



**Regence**  
**ValueCare**

An Independent Licensee of the Blue Cross  
and Blue Shield Association

# APPLICATION FOR INDIVIDUALS AND FAMILY

Member Number \_\_\_\_\_

BAR \_\_\_\_\_

UMA \_\_\_\_\_

FBL \_\_\_\_\_

Other \_\_\_\_\_

**FOR OFFICE USE ONLY**

Group Number \_\_\_\_\_

Effective Date \_\_\_\_\_

**PAYMENT PLAN:**

SurePay

Coupon Book

Quarterly

P.O. Box 25956, Salt Lake City, Utah 84125-0956

Please follow instructions carefully. Inaccurate, incomplete, or illegible applications will be returned.

- MUST BE COMPLETED EXCLUSIVELY BY THE APPLICANT AND SIGNED AND DATED ON THE BACK PAGE.**
- Complete ALL items. Print in BLACK or BLUE ink.
- Enclose CHECK or MONEY ORDER based on payment option selected.

**COVERAGE APPLIED FOR**

<b>ValueCare Premier</b>  <input type="checkbox"/> Zero Deductible	<b>PLAN OPTIONS</b> <b>ValueCare Advantage</b> <input type="checkbox"/> \$250 Deductible <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1,000 Deductible	<b>ValueCare Classic</b> <input type="checkbox"/> \$250 Deductible <input type="checkbox"/> \$500 Deductible <input type="checkbox"/> \$1,000 Deductible	<b>STATUS</b> <input type="checkbox"/> Single (One Insured) <input type="checkbox"/> Two-Party (Two Insureds) <input type="checkbox"/> Family (Three or more Insureds)

**GENERAL INFORMATION**

COMPLETE THIS SECTION FOR APPLICANT AND SPOUSE (IF APPLICABLE)

APPLICANT			LAWFUL SPOUSE		
Last Name	First Name	Initial	Last Name	First Name	Initial
Mailing Address/Box No.			Mailing Address/Box No.		
City, State, ZIP			City, State, ZIP		
<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed		
Home Phone ( ) - ( )	Work Phone ( ) - ( )		Home Phone ( ) - ( )	Work Phone ( ) - ( )	
Occupation		Hours Per Week	Occupation		Hours Per Week
Employer's Name	Location (City, State)	# of Employees	Employer's Name	Location (City, State)	# of Employees
Name of employer's group health insurance company. (If none, write "none")			Name of employer's group health insurance company. (If none, write "none")		

**INDIVIDUAL AND FAMILY INFORMATION — REQUIRED FOR ALL APPLICANTS**

YOU MUST LIST THE FOLLOWING INFORMATION FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE

Family Members	Sex	Relationship To Applicant*	Birthdate Mo/Day/Yr	Height Ft - In	Weight Lbs.	Social Security Number	Name of Current Physician	P E C
Applicant	<input type="checkbox"/> M <input type="checkbox"/> F	Applicant	/ /	-		- -		
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	Spouse	/ /	-		- -		
Unmarried children (under 26 – eldest first)	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		

\* e.g., child, stepchild, adopted child, child under legal guardianship, etc.

**REQUIRED AND IMPORTANT INFORMATION. PLEASE ANSWER ALL QUESTIONS**

IF ANSWER REQUIRES EXPLANATION OR ADDITIONAL INFORMATION, PLEASE PROVIDE INFORMATION, COMMENTS AND EXPLANATIONS BELOW.

	YES	NO		YES	NO
1. Are you, your spouse, and all eligible children applying for coverage? If no, please explain below. ....	<input type="checkbox"/>	<input type="checkbox"/>	5. Have you or any listed Family Member been covered by any health insurance program within the past 62 days from the date of this application? If yes, please attach a "Certification of Coverage" form provided by your prior employer or insurer. ....	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you or any listed Family Member live, work, or attend school outside Utah? If yes, please explain below, including percent of time spent outside Utah. ....	<input type="checkbox"/>	<input type="checkbox"/>	6. Within the past 93 days, have you or any listed Family Member been covered, or declined to be covered under any health or medical insurance plan or arrangement? If yes, please explain below. ....	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you or all listed Family Members resided in Utah for at least the twelve consecutive months immediately preceding the date of this application? If no, please explain below. ....	<input type="checkbox"/>	<input type="checkbox"/>	7. Does your or any employer of a listed Family Member offer Regence BlueCross BlueShield of Utah, ValueCare, or HealthWise group health insurance coverage? If yes, please explain below why you are not enrolling the Family Members in that coverage. ....	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you or any listed Family Member covered or eligible for coverage under any of the following: (a) public health insurance including, but not limited to, Medicare, Medicaid or the Utah Comprehensive Health Insurance Pool (HIP); (b) private health insurance including, but not limited to, (i) Medicare Supplement, (ii) conversion coverage, (iii) continuation or extension under COBRA, or (iv) state extension; (c) an association; (d) individual/group health plan coverage? If yes, please include name of health carrier and policy number below. ....	<input type="checkbox"/>	<input type="checkbox"/>	8. Has any insurance company (including Regence BlueCross BlueShield of Utah) refused, up-rated or restricted any health coverage on you or any of the listed Family Members? If yes, please explain below. Please include insurance company's name, reason, and date. ....	<input type="checkbox"/>	<input type="checkbox"/>

