BlueCross BlueShield of Texas

PPO Select Basic℠

Miscellaneous Change Form

P.O. Box 3236
Naperville, IL 60566-7236
888-697-0683

To help us process your application promptly, please remember to:

- Print all answers in black ink. Pencil will not be accepted.
- Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent child(ren) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line. Parent/guardian must sign if primary applicant is a minor.
- If you are downgrading (decreasing benefits), you do not need to complete Part Two, Sections A and B.

SECTION A — PERSON(S) APPLYING FOR COVERAGE (please print)

In addition to having a permanent residence in Texas, all persons applying for coverage must be a United States citizen, or if not a citizen, must be able to provide medical records from a licensed U. S. Physician, including but not limited to, a health evaluation conducted within the past two years. All others are ineligible for coverage.

PRIMARY APPLICANT

First Name, Middle Initial, Last Name		Social Security #	Sex (M/F)	Age	Date of Birth (mo/day/yr) / /	Height (ft., in.)	Weight (lbs.)
Home Phone # ( )	Business Phone # ( )	Fax # (if available) ( )	Occupation/Duties			Spouse's Business # (if applying)	
Residence Street Address		City/State/ZIP				County	
Email (if available)		Best place and time to call (if necessary) for a phone interview. ☐ Home ☐ Business ☐ Morning ☐ Afternoon					

Spouse and dependent child(ren) you wish to cover (dependents must be under age 26).

If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)? ☐ Yes ☐ No

Name: First	Middle Initial	Last	Relation (spouse or child)	Sex	Height (ft., in.)	Weight (lbs.)	Date of Birth (mo/day/yr)	Social Security Number	Court Ordered for Dependents
				☐ M ☐ F			/ /		☐ Yes ☐ No
				☐ M ☐ F			/ /		☐ Yes ☐ No
				☐ M ☐ F			/ /		☐ Yes ☐ No
				☐ M ☐ F			/ /		☐ Yes ☐ No
				☐ M ☐ F			/ /		☐ Yes ☐ No

Is any dependent coverage required by court order? ☐ Yes ☐ No If "yes," was it effective within the last 30 days? ☐ Yes ☐ No
If "yes," to apply for court-mandated coverage for dependent children, contact Blue Cross and Blue Shield of Texas for the appropriate form.

SECTION B — PPO SELECT BASIC COVERAGE APPLIED FOR (make selection below)

☐ Add Dependents as indicated in Section A ☐ Change Health Deductible: (If changing to **lower** Deductible–complete pages 2 and 3.)

Options	Health Deductibles		Coinsurance Amounts		PDP			
	Network Individual/Family	Out-of-Network Individual/Family	Network	Out-of-Network	Generic	Preferred Brand Name	Non-Preferred Brand Name	Deductible does not apply to Generic Drugs
Plan I ☐	$1,500/$4,500	$3,000/$9,000	$3,000/$9,000	No Limit	$10	$50	$65	$500
Plan II ☐	$2,500/$7,500	$5,000/$15,000						
Plan III ☐	$3,500/$10,500	$7,000/$21,000						
Plan IV ☐	$5,000/$15,000	$10,000/$30,000						

SECTION C — Cancel Coverage

☐ Health and Dental **(If covered dental, cancelling health coverage automatically cancels dental coverage)**

☐ Dental Only ☐ All Dependent(s) Coverage ☐ Cancel Spouse

List name of dependent(s) to be cancelled_____

☐ Cancel Insured Only – Continue Dependent(s) – a separate Continuation of Coverage Application Form must be completed.

Reason: ☐ Married ☐ Divorced ☐ Deceased ☐ Other_____

Applicant Name: _____ Social Security No. _____

STATEMENT OF HEALTH

Please Complete the Following Health Questions: For this insurance to be in force, you must answer the following health questions fully and truthfully and provide all of the health information asked for, including routine physical examinations, and Blue Cross and Blue Shield of Texas must approve this supplement to your application. No one may change this requirement for you in any way. An act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. You will be provided with at least 30 days' advance written notice before you or your dependent's coverage may be rescinded, retroactive to the effective date of coverage. **Please do not mark over or strike out any signature, date or health question information. Important! Do not cancel any existing health coverage until notified of your acceptance.**

If you answer "Yes" to ANY questions on this page, please give details on the next page. Please note the timeframe reference for each question.

1. Has any person applying for coverage been advised to seek treatment for alcohol use or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism within the last **10 years**? . . . . . ☐ Yes ☐ No
2. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use or dependency within the last **10 years**? . . . . . ☐ Yes ☐ No
3. Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last **10 years** for the following: Please check ☑ Yes or ☑ No. If any boxes are checked "Yes" (☑Yes), also circle the condition, e.g. (**migraines**), and give details on the next page.

