FOR YOUR SPOUSE, ENTER THIS PERSON AS THE PRIMARY APPLICANT. (NOTE: THIS MAY IMPACT YOUR BLUE SHIELD HEALTH PLAN DUES RATE.) 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 FAMILY MEMBER AGE 18 AND OVER (IF APPLYING) X____________________ PRINT NAME ____________________

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 _____ _____ _____ _____ _____ _____ _____ _____ _____	TELEPHONE NUMBER	FAX NUMBER
PRODUCER NAME	EMAIL ADDRESS	
PRODUCER ADDRESS		
SUPER PRODUCER NAME	SUPER PRODUCER NUMBER _____ _____ _____ _____ _____ _____ _____ _____ _____	

TODAY'S DATE (REQUIRED) _____/_____/_____ **PRODUCER SIGNATURE (REQUIRED)** X____________________

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**.

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. IF YOU KNOW THAT YOU WON'T 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.

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 COVERAGE.)

☐ 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.

SIGNATURE OF APPLICANT OR LEGAL GUARDIAN X____________________ DATE _____/_____/_____

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