Question #	First Name of Family Member	Relationship to Applicant	Additional Information, Comments and Explanations

**HEALTH STATEMENT – (EACH CONDITION MUST BE CHECKED "YES" OR "NO")**

If complete health information is not received, this application will be returned. Inaccurate health information may result in your policy being cancelled retroactively.

Have you or any listed Family Members EVER experienced problems with, been diagnosed with, or been treated for any of the following:	Yes	No		Yes	No		Yes	No	
			32. Asthma			70. Do you or does any listed Family Member have any medical problems, concerns or deformities not listed above?			
1. AIDS/HIV positive			33. Bladder/Urinary Disorder			71. Have you or has any listed Family Member experienced any condition for which future consultation, treatment or surgery is contemplated or advised?			
2. Amputation			34. Bone/Joint			72. Do you smoke now or have you smoked in the past? Does any listed Family Member smoke now or has smoked in the past? If "Yes," please specify who smoked, for how long, and when the individual quit smoking (if applicable).			
3. Arteries/Veins			35. Breast Disorder			73. Have you or has any listed Family Member received any treatments or tests within the last 12 months?			
4. Arthritis or Rheumatism			36. Dental/Jaw Problems			74. Have you or has any listed Family Member received any medications, drugs or injections within the last 12 months?			
5. Autism			37. Depression/Chemical Imbalance			75. Have you or has any listed Family Member consulted a physician in the last 12 months? Give date(s) and reason(s).			
6. Back Problems/Surgery			38. Digestive System			<b>COMPLETE THE FOLLOWING QUESTIONS FOR ALL IMMEDIATE FAMILY MEMBERS WHETHER OR NOT PROPOSED FOR INSURANCE.</b>			
7. Birth Defects			39. Drug Abuse/Addiction						
8. Blood Disease or Problems			40. Eyes, Ears, Nose, Throat			76. Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period?			
9. Bowel Disorder/Colitis			41. Female or Menstrual Problems			77. Are you, your spouse or any eligible child (whether or not proposed for insurance) currently pregnant?			
10. Cancer			42. Foot Problems			78. Is anyone currently pregnant with your child, or your spouse's child?			
11. Congenital Disorders/Defects			43. Fracture or Dislocation						
12. Diabetes			44. Gall Bladder/Gall Stones						
13. Endometriosis			45. Glandular/Hormone System						
14. Epilepsy, Seizure, or Convulsions			46. Gout						
15. Heart Disease or Problems			47. Headaches or Dizziness						
16. Liver Disorder/Cirrhosis			48. Hemorrhoids/Rectal Problems/Polyps						
17. Lung Disease/Tuberculosis			49. Hernia						
18. Lupus			50. High Blood Pressure						
19. Mental Retardation			51. Infertility						
20. Neurological Disease			52. Irritable Bowel Syndrome						
21. Paralysis			53. Kidney Disorder/Nephritis						
22. Polio (late effect)			54. Kidney Stones						
23. Spinal/Disc Disorder			55. Knee Problems						
24. Suicide (attempted)			56. Migraines						
25. Stroke/Brain			57. Mental Illness						
26. Tumor or Growth (include location)			58. Muscular/Nervous System						
Within the LAST FIVE YEARS have you or any listed Family Members experienced problems with, been diagnosed with, or been treated for any of the following:	Yes	No	59. Pain (intractable or uncontrollable)						
			60. Pregnancy (complications of)						
			61. Prostate Disorder/Male Organs/Impotence						
			62. Sexually Transmitted Disease						
			63. Sinus Disorder						
27. Abnormal Pap Test			64. Skin Disorder						
28. Abnormal PSA (Prostate Specific Antigen)			65. Stomach/Intestine Disorder						
29. Accidental Injuries			66. Surgical Operation(s)						
30. Alcoholism			67. Thyroid Disorder or Goiter						
31. Allergies/Hay Fever			68. Ulcers						
			69. Varicose Veins						

IF ANY OF THE ABOVE CONDITIONS OR QUESTIONS ARE CHECKED "YES," PLEASE EXPLAIN IN THE SPACES PROVIDED ON THE FOLLOWING PAGE.

