



# BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.



# HEALTH CHECK

Select Care and Children's Major Medical

## MEMBER SERVICE LIFE

Member Service Life Insurance Company is a wholly owned subsidiary of Blue Cross and Blue Shield of Oklahoma, a member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

## APPLICATION FOR MEMBERSHIP

RETURN THIS FORM WITH YOUR VOIDED CHECK TO:

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA • P.O. BOX 60545 • OKLAHOMA CITY, OK 73146-0545

PLEASE PRINT IN BLUE OR BLACK INK OR TYPE

TELL US WHO YOU WANT TO ENROLL (CHECK ONE)				PART A
<input type="checkbox"/> APPLICANT ONLY <small>(Complete items 1 through 7, 10 through 13)</small>	<input type="checkbox"/> APPLICANT & SPOUSE <small>(Complete items 1 through 8, 10 through 13)</small>	<input type="checkbox"/> APPLICANT & UNMARRIED CHILD(REN) UNDER AGE 19 <small>(Complete items 1 through 7, 9 through 13)</small>	<input type="checkbox"/> APPLICANT, SPOUSE & UNMARRIED CHILD(REN) UNDER AGE 19 <small>(Complete items 1 through 13)</small>	

SELECT YOUR COVERAGE				PART B
<b>1</b> Check One Deductible:				
<input type="checkbox"/> \$200	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1000	<input type="checkbox"/> \$1500	<input type="checkbox"/> \$5000
<small>MATERNITY BENEFITS (FOR FEMALE APPLICANT OR SPOUSE AGE 19 AND OVER - CHECK ONE)</small> <input type="checkbox"/> COVERAGE WITH MATERNITY   <input type="checkbox"/> COVERAGE WITHOUT MATERNITY		<small>APPLICANT</small> I HAVE <input type="checkbox"/>   HAVE NOT <input type="checkbox"/>   SMOKED OR USED TOBACCO PRODUCTS IN THE LAST 12 MONTHS.		<small>SPOUSE (IF APPLYING)</small> I HAVE <input type="checkbox"/>   HAVE NOT <input type="checkbox"/>   SMOKED OR USED TOBACCO PRODUCTS IN THE LAST 12 MONTHS

TELL US ABOUT THE APPLICANT				PART C
<b>2</b> NAME OF APPLICANT (LAST) (FIRST) (MIDDLE)				RESIDENCE TELEPHONE A/C
<b>3</b> RESIDENCE ADDRESS (STREET OR BOX NO.) (CITY) (STATE) (ZIP-CODE)				(OFFICE USE ONLY) TM AE
<b>4</b> SOCIAL SECURITY NO.	DATE OF BIRTH MO. DAY YR.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED	BUSINESS PHONE A/C
<b>5</b> I AM EMPLOYED BY (NAME OF COMPANY)		ADDRESS (STREET OR P.O. BOX NO., CITY, STATE, ZIP)		DATE EMPLOYED FULL TIME MO. DAY YR.
<b>6</b> DO YOU NOW HAVE BLUE CROSS/ BLUE SHIELD? <input type="checkbox"/> YES <input type="checkbox"/> NO	YOUR CURRENT BLUE CROSS/BLUE SHIELD SUBSCRIBER NO.	YOUR CURRENT BLUE CROSS / BLUE SHIELD GROUP NO.	IS THIS AN APPLICATION FOR TRANSFER FROM AN EXISTING BLUE CROSS / BLUE SHIELD COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>7</b> DOES ANYONE APPLYING FOR THIS COVERAGE HAVE OTHER GROUP HEALTH INSURANCE OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, LIST OTHER GROUP INSURER	NAME OF POLICY HOLDER	POLICY NO.	TYPE OF COVERAGE <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY

TELL US ABOUT OTHER FAMILY MEMBERS APPLYING FOR COVERAGE				PART D
<b>8</b> NAME OF SPOUSE (FIRST, MIDDLE, LAST)				DATE OF BIRTH MO. DAY YR.
SOCIAL SECURITY NO.		EMPLOYED BY (NAME OF COMPANY)		BUSINESS PHONE A/C
<b>9</b> DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)		RELATIONSHIP TO APPLICANT		DATE OF BIRTH MO. DAY YR.
SOCIAL SECURITY NO. (IF ISSUED)		IS THIS DEPENDENT UNMARRIED, UNDER AGE 19, AND LIVING WITH YOU IN A PARENT-CHILD RELATIONSHIP? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF "NO," IS IT STATED IN A COURT DECREE THAT YOU ARE TO PROVIDE HEALTH COVERAGE FOR THEM? IF "YES," ATTACH A COPY OF COURT DECREE		<input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)		RELATIONSHIP TO APPLICANT		DATE OF BIRTH MO. DAY YR.
SOCIAL SECURITY NO. (IF ISSUED)		IS THIS DEPENDENT UNMARRIED, UNDER AGE 19, AND LIVING WITH YOU IN A PARENT-CHILD RELATIONSHIP? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF "NO," IS IT STATED IN A COURT DECREE THAT YOU ARE TO PROVIDE HEALTH COVERAGE FOR THEM? IF "YES," ATTACH A COPY OF COURT DECREE		<input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)		RELATIONSHIP TO APPLICANT		DATE OF BIRTH MO. DAY YR.
SOCIAL SECURITY NO. (IF ISSUED)		IS THIS DEPENDENT UNMARRIED, UNDER AGE 19, AND LIVING WITH YOU IN A PARENT-CHILD RELATIONSHIP? <input type="checkbox"/> YES <input type="checkbox"/> NO		
IF "NO," IS IT STATED IN A COURT DECREE THAT YOU ARE TO PROVIDE HEALTH COVERAGE FOR THEM? IF "YES," ATTACH A COPY OF COURT DECREE		<input type="checkbox"/> YES <input type="checkbox"/> NO		

### IMPORTANT: PLEASE COMPLETE ALL PARTS OF THIS FORM

FOR OFFICE USE ONLY	GROUP NO.	F/C AGREEMENT NO.	F/C CODE	WVR CODE	WVR CODE EXP. DATE	DIV CODE	CROSS-REF AGREEMENT NO.			COB	BRK IND	BRK NO.
	INVOICE NO.	MISC. CODE	EFF. DATE	SUB BASIC CHAR.	DEP BASIC CHAR	SUB DENTAL CHAR.	DEP DENTAL CHAR.	PROD	SMK	LIFE	LINC'S POLICY NO. PHCM	
	LOB	EFF. DATE	TERM. DATE	LOB	EFF. DATE	TERM. DATE	LOB	EFF. DATE	TERM. DATE	LOB	EFF. DATE	TERM. DATE

CALL 1-800-378-2362 IF YOU HAVE QUESTIONS ABOUT THIS APPLICATION.

**ANSWER THESE QUESTIONS FOR EACH PERSON APPLYING FOR COVERAGE**

**10 ALL HEALTH QUESTIONS MUST BE ANSWERED "YES" OR "NO." IF "YES," COMPLETE THE WHITE SECTION BELOW.**

	Y E S	N O		Y E S	N O
a. HAVE YOU OR ANY FAMILY DEPENDENTS LISTED HEREIN HAD LIFE, ACCIDENT, OR HEALTH INSURANCE POSTPONED, RATED UP, RIDERED, DECLINED OR CANCELLED?	<input type="checkbox"/>	<input type="checkbox"/>	i. ANY DISEASE OR DISORDER OF THE BRAIN OR NERVOUS SYSTEM, EPILEPSY, CONVULSIONS, MIGRAINE HEADACHES, STROKES OR PARALYSIS?	<input type="checkbox"/>	<input type="checkbox"/>
b. HAS ANYONE EVER HAD AIDS, AIDS-RELATED COMPLEX OR IMMUNE SYSTEM DISORDER (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	j. ANY DISEASE OR DISORDER OF THE BLOOD OR LYMPH GLANDS?	<input type="checkbox"/>	<input type="checkbox"/>
c. ANY DISEASE OR DISORDER OF THE HEART OR CIRCULATORY SYSTEM, HIGH BLOOD PRESSURE, HEART ATTACK, PHLEBITIS?	<input type="checkbox"/>	<input type="checkbox"/>	k. ANY DISORDER OF THE MALE OR FEMALE GENITAL AND / OR URINARY SYSTEMS?	<input type="checkbox"/>	<input type="checkbox"/>
d. DIABETES, THYROID, OTHER GLANDULAR DISORDER?	<input type="checkbox"/>	<input type="checkbox"/>	l. HAVE YOU OR ANY FAMILY DEPENDENTS LISTED HEREIN RECEIVED TREATMENT FOR ALCOHOL OR DRUG ABUSE?	<input type="checkbox"/>	<input type="checkbox"/>
e. ANY TYPE OF CANCER, TUMOR, CYST, GROWTH OR SKIN DISORDER?	<input type="checkbox"/>	<input type="checkbox"/>	m. IS THERE ANY ABNORMALITY, DEFORMITY, OR DISORDER NOT ALREADY SPECIFIED, OR ANY CONDITION THAT MAY REQUIRE TREATMENT?	<input type="checkbox"/>	<input type="checkbox"/>
f. HAS ANYONE EVER HAD ANY DISEASE OR DISORDERS OF THE STOMACH OR INTESTINES, GALLBLADDER, LIVER, PANCREAS, OR RECTUM?	<input type="checkbox"/>	<input type="checkbox"/>	n. HAVE YOU OR ANY FAMILY DEPENDENTS LISTED HEREIN CONSULTED A PHYSICIAN OR HEALTH PRACTITIONER FOR ANY REASON IN THE PAST THREE YEARS?	<input type="checkbox"/>	<input type="checkbox"/>
g. ANY DISEASE OF THE LUNGS OR RESPIRATORY SYSTEM, ASTHMA, TUBERCULOSIS, EMPHYSEMA?	<input type="checkbox"/>	<input type="checkbox"/>	o. HAVE YOU OR ANY FAMILY DEPENDENTS LISTED HEREIN BEEN A PATIENT IN A HOSPITAL WITHIN THE LAST THREE YEARS?	<input type="checkbox"/>	<input type="checkbox"/>
h. HAS ANYONE EVER HAD ANY DISEASE OR DISORDER OF THE BACK, SPINE, BONES, JOINTS, ARTHRITIS?	<input type="checkbox"/>	<input type="checkbox"/>	p. ARE ANY FEMALES TO BE COVERED NOW PREGNANT?	<input type="checkbox"/>	<input type="checkbox"/>
				IF YES, EXPECTED DELIVERY DATE (MO/DAY/YR) AND PATIENT'S NAME.	

