



BlueCross BlueShield  
of Tennessee  
801 Pine Street  
Chattanooga, Tennessee  
37402-2555  
www.bcbst.com

**Personal Health Coverage**

**Application Instructions**

Use Only Blue or Black Ink. DO NOT Use  
Red Ink. Please Print Clearly.

Plan Use Only

Rec: \_\_\_\_\_

F

Instructions for completing your BlueCross BlueShield of Tennessee Personal Health Coverage Application:

Please print clearly in capital letters as shown below. DO NOT USE RED INK OR PENCIL.  
DO NOT MARK OUTSIDE THE BOXES.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	0	1	2	3	4	5	6	7	8	9
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Thank you for choosing BlueCross BlueShield of Tennessee.

In order to process your application as quickly as possible, it is necessary to read all of the following instructions and provide the information requested.

**\*\*If you do not reside in the state of Tennessee or do not legally reside in the United States, you are not eligible for this coverage. \*\***

*We will be unable to accept an application for coverage if the applicant or any dependent is pregnant.  
Future application can be made after pregnancy has ended.*

Section 1 Complete the information in this section regarding yourself, the benefits you are purchasing and method of payment desired. Please remember, do not put a PO Box for the Street Address; however a PO Box is acceptable for the Billing Address. Regarding payment information, if you do not want to pay your premiums by Automatic Bank Draft or Credit Card, do not mark any of those boxes.

**YOU WILL AUTOMATICALLY BE BILLED MONTHLY TO THE BILLING ADDRESS YOU LISTED.**

**Note: All dates must include the century (ex. 01012001).**

Section 2 Please complete the information in this section for each of your dependents, whether you are requesting coverage for them or not. For dependents other than spouse, tell us how you are related. If declining coverage for a specific dependent, please mark the "Declining Coverage" box and specify a reason for declining coverage. If you need to add more dependents than the form will allow, please attach a sheet of paper with the required dependent information.

**Please fully complete the Health Questionnaire. This applies to past and present BlueCross BlueShield of Tennessee subscribers. Ensure that every item is either marked "Yes" or "No" by carefully filling in the appropriate circles. Please sign and date this application. If this questionnaire is not filled out completely, we will be unable to continue the application process. Your spouse must also sign, if you are applying for dependent coverage.**

The agent information is to be filled out by your insurance agent or representative if you are utilizing an agent.

**HIPAA Rights**

If you or any member for whom you are applying has had at least 18 consecutive months of group, COBRA, federal government or church coverage AND it has been no more than 63 days since that coverage terminated, you may be eligible for waivers of our normal pre-existing condition waiting periods. These rights are made available to you under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. If you would like to exercise your HIPAA rights, please call our Individual Sales Department since we will require a different application be completed.

**Prior Coverage Effective and Termination Dates**

This coverage has a 12-month pre-existing condition waiting period. This means that no benefits would be available for any condition that existed during the 12-month period prior to the date your coverage goes into effect until you have had the coverage for 12 months. If you are changing coverage from another BlueCross BlueShield of Tennessee individual product, you may be eligible to reduce your pre-existing waiting period. Information about this can be obtained through your BlueCross BlueShield of Tennessee sales personnel or your insurance agent or representative.

**Premium Payments**

If you selected **Automatic Monthly Bank Draft**, provide the bank routing number and the checking/savings account number. The routing number can be found at the bottom left side of your checks.

If you selected **Credit Card Payments**, provide the credit card account number and expiration date. Please notice that we can only accept certain major credit cards. Refer to your sales literature or authorized agent for more information.

Thank you for taking the time to fill out your application completely.

*Our goal is to have ID cards to members within 21 days of receipt of the application and any required medical information. Due to peak enrollment periods, some ID cards may take a few days longer.*

A scanned, imaged or photocopied version of this completely executed application will have the same force and effect as the original document.



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# Personal Health Coverage Application

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## Section 1 - Primary Member Information

LAST NAME FIRST NAME MI

DATE OF BIRTH SOCIAL SECURITY NUMBER SEX

m m d d y y y y M F

STREET ADDRESS (PO BOX IS NOT ACCEPTABLE - PLEASE PROVIDE PLACE OF RESIDENCE)

CITY STATE ZIP CODE

T N

BILLING ADDRESS IF DIFFERENT FROM ABOVE (PO BOX IS ACCEPTABLE) CITY

STATE ZIP CODE DAYTIME PHONE NUMBER

( )

EMAIL ADDRESS

OPTION NUMBER OF BENEFIT PLAN YOU WISH TO PURCHASE: \_\_\_\_\_

REQUESTED EFFECTIVE DATE: m m d d y y y y

DO YOU WISH TO PURCHASE MATERNITY COVERAGE? YES NO

I WISH TO PAY MY PREMIUMS (YOU WILL BE BILLED MONTHLY VIA PAPER BILL UNLESS YOU CHECK A BOX BELOW):