A. Migraines; headaches; carpal tunnel syndrome; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? . . . . . ☐ Yes ☐ No

B. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? . . . . . ☐ Yes ☐ No

C. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/ high blood pressure (HBP)? . . . . . ☐ Yes ☐ No

If "Yes" to HBP, provide 3 readings and their dates w/in the last year

_____and_____and_____

D. Varicose veins/spider veins/varicosities; elevated cholesterol or lipids; anemia; blood clot or any other blood disorder? . . . . . ☐ Yes ☐ No

E. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; or any breathing difficulty, lung or respiratory disease, disorder or condition? . . . . . ☐ Yes ☐ No

F. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach or duodenum, or any other digestive disorder or condition? . . . . . ☐ Yes ☐ No

G. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? (indicate type of hepatitis_____) . . ☐ Yes ☐ No

H. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? (indicate diagnosis and location _____ _____) . . ☐ Yes ☐ No

I. Acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other skin disorder? . . . . . ☐ Yes ☐ No

J. Kidney stones; reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? . . . ☐ Yes ☐ No

K. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? . . . . . ☐ Yes ☐ No

L. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; bunions; joint replacement; or manipulation therapy? . . . . . ☐ Yes ☐ No

M. Thyroid disorder; goiter; Graves disease; diabetes; lupus; pituitary or adrenal disorder? . . . . . ☐ Yes ☐ No

N. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? . . . . . ☐ Yes ☐ No

O. Has anyone applying for coverage ever been diagnosed as having or told by a medical doctor that you have AIDS, HIV, or ARC disorders? . . . . . ☐ Yes ☐ No

P. Have you or any person applying for coverage ever been tested positive for antibodies for the AIDS virus? . . . ☐ Yes ☐ No

Q. Has any person applying been diagnosed by a member of the medical profession as having AIDS and/or has any proposed insured received treatment from a member of the medical profession for AIDS? . . . . . ☐ Yes ☐ No

R. **Questions for male applicants**
Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? . . . . . ☐ Yes ☐ No

S. **Questions for female applicants**
Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? . . . . . ☐ Yes ☐ No

Applicant Name: _____ Social Security No. _____

4. During the last **5 years**, has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist? . . . . . ☐ Yes ☐ No

5. Has any person applying for coverage been prescribed or taken any medications due to sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss in the last **12 months**? . . . . . ☐ Yes ☐ No

6. Have you, your spouse (if to be insured), or any child (if to be insured) smoked or used any tobacco products – such as cigarettes, pipes, cigars, snuff or chewing tobacco – in the last **12 months**? YOU ☐ Yes ☐ No YOUR SPOUSE ☐ Yes ☐ No YOUR CHILD ☐ Yes ☐ No. If Yes,

   Name(s) _____

7. A. **Question for female applicants:** Is any female applying for coverage now pregnant? . . . . . ☐ Yes ☐ No

   B. **Question for male applicants:** Is any male applying for coverage now an expectant parent? . . . . . ☐ Yes ☐ No

   For policies with an initial effective date prior to March 23, 2010, if you answered either question "Yes", coverage cannot be offered. For policies with an initial effective date on or after March 23, 2010, if you answered either question "Yes" and the applicant is age 19 and over, coverage cannot be offered.

8. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin or penile implant), internal fixation (e.g. pins, plates or screws), prosthesis, pacemaker, valve replacement, shunt or monitoring device? . . . . . ☐ Yes ☐ No

9. Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery which has not yet been performed? . . . . . ☐ Yes ☐ No

10. Has any person applying for coverage **ever** been hospitalized or been treated in the emergency room or had any physical impairment, deformity, congenital anomaly, sickness, operation, injury or hospitalization other than admitted to on this page? . . . . . ☐ Yes ☐ No

11. Is each person applying for coverage a permanent resident of Texas, except for court-ordered dependents? . . . . . ☐ Yes ☐ No

DETAILS OF MEDICAL HISTORY:

If you answered “Yes” to ANY questions on the previous page, please provide further information using the chart below.
Be sure to use the “correct” example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

	Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment, Advice Given, and Medications Prescribed	Name, Address and Phone Number of Doctors and Hospitals
			What is it?	Date that is Started	Date of Recovery (if applicable)			
Correct Example:	3C	Joe Smith	high blood pressure	1/10	none	no, ongoing	40mg Atenolol once	Dr. Jones St. Mary’s Peoria, IL (309) 555-1212

Applicant Name: _____ Social Security No. _____

Change Name/Address

New Name_____ Reason for Change ☐ Married ☐ Divorced

New Address_____ City_____ State_____ZIP_____

Home Phone #( ) _____ Effective Date of Change_____

As a Supplement to my previous application, I request the change(s) in coverage as indicated on page 1. I understand that an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days' advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage.

Medical Authorization: I authorize any hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Important: Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant's Signature: _____ Date Signed: _____

Spouse's Signature (ONLY if to be insured): _____ Date Signed: _____

Parent/Guardian Signature (if Primary Applicant is a Minor): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

Do Not Write in Spaces Below

Approved Preferred	☐	Underwriter _____		The following named Applicant(s) shall not be
Approved Standard	☐	Decision Date _____		included for coverage under this Contract:
Approved Preferred w/Rider	☐	Effective Date _____		_____
Approved Standard w/Rider	☐	Condition/Waiver _____		_____
Declined	☐	_____		_____
Incomplete	☐	Smoker/Tobacco User:	☐	_____
		Non-Smoker/Tobacco User:	☐	

Changes in state or federal law, or regulations or interpretations thereof, may change the terms and conditions of coverage.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association