<b>Applicant:</b>	<b>Exact Height</b>	<b>Exact Weight</b>	<b>Spouse:</b>	<b>Exact Height</b>	<b>Exact Weight</b>
	Feet _____ Inches _____	_____ lbs.		Feet _____ Inches _____	_____ lbs.

**COMPLETE THIS SECTION FOR EACH QUESTION ANSWERED "YES"** Attach additional sheet of necessary

QUESTION LETTER(S)	PERSON AFFECTED	TYPE OF AILMENT, SYMPTOM, OR DIAGNOSIS OF CONDITION	DEGREE OF RECOVERY	ONSET DATE	DATE OF LAST TREATMENT OR SURGERY	PRESCRIPTION DRUGS (LIST DATES TAKEN)	NAME(S) AND ADDRESSES OF PHYSICIAN, PRACTITIONER, HOSPITAL OR INSTITUTION
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		
			<input type="checkbox"/> NONE <input type="checkbox"/> PARTIAL <input type="checkbox"/> FULL		Treatment Surgery		

This section must be completed for any yes answers from the above Statement of Health.

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**BENEFICIARY DESIGNATION INFORMATION – IMPORTANT: PLEASE READ THE ENCLOSED INSTRUCTION SHEET**

**11 APPLICANT:**

I, on behalf of myself only, hereby apply for \$5,000 of your guaranteed renewable life insurance and \$5,000 of guaranteed renewable accidental death and dismemberment benefits with Member Service Life Insurance Company.

IS THIS LIFE INSURANCE TO REPLACE ANY OTHER POLICY?  YES  NO IF "YES" GIVE COMPANY NAME AND POLICY NUMBER

BENEFICIARY NAME (FIRST) (MIDDLE) (MAIDEN) (LAST) RELATIONSHIP TO APPLICANT

BENEFITS WILL BE PAYABLE TO INSURED'S ESTATE IF NO BENEFICIARY IS NAMED AND SPOUSE IS NOT LIVING.

BENEFICIARY ADDRESS (STREET OR BOX NO.) (CITY) (STATE) (ZIP CODE)

**SPOUSE:**

I, on behalf of myself only, hereby apply for \$5,000 of your guaranteed renewable life insurance and \$5,000 of guaranteed renewable accidental death and dismemberment benefits with Member Service Life Insurance Company.

IS THIS LIFE INSURANCE TO REPLACE ANY OTHER POLICY?  YES  NO IF YES GIVE COMPANY NAME AND POLICY NUMBER

BENEFICIARY NAME (FIRST) (MIDDLE) (MAIDEN) (LAST) RELATIONSHIP TO APPLICANT

BENEFITS WILL BE PAYABLE TO INSURED'S ESTATE IF NO BENEFICIARY IS NAMED AND SPOUSE IS NOT LIVING.

BENEFICIARY ADDRESS (STREET OR BOX NO.) (CITY) (STATE) (ZIP CODE)

**REMINDER**

**Your VOIDED CHECK from a participating Oklahoma financial institution must be attached here.**

**(Please do not use glue)**

ATTACH VOIDED CHECK HERE

**FINANCIAL INSTITUTION DEBIT AUTHORIZATION**

**12**

I hereby request and authorize Blue Cross and Blue Shield of Oklahoma to initiate debit entries to my account on or around the date payment is due. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer-sponsored health insurance plan. Further, I certify that the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future.