AUTOMATIC MONTHLY BANK DRAFT  CREDIT CARD INITIAL PAYMENT ONLY  CREDIT CARD RECURRING PAYMENTS ONLY  CREDIT CARD INITIAL AND RECURRING PAYMENTS

NAME OF CARD: \_\_\_\_\_ CREDIT CARD EXPIRATION DATE: m m y y y y

CREDIT CARD NO.: \_\_\_\_\_

BANK DRAFT ROUTING NUMBER: \_\_\_\_\_ ACCOUNT HOLDER NAME: \_\_\_\_\_

CHECKING ACCOUNT NO.: \_\_\_\_\_

## Section 2 - Dependent Information (If you want family coverage, list all dependents, even if you are declining coverage for one or more dependents).

LEGAL SPOUSE LAST NAME SPOUSE FIRST NAME MI

SEX DATE OF BIRTH SOCIAL SECURITY NUMBER

M F m m d d y y y y

DECLINING COVERAGE IF DECLINING COVERAGE, SPECIFY REASON: \_\_\_\_\_

DEPENDENT LAST NAME DEPENDENT FIRST NAME MI

RELATIONSHIP

NATURAL CHILD OR STEPCHILD  LEGAL GUARDIANSHIP/ADOPTED  OTHER (SPECIFY): \_\_\_\_\_

SEX DATE OF BIRTH SOCIAL SECURITY NUMBER

M F m m d d y y y y

DECLINING COVERAGE IF DECLINING COVERAGE, SPECIFY REASON: \_\_\_\_\_

DEPENDENT LAST NAME DEPENDENT FIRST NAME MI

RELATIONSHIP

NATURAL CHILD OR STEPCHILD  LEGAL GUARDIANSHIP/ADOPTED  OTHER (SPECIFY): \_\_\_\_\_

SEX DATE OF BIRTH SOCIAL SECURITY NUMBER

M F m m d d y y y y

DECLINING COVERAGE IF DECLINING COVERAGE, SPECIFY REASON: \_\_\_\_\_

Please read and sign other side. Please remember to enclose first month's premium payment.

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# Personal Health Coverage Health Questionnaire

Use Only Blue or Black Ink. DO NOT Use Red Ink.  
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Plan Use Only

Rec: \_\_\_\_\_

EE

Primary Member Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Social Security Number \_\_\_\_\_

Your Height feet inches Your Weight pounds Spouse's Height feet inches Spouse's Weight pounds

When answering the following questions, consider the past and present health of you and your dependents (including children) to be covered by this contract. Please fill in the circle for either "Yes" or "No" to each question. If you mark "Yes" to a question, complete the additional information requested. Have you or anyone for whom you are applying ever had any of the conditions or illnesses listed below?

