

# Application for Health and Life Insurance

Complete all sections in black ink (please print) and sign.

## 1 PROPOSED INSURED (OLDEST PERSON TO BE COVERED)

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SEX	BIRTH DATE	SOCIAL SECURITY NO.	HEIGHT	WEIGHT
			Self					

## 2 PARENT/GUARDIAN (IF POLICY FOR A MINOR)

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP

## 3 SPOUSE (IF APPLYING)

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SEX	BIRTH DATE	SOCIAL SECURITY NO.	HEIGHT	WEIGHT
			Spouse					

## 4 DEPENDENT CHILDREN (IF APPLYING)

In the RELATIONSHIP box below, please indicate **son, daughter, stepson** or **stepdaughter** beside each dependent's name. **IMPORTANT:** If any dependents named on this application do NOT reside with the proposed insured, we must also have the custodial parent's signature. See page 6 of this application. **Dependents age 19 to 23 must be full-time students.**

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	SEX	BIRTH DATE	SOCIAL SECURITY NO.	HEIGHT	WEIGHT

## 5 STUDENT INFORMATION [Dependent(s) Age 19 to 23] Must be full-time student(s).

DEPENDENT	SCHOOL ATTENDING	SEMESTER HRS.	EST. DATE OF GRADUATION

## 6 PERSONAL INFORMATION

PROPOSED INSURED MARITAL STATUS:  SINGLE  MARRIED  DIVORCED  SEPARATED  WIDOWED

PROPOSED INSURED RESIDENT STATUS: U.S. CITIZEN  YES  NO IF NO, PLEASE EXPLAIN \_\_\_\_\_

## 7A BILLING ADDRESS (only for billing)

## 7B MAILING ADDRESS\* (if different from billing address)

STREET			STREET		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

**\*IMPORTANT: Confidential medical information may be mailed to the mailing address.**

## 8 TELEPHONE INFORMATION

HOME PHONE NO. ( )	BUSINESS PHONE NO. ( )	BEST TIME TO CALL AM PM	<input type="checkbox"/> HOME <input type="checkbox"/> BUSINESS

I.D. NO.	GROUP NO.	EFFECTIVE DATE

## 9 HOUSEHOLD INFORMATION

A. Do all proposed insureds reside in the same household?  Yes  No

If no, provide reason: \_\_\_\_\_ Address: \_\_\_\_\_

B. Do all proposed insureds reside in Arkansas?  Yes  No

If no, provide reason: \_\_\_\_\_ Address: \_\_\_\_\_

## 10 PROPOSED INSURED'S EMPLOYMENT INFORMATION

EMPLOYER

JOB DUTIES

## 11 SPOUSE'S EMPLOYMENT INFORMATION (if applicable)

EMPLOYER

JOB DUTIES

## 12 CURRENT INSURANCE INFORMATION

NAME OF COMPANY

I.D. NO.

GROUP OR POLICY NO.

Will the coverage applied for replace or change your current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?  Yes  No

If yes, termination date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 13 PREVIOUS COVERAGE

Have any of the proposed insureds ever had coverage with Arkansas Blue Cross and Blue Shield, Health Advantage, USAble Administrators or First Pyramid Life?  Yes  No

If yes, termination date: \_\_\_\_/\_\_\_\_/\_\_\_\_ I.D. Number \_\_\_\_\_

## 14 MEDICARE INFORMATION

Are you or any dependent to be covered by this policy also covered by Medicare?  Yes  No

Persons covered by Medicare:

(1) \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ HIC # \_\_\_\_\_

(2) \_\_\_\_\_ Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_ HIC # \_\_\_\_\_