Preference of effective date / monthly withdrawal date – 1<sup>st</sup> only  ; 15<sup>th</sup> only  ; **Either the 1<sup>st</sup> or 15<sup>th</sup>**  of month.

**NOTE: If you would like to be considered for the earliest possible effective date for coverage, please check the "Either the 1st or 15th."**

FINANCIAL INSTITUTION NAME	
CITY	STATE
TRANSIT ROUTING NUMBER (From lower left corner of your check)	ACCOUNT NUMBER
This authority is to remain in full force and effect until Blue Cross and Blue Shield of Oklahoma has received written notification from me of its termination in such time and in such manner as to afford it a reasonable opportunity to act.	
NAME OF ACCOUNT HOLDER (Please Print)	DATE
SIGNATURE OF ACCOUNT HOLDER <b>X</b>	RELATIONSHIP TO APPLICANT

**13** I and any persons whose names appear on this application hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma and Member Service Life Insurance Company as indicated in this application.

I understand, certify, and agree to the items listed below:

- This is an application only, and I should not cancel any existing coverage unless I am notified in writing by Blue Cross and Blue Shield of Oklahoma of acceptance.
- I appoint the Board of Directors of Blue Cross and Blue Shield of Oklahoma my true and lawful attorney to represent me at any and all meetings of the members of Blue Cross and Blue Shield of Oklahoma and to vote in my name upon any matters arising at said meetings. However, I retain the right to attend and vote at any and all meetings of the members.
- Any insurance agent, examining physician, or other person who knowingly and willfully makes a false or fraudulent statement or representation in or relative to any application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.
- I understand that this coverage is not an employer group health plan and is not intended, in any way, to be an employer sponsored health insurance plan. Further, I certify that my employer will not contribute any part of the premium, nor will I be reimbursed for any part of the premium by my employer now, or in the future.
- I authorize any physician, practitioner, hospital or other institution to release and furnish to Blue Cross and Blue Shield of Oklahoma for its review and retention in connection with my application for coverage and health benefits coverage and future claims, any and all information, records, or copies of records relating to medical history and conditions, including, but not limited to, diagnosis, treatment, surgery, and the dates thereof.
- I understand that if my application is accepted, no benefits will be provided for any pre-existing condition or complication of a pre-existing condition for a period of twelve (12) months after my coverage becomes effective. This provision applies to any condition existing during the twelve (12) months immediately before the coverage effective date.
- I understand that maternity coverage must be in effect for 365 days prior to delivery before maternity benefits will be available.
- If my application is being handled through a producer, I understand that the producer is my agent for this coverage.
- This application when processed may result in denial, exclusion, or limitation of coverage.
- I have read all the statements on this application and represent that they are true and complete to the best of my knowledge and belief. I understand that any false or incomplete information can result in retroactive cancellation of membership and coverage for all persons covered under the membership, and I will be obligated to repay promptly any benefit payments to which persons covered under the membership were not entitled. Blue Cross and Blue Shield of Oklahoma may also recoup any monies paid as benefits prior to a determination by the Plan that any medical condition(s) or other information required to be reported was not correctly represented.
- This is an age-rated health plan. Rates are subject to change based upon age and other factors.

**NOTE:** PLEASE READ THE "APPLICATION AGREEMENT" SECTION ABOVE BEFORE SIGNING THIS APPLICATION.

APPLICANT'S SIGNATURE (IF AGE 15 OR OVER) <b>X</b>	TODAY'S DATE
PARENT OR LEGAL GUARDIAN (MUST SIGN IF APPLICANT IS UNDER 18) <b>X</b>	TODAY'S DATE
SPOUSE'S SIGNATURE (IF APPLYING FOR COVERAGE) <b>X</b>	TODAY'S DATE

**REMINDER: ARE ALL QUESTIONS ANSWERED? IS THIS DOCUMENT SIGNED AND DATED?**

**IF LEGAL GUARDIAN PLEASE ENCLOSE COURT DECREE.**

**PRODUCER INFORMATION (IF APPLICABLE)**

**PART I**

**THIS PART IS TO BE COMPLETED BY THE PRODUCER OR AGENT, IF ANY, WHO REPRESENTS THE APPLICANT.**

PRODUCER NAME				
ADDRESS (STREET)	(CITY)	(STATE)	(ZIP)	TELEPHONE
PRODUCER SIGNATURE <b>X</b>	<b>BLUE CROSS AND BLUE SHIELD PRODUCER NUMBER</b>		<b>STATE LICENSE NUMBER</b>	