- Yes No 1. Diabetes 2. Crohn's Disease 3. Hepatitis C 4. AIDS/HIV+Infection/HTLV-3 or its Antibodies 5. Rheumatoid Arthritis 6. Systemic Lupus Erythematosus 7. Hemophilia 8. Ulcerative Colitis/Proctitis 9. Cirrhosis of the Liver 10. Alzheimer's 11. Renal Failure/Dialysis 12. Epilepsy 13. Multiple Sclerosis 14. Muscular Dystrophy 15. Parkinson's Disease 16. Cystic Fibrosis 17. Discussed Possible Transplant 18. Bipolar Disorder/Manic Depressive 19. Irritable Bowel Syndrome (IBS) 20. Chemotherapy/Radiation Therapy 21. Illegal Drug Use/Drug Abuse 22. High Blood Pressure/Hypertension 23. Sexually Transmitted Disease 24. History of pregnancy complications 25. Fibromyalgia 26. Diverticulosis/Polyps 27. Enlarged Lymph Nodes 28. Asthma/Allergies 29. Pneumonia/Chronic Bronchitis 30. Chronic Ear Infections 31. Acoustic Neuroma 32. Chronic Tonsillitis/Adenoiditis 33. Chronic Sinusitis/Deviated Septum 34. Cleft Lip/Palate 35. Overweight If "Yes," include height and weight in details below. 36. Chronic Prostatitis/Enlarged Prostate 37. Discoid (subcutaneous) Lupus, Drug Induced Lupus 38. Anyone currently pregnant (including those persons declining coverage)? 39. Anyone currently taking or prescribed medications or special immunizations of any kind? 40. Anyone taken or prescribed medications in the last 12 months but no longer taking? 41. Advised to have surgery, testing or special immunizations of any kind, not yet done? 42. Polycystic Kidney Disease 43. Breast Cancer 44. Lung Cancer 45. Liver Cancer 46. Colon Cancer 47. Heart Attack 48. Bypass Surgery 49. Alcoholism 50. Hodgkin's/Lymphoma 51. Anorexia/Bulimia 52. Melanoma 53. Leukemia 54. Angina 55. Angioplasty 56. Anemia 57. Skin Ulcer 58. Infertility 59. Endometriosis 60. Uterine Fibroids 61. Bleeding Ulcer 62. Hepatitis B 63. Migraines/Headaches 64. Seizures 65. Paralysis 66. Emphysema 67. Tuberculosis 68. Sleep Apnea 69. Glaucoma/Cataracts 70. Retinopathy 71. TMJ 72. Kidney Stones 73. Osteoarthritis 74. Spina Bifida 75. Counseling 76. ADD/ADHD 77. Bulging Disc/Herniated Disc 78. Pulled Back/Muscle/Back Strain 79. Abdominal/Inguinal Hernia 80. Pituitary Dwarfism/Growth Hormones 81. Knee Injury or Impairment 82. Organ Transplant 83. Bone Marrow Transplant 84. RSV or Immunizations for RSV 85. Used tobacco in the past year 86. Unexplained weight change in the last year 87. Physical exam with abnormal results 88. Had inpatient or outpatient surgery 89. Polycystic Ovarian Disease 90. Short or Long Term Disability 91. Congenital Lung Disease 92. Anxiety/Depression 93. Heart Murmur/MVP 94. Stroke/Aneurysm 95. Cerebral Palsy 96. Chronic Pancreatitis 97. Hiatal Hernia/Reflux 98. Other Immune System Disorder 99. Other Mental Health Disorder 100. Other Bone/Skeletal/Muscle Disorder 101. Other Urinary/Kidney Disorder 102. Other Eye/Ear/Nose/Throat Disorder 103. Other Lung or Respiratory Disorder 104. Other Heart or Circulatory Disorder 105. Other Intestinal/Endocrine Disorder 106. Other Reproductive System Disorder 107. Other Cancer 108. Other Brain/Nervous System Disorder 109. Other Condition/Disorder/Disease not listed above

Have you or any of your dependents ever been covered by BlueCross BlueShield of Tennessee? Yes No If "Yes," please list ID Number: \_\_\_\_\_

Do you or your dependents consume alcohol? Yes No If "Yes", what is the average daily consumption of alcohol for each person for whom coverage is being requested? \_\_\_\_\_

Question #	Family Member Name	Diagnosis, Treatment/Medication, Height & Weight, or Reason for Visit	Date of Onset	Last Treatment Date	Physician Name	Was Recovery Complete?

If medical records will be supplied separately, list the names of the corresponding physicians below: \_\_\_\_\_

List any physicians or practitioners seen within the last year by you or your dependents. (Please also list person's name and reason for each visit). \_\_\_\_\_

### Please Read Carefully and Sign Below

- If the Primary Member is a minor child, on signing this application, I hereby certify that I am the child's legal guardian.
- I hereby certify that I have read and understand the Declaration and Authorization page, on the back of this application.

Primary Member Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Today's Date m m d d y y y y

Spouse's Signature: \_\_\_\_\_ Date: m m d d y y y y

I certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Licensed Agent's Name: George Wing Agent's ID Number: 6798 Date: \_\_\_\_\_

Agent's Signature: \_\_\_\_\_ Arrangement Code: \_\_\_\_\_

A scanned, imaged or photocopied version of this completely executed application will have the same force and effect as the original document.

## **Declaration and Authorization**

### **It is understood and agreed as follows:**

1. I have read the statements and answers recorded on this application. They are true and complete and correctly recorded. They will become part of this Application and any policy(ies) issued on it.
2. I understand that BlueCross BlueShield of Tennessee is relying on the truthfulness and completion of the statements and answers on this Application in making the decision to issue any policies of insurance on health coverage.
3. No broker has authority to waive any of BlueCross BlueShield of Tennessee's rights or requirements, or to make or alter any contract or policy.
4. I certify that I am a resident of Tennessee and legally reside in the United States.
5. I understand that if my answers on this application are incorrect or untrue, BlueCross BlueShield of Tennessee may have the right to deny benefits or rescind my coverage.
6. This insurance coverage is not designed or marketed as employer-provided insurance. I certify that I understand that I am applying for personal health coverage.
7. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

### **Disclosure Authorization**

**I AUTHORIZE:** any doctor, hospital, clinic, provider of health care, insurance (or reinsuring) company, consumer reporting agency, my insurance agents, employers or any other person or firm having: (1) Information as to cause, treatment, diagnosis, prognosis or advice of my physical or mental condition; or (2) any other information needed to determine my eligibility for insurance; to give BlueCross BlueShield of Tennessee, its affiliates, its employees and agents, my broker, or any consumer reporting agency, all such information. This may include (but is not limited to): information about driving records, mental illness, and use of alcohol or drugs.