## 15 DRIVER'S LICENSE INFORMATION (age 15 and older)

Proposed Insured's Driver's License # \_\_\_\_\_ State Issued \_\_\_\_\_

Spouse's Driver's License # \_\_\_\_\_ State Issued \_\_\_\_\_

Dependent's Driver's License # \_\_\_\_\_ State Issued \_\_\_\_\_

Dependent's Driver's License # \_\_\_\_\_ State Issued \_\_\_\_\_

**Has any person to be covered had:**

- a. his/her driver's license suspended or revoked? (a)  Yes  No
- b. two or more moving traffic violations in the past two years? (b)  Yes  No
- c. been convicted or charged with driving under the influence of alcohol or a controlled substance? (c)  Yes  No

If you answered "yes" to any of the above questions, you must provide the following information:

Name of person(s) and date of occurrence(s) \_\_\_\_\_

## 16 SPORTING OR HOBBY INFORMATION (age 15 and older)

Does any person to be covered intend to pilot a private aircraft or participate in sky or scuba diving; ballooning; motor vehicle, boat or snowmobile racing; mountain climbing; hang gliding, or any other hazardous sport, hobby or activity?  Yes  No

Name of person \_\_\_\_\_ Please explain: \_\_\_\_\_

Name of person \_\_\_\_\_ Please explain: \_\_\_\_\_

Name of person \_\_\_\_\_ Please explain: \_\_\_\_\_

## 17 EXPECTANT PARENT INFORMATION

Is any person to be covered, or a dependent of the proposed insured (whether applying for coverage or not), now pregnant or an expectant parent?  Yes  No

Name \_\_\_\_\_ Expected Delivery Date \_\_\_\_\_

## 18 TRAVEL OUTSIDE THE USA

Is any person to be covered planning to travel or work outside the USA within the next two years?  Yes  No

If yes, country \_\_\_\_\_ Reason for travel \_\_\_\_\_ Length of stay \_\_\_\_\_

## 19 TYPE OF COVERAGE

(Proposed insured must be age 18 or older to apply for coverage other than individual.)

Individual  Individual and Spouse  Individual and Child(ren)  Family

## 20 BILLING MODE

Monthly Bank Draft  Quarterly  Semi Annually  Annually  List Bill Additions (for agent use only) List Bill # \_\_\_\_\_

## 21 BENEFITS SELECTION (Check desired selections.)

### BLUECARE PPO PLUS

\$20 co-pay for in-network General Practice, Family Practice, Internal Medicine and Pediatric visits. Other coverage is available after the deductible and coinsurance have been satisfied and as detailed in the Outline of Coverage or the policy contract. The lifetime maximum is \$2,000,000 per covered individual.

#### CHOOSE PLAN A OR B

**PLAN A (100% after Deductible)**

I choose to pay my in-network Deductible of \$2,500

Out-of-network expenses under Plan A are subject to twice the annual deductible, 80% coinsurance and no calendar-year coinsurance maximum.

**PLAN B (80% / 20% after Deductible)**

I choose to pay my in-network **Deductible** of

\$500  \$1,000  \$1,500

THEN 20% of my **Calendar-year coinsurance maximum**

\$5,000  \$10,000

Out-of-network expenses under Plan B are subject to twice the annual deductible, 60% coinsurance and twice the calendar-year coinsurance maximum.

### BLUECARE PPO

After you pay your selected in-network deductible and coinsurance percentage, Arkansas Blue Cross and Blue Shield will pay 100% of remaining eligible expenses for the calendar year, up to the lifetime maximum of \$2,000,000 per covered individual.

#### CHOOSE PLAN A OR B

**PLAN A (100% after Deductible)**

I choose to pay my in-network Deductible of \$2,500

Out-of-network expenses under Plan A are subject to twice the annual deductible, 80% coinsurance and no calendar-year coinsurance maximum.

**PLAN B (80% / 20% after Deductible)**

I choose to pay my in-network **Deductible** of

\$500  \$1,000  \$1,500

THEN 20% of my **Calendar-year coinsurance maximum**

\$5,000  \$10,000

Out-of-network expenses under Plan B are subject to twice the annual deductible, 60% coinsurance and twice the calendar-year coinsurance maximum.