(Attach additional pages if necessary)

**HEALTH STATEMENT (continued)**

IF YOU ANSWERED 'YES' TO ANY OF THE QUESTIONS OR CONDITIONS LISTED UNDER THE HEALTH STATEMENT SECTION ON THE PREVIOUS PAGE, PLEASE EXPLAIN OR PROVIDE THE REQUESTED INFORMATION IN THE SPACES PROVIDED BELOW.

ATTACH ADDITIONAL PAGES IF NECESSARY.

Question or Condition Number	Name of Family Member	Describe in detail each of the following that applies: (1) Name and nature of condition, (2) symptoms, (3) type of surgery, test, treatments, consultations, or medications (including dosages) received or contemplated, and (4) degree of recovery.	Was patient hospitalized	Name and Address of Attending Physician	Dates of Care Mo/Yr
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
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			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From To

**PAYING YOUR PREMIUMS**

CHOOSE ONE OF THE FOLLOWING THREE OPTIONS (Check appropriate box):

- Monthly SurePay** Payment is automatically withdrawn from your checking account each month. Please include a check for the first month's premium. **SIGN THE AUTHORIZATION FORM ENCLOSED AND ATTACH A "VOIDED" CHECK OR DEPOSIT SLIP.**
- Monthly Coupon Book** Payments are monthly and must include a \$5.00 monthly service charge. Submit a check or money order in the amount of the **FIRST MONTH'S PREMIUM PLUS THE \$5.00 MONTHLY COUPON BOOK SERVICE CHARGE** with your application. Make the check or money order payable to ValueCare.
- Quarterly Billing** Premiums are billed quarterly. Submit a check or money order for the **FIRST QUARTER'S PREMIUM WITH THIS APPLICATION.** Make the check or money order payable to ValueCare.

**CONDITIONS OF COVERAGE — PLEASE READ CAREFULLY**

In making application for membership in ValueCare:

1. I authorize any source to release to ValueCare any medical or health records pertaining to any Family Member for whom this application is submitted. A photographic copy of this authorization shall be as valid as the original.
2. I understand and agree that ValueCare may: (a) require me to provide evidence of insurability at my own expense, (b) accept this application, but exclude certain Family Members, (c) deny coverage and refund any payments submitted. I understand ValueCare will retain as the exclusive property of ValueCare this and all other documents submitted by me.
3. I understand and agree that receipt of this application and/or my initial premium by an agent, employee or representative of ValueCare in no way binds ValueCare to cover any Family Members until and unless I receive written notice assigning the date coverage will start.
4. I understand and agree that if I am accepted for coverage, I will receive a Health Care Agreement which I will have ten days to review before acceptance. If the Health Care Agreement is not acceptable to me for any reason, I may return it to ValueCare within the ten-day period and will receive a full refund of premiums paid.
5. I understand and agree that no agent or representative of ValueCare can alter the terms and conditions of the Health Care Agreement, unless such changes are approved in writing by an officer of ValueCare.
6. I understand and agree that this coverage will not pay for expenses falling within the minimum legal requirement for no-fault automobile insurance.
7. I understand that certain procedures/conditions are excluded from coverage for twelve months, and that pre-existing conditions are covered only after twelve months of continuous coverage. Credit may, however, be given toward these waiting periods for certain prior coverage(s).
8. I certify that all Family Members for whom this application is submitted are current Utah residents and are expected to reside continuously in Utah as long as coverage is in effect.
9. I understand and agree that coverage, if issued, **will not terminate due to health reasons**, but will automatically terminate for any covered Family Member who ceases to be a resident of Utah, or fails to pay premiums when due.
10. I understand and agree that ValueCare is not an insurance company but has instituted a provider network and has the administrative capacity to perform the functions of a Preferred Provider plan as are more particularly described in the Health Care Agreement; the coverage for which this application is submitted is insured by Regence BlueCross BlueShield of Utah, an independent licensee of the Blue Cross and Blue Shield Association.
11. I understand that coverage, if issued, is issued on the basis of information contained in this application. **If any information provided is untrue or incomplete, or if information called for is omitted, ValueCare may, without advance notice and at ValueCare's option, cancel the coverage, exclude the relevant Family Member, or declare the contract null and void.**
12. I understand and agree that this insurance is not available if any of the following conditions exist: (a) any portion of the premium is paid by an employer, (b) any portion of the premium is reimbursed by an employer, or (c) the employer's involvement with the plan brings it within the definition of a group plan in state or federal law.
13. I certify that this is not an employer-sponsored plan and neither my employer nor I will treat or represent the premiums as part of an employer-sponsored health insurance