**I UNDERSTAND** the information obtained with this authorization will be used by BlueCross BlueShield of Tennessee to determine my eligibility for insurance. A photocopy of the authorization is valid. I or my authorized representative may request a copy of this authorization. This authorization will be in force for two years and six months from the date shown below.

**I UNDERSTAND** my signature on this application will authorize any doctor, hospital or other provider of treatment to furnish to BlueCross BlueShield of Tennessee, any and all medical records pertaining to any person who is to be covered by this contract, and I am responsible for any fee for these records.

**I UNDERSTAND** if I have selected Credit Card Payments or Automatic Bank Draft as my payment method, I am authorizing BlueCross BlueShield of Tennessee to draft/charge the checking or savings account or credit card account, for the purpose of paying the premiums due for this health coverage, regardless of whether such Contract is listed in name of the subscriber or the name of some other person, and confirm that I have received the Card Holder's expressed consent.

The premiums drafted/charged will be accurately reflected as those which are shown on the health insurance policy or the most recent premium change notifications issued to the health insurance policy holder (the subscriber) by BlueCross BlueShield of Tennessee. This authority is to remain in effect until revoked by you in writing; and until we actually receive such notice, we shall be fully protected in honoring any such draft/charge.



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# Prior Health Coverage Questionnaire for Personal Health Coverage

The coverage you have applied for through BlueCross BlueShield of Tennessee, Inc. has a 12-month pre-existing condition waiting period. This means that no benefits would be available for any condition that existed during the 12-month period prior to the date your coverage goes into effect until you have had the coverage for 12 months. However, the pre-existing condition waiting period for persons covered under the policy issued to you may be reduced to the extent they were partially or fully satisfied under a prior plan's medical insurance. To help determine how much, if any, of the waiting period you and your dependents must still satisfy under this coverage, please complete this form and submit it with your application for coverage.

To be accepted, this form and application for coverage must be received no more than 63 days after the date your previous coverage ended.

- 1. Are you or your dependents currently covered by a health coverage plan?  Yes  No

- 2. Have you or your dependents been covered by a health coverage plan at any time during the past 12 months?  Yes  No

**NOTE:**

Your application must be received by BlueCross BlueShield of Tennessee, Inc. within 63 days from the time your prior coverage ended to be eligible for a reduction in the pre-existing waiting period.

If "**NO**" on both of the above questions, **STOP HERE, sign and date this form on the back.**

If the answer to either question above is "**YES**", **complete the following information.** Attach a separate piece of paper if needed.

- Do you have a Certificate of Creditable Coverage issued to you by your prior health care carrier?  Yes  No

If "**YES**" to this question, **STOP HERE, sign and date this form on the back.** Attach the Certificate of Creditable Coverage to this form and submit it along with your application. If "**NO**", **complete the following information.**

Name of Insurance Company \_\_\_\_\_ Identification Number \_\_\_\_\_  
Street Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Type of Coverage:  Medical  Accident Only  
 Dental Only  Short Term Care  
 Vision Only  Medicare

Name of Insurance Company \_\_\_\_\_ Identification Number \_\_\_\_\_  
Street Address: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Type of Coverage:  Medical  Accident Only  
 Dental Only  Short Term Care  
 Vision Only  Medicare

***This form is not valid unless signed and dated on the back.  
It must be submitted with your application for coverage.***

**This insurance coverage is / was:**

- Group insurance provided by my employer
- Group insurance provided by my spouse's employer
- A personal coverage plan (**not** through an association)
- Medicare
- Medicaid / TennCare<sup>SM</sup>
- Through an association membership (specify name of association): \_\_\_\_\_  
\_\_\_\_\_
- Other (please explain): \_\_\_\_\_  
\_\_\_\_\_

**Information About Persons Insured Under Prior Health Coverage Plan:**

Name	Prior Insurance Effective Date	Prior Insurance Termination Date	Prior Insurance Policy Number	Reason for Termination
Applicant				
Spouse				
Dependent				
Dependent				
Dependent				

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

**I certify that I have truly and accurately recorded on this application the information supplied by the applicant.**

Agent's Name: \_\_\_\_\_  
(Please print clearly)

Agent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent's Identification Number: \_\_\_\_\_

**Arrangement Code:**

			-			-					-			
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