## OPTIONAL BENEFITS AVAILABLE WITH BLUECARE PPO OR BLUECARE PPO PLUS

**MATERNITY COVERAGE** — Subject to annual deductible and coinsurance (Proposed insured must be age 18 or older.)

**TERM LIFE INSURANCE** — Underwritten by US Able Life. Term Life is available only on the proposed insured. (Proposed insured must be age 18 or older.)  \$10,000  \$30,000  \$50,000

## BENEFICIARY DESIGNATION FOR OPTIONAL TERM LIFE INSURANCE BENEFITS

Name (Last, First, MI)	Birth Date	Relationship	Primary/Secondary	Indicate Percentage Distribution
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	
			<input type="checkbox"/> Primary or <input type="checkbox"/> Secondary	

## 22 MEDICAL QUESTIONNAIRE

### ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question answered "YES," circle the condition requiring treatment and give full details in the ADDITIONAL MEDICAL INFORMATION box below.

1. Has any person to be insured ever had or been told he/she had:
  - a. asthma, allergies, bronchitis, emphysema, obstructive or reactive airway disorder, pleurisy, sleep apnea, or any disorder of lungs, bronchial tubes, or respiratory system? 1. (a) \_\_\_ Yes \_\_\_ No
  - b. epilepsy, convulsions, seizures, vertigo or fainting, paralysis, parkinsonism, neuritis, migraine headaches, or any disorder of the brain or nervous system? (b) \_\_\_ Yes \_\_\_ No
  - c. mental disease, nervous disorder, emotional problems, anxiety, depression, eating disorder, psychiatric treatment, counseling, drug overdose, or attempted suicide? (c) \_\_\_ Yes \_\_\_ No
  - d. high blood pressure, arteriosclerosis, heart attack, stroke, heart murmur, palpitation of the heart, chest pain or shortness of breath, or any disorder of the heart, blood, blood vessels or circulatory system? (d) \_\_\_ Yes \_\_\_ No
  - e. back pain, arthritis, arthralgia, fibromyalgia, chronic fatigue, rheumatic fever, gout or any disorder of the muscles, bones or joints? (e) \_\_\_ Yes \_\_\_ No
  - f. cataracts, glaucoma, nasal septal defect, sinusitis, tonsillitis, or any disorder of the eyes, ears, nose, throat or esophagus? (f) \_\_\_ Yes \_\_\_ No
  - g. gastric or duodenal ulcer, indigestion, colitis or irritable bowel syndrome, gastric bypass, gastric reflux, hernia, hepatitis, or disorder of the stomach, intestines, liver, gall bladder or rectum? (g) \_\_\_ Yes \_\_\_ No
  - h. diabetes, goiter or any other disorder of the thyroid, pituitary, adrenal, pancreas or other glands? (h) \_\_\_ Yes \_\_\_ No
  - i. renal stones, bladder stones, nephritis, albumin, sugar or blood in the urine, or any disorder of the kidneys or urinary tract, or male or female reproductive organs including prostate, ovaries or breasts? (i) \_\_\_ Yes \_\_\_ No
  - j. cancer, melanoma, leukemia, anemia, tumor, neoplasm, malignancy of any kind or disorder of the lymphatic system or skin? (j) \_\_\_ Yes \_\_\_ No
  - k. any existing injury, deformity, incapacitation, disease or condition not listed elsewhere? (k) \_\_\_ Yes \_\_\_ No
2. Has any person to be insured, or a dependent of the proposed insured (**whether applying for coverage or not**), ever been treated for infertility? 2. \_\_\_ Yes \_\_\_ No
3. Has any person to be insured ever had a c-section? 3. \_\_\_ Yes \_\_\_ No
4. During the past 5 years has any proposed insured:
  - a. consulted, been examined, or treated by any physician or practitioner? 4. (a) \_\_\_ Yes \_\_\_ No
  - b. had x-rays, EKG, or any laboratory test or study? (b) \_\_\_ Yes \_\_\_ No
  - c. had or been advised to have a surgical operation? (c) \_\_\_ Yes \_\_\_ No
  - d. been confined or treated at any hospital, clinic, sanitarium, or other medical facility? (d) \_\_\_ Yes \_\_\_ No

#### ADDITIONAL MEDICAL INFORMATION

List below full details to questions answered "YES." (Use separate sheet if necessary, sign, date and attach to the application.)

Question Number	Person Treated	Condition and Type of Treatment	Date Occurred	Date Recovered	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	

## 22 MEDICAL QUESTIONNAIRE (continued)

### PRESCRIPTION INFORMATION

List below full details to questions answered "YES." (Use separate sheet if necessary, sign, date and attach to the application.)

5. Is any proposed insured currently taking any prescription medication, or taken prescription medication in the last 3 years? 5. \_\_\_ Yes \_\_\_ No

If "YES," provide details in the PRESCRIPTION INFORMATION box below.

Person Treated	Name of Drug	Dosage	Condition or Illness	Start Date	Stop Date	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	

### THERAPY OR TREATMENT INFORMATION

List below full details to questions answered "YES." (Use separate sheet if necessary, sign, date and attach to the application.)

6. Has any proposed insured received occupational therapy, physical therapy, speech therapy, or chiropractic treatments? 6. \_\_\_ Yes \_\_\_ No

7. Has any person to be insured ever:

a. consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions? 7. (a) \_\_\_ Yes \_\_\_ No

b. used any addictive or non-addictive drug or substance except as provided by a physician? (b) \_\_\_ Yes \_\_\_ No

c. been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), or AIDS-related complex or Immune Deficiency Disorder? (c) \_\_\_ Yes \_\_\_ No

Person Treated	Number of Treatments	Condition and Type of Treatment	Date of First Visit	Date of Last Visit	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	

8. Have questions 1 through 7 been answered with respect to all persons to be covered? If no, explain \_\_\_\_\_ 8. \_\_\_ Yes \_\_\_ No

## 23 TOBACCO USAGE

Have you or any of the persons to be covered used any form of tobacco within the last 12 months? If yes, list name of person(s) below and type and amount of tobacco used per day:  Yes  No

Name \_\_\_\_\_ Type \_\_\_\_\_ Amount \_\_\_\_\_

Name \_\_\_\_\_ Type \_\_\_\_\_ Amount \_\_\_\_\_

Name \_\_\_\_\_ Type \_\_\_\_\_ Amount \_\_\_\_\_

## 24 PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application may be rejected. (2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card and the initial premium is paid in full, but in no event will insurance become effective earlier than 10 days after the date of this application. (3) In addition to other exclusions and limitations, NO ARKANSAS BLUE CROSS AND BLUE SHIELD BENEFITS WILL BE AVAILABLE FOR 12 MONTHS FOR THE TREATMENT OF ANY CONDITION WHICH EXISTED BEFORE THE EFFECTIVE DATE OF MY COVERAGE. (4) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (5) I agree any provider of medical services or supplies is authorized and directed to furnish Arkansas Blue Cross and Blue Shield, its agents or any of its subsidiaries, all records or copies thereof, relating to such services or supplies. (6) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (7) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded to the best of my knowledge and belief; (b) authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company or any third party engaged by Arkansas Blue Cross and Blue Shield to secure medical or non-medical information having information with respect to any physical or mental condition, treatment or any non-medical information on me, or any member of my family (if applicable), to give Arkansas Blue Cross and Blue Shield, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (d) agree that this authorization shall be valid without time limit; (e) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request; (f) and authorize the Office of Driver Services to release my traffic violation record to Arkansas Blue Cross and Blue Shield.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

## 25 SIGNATURE LOCATION (This application must be signed in the state of Arkansas.)

This application was signed in \_\_\_\_\_, Arkansas.  
City

## 26 SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured's Signature <b>OR</b> Parent's/Legal Guardian's Signature (if policy for a minor)	<b>X</b>	Date Signed	
Spouse's Signature (if applying)	<b>X</b>	Date Signed	

**If any dependents named on this application do NOT reside with the proposed insured, the custodial parent's signature is required.**

Custodial Parent's Name (please print)			
Custodial Parent's Signature	<b>X</b>	Date Signed	

## THIS SECTION TO BE COMPLETED BY SALES REPRESENTATIVE

To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?  Yes  No

SALES REP S.S. #	SALES REPRESENTATIVE'S SIGNATURE <b>X</b>	DATE SIGNED
AGENCY FEDERAL TAX ID # (if applicable)	SALES REPRESENTATIVE'S NAME (please print)	

COMMENTS:

## FOR HOME OFFICE USE ONLY

HOME OFFICE ENDORSEMENTS:

**THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.**

# Tired of Paying Your Health Insurance Bill?

**—Then Let Us Do it for You!**



**Arkansas  
BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

## Enroll in Arkansas Blue Cross and Blue Shield's Pre-authorized Monthly Bank Draft Program!

- *No checks to write, no bills to keep, no stamps to buy.*
- *Bills are paid even when you're away from home.*
- *Never risk a lapse in coverage.*
- *This service is provided at no cost to you.*

**Important Note: Your first monthly premium cannot be paid by bank draft. You must pay at least one month's premium by check. Please do not pay your premium now. You will be billed later.**

## Here's How to Sign Up ...

1. Complete the information requested below.
2. Since we need information on your check, please attach a blank check from the account from which you want payment taken. Be sure to write "void" on the check before mailing it.
3. Complete the authorization form below and return to Arkansas Blue Cross and Blue Shield, P.O. Box 2181, Little Rock, AR 72203-2181, along with voided check and application.
4. If payment is to be withdrawn from an account other than yours, the person making your payments should follow the above directions.

After we receive your Authorization Form and voided check, we will change your payment method to the Bank Draft Program. You will be notified by letter of the effective date of your first draft. Please allow approximately 30 days to establish the pre-authorized draft. If you receive a bill during this time, pay it as you normally would.

### IMPORTANT: PLEASE READ AND COMPLETE THIS SECTION.

I authorize Arkansas Blue Cross and Blue Shield, a Mutual Insurance Company, and the BANK\* indicated below, to debit my Arkansas Blue Cross and Blue Shield premium from my checking account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and such manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK'S termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I will also be terminating my Arkansas Blue Cross and Blue Shield coverage, UNLESS Arkansas Blue Cross and Blue Shield has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

Bank Name \_\_\_\_\_

Location \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Account No. \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Address \_\_\_\_\_ Street \_\_\_\_\_ Apt. No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Account Holder

\*BANK also applies to Savings and Loan.

**REMEMBER TO ENCLOSE A VOIDED CHECK WITH REQUEST.**

### FOR OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)

I.D. NO.	GROUP NO.	EFFECTIVE DATE	AMOUNT	STATUS



**Arkansas**  
**BlueCross BlueShield**  
An Independent Licensee of the Blue Cross and Blue Shield Association

**Please read carefully and  
keep for your records.**

### Fair Credit Reporting Act Notice

#### **NOTICE TO PROPOSED INSURED**

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

#### **Policy Effective Date**

Policy Effective Date, as the term is used herein, will be:

- (a) the 1st of the following month, if approval date is 6th-20th of month, OR the next 15th of the month, if approval date is 21st-5th; however,
- (b) no earlier than 10 and no later than 90 days after the date on which the application was signed.
- (c) For list bill, the 1st of the month, if approval date is 1st-20th; the 1st of the month after next, if approval date is 21st-end of month.

Coverage becomes effective upon the date of policy and contingent upon receipt of premium.

#### **Application Checklist**

##### **Have you . . .**

- Answered all the questions?
- Signed and dated the application?
- Enclosed a completed Pre-authorized Monthly Bank Draft form signed by account holder (if monthly bank draft is requested)?
- Enclosed a voided check from account to be charged (if monthly bank draft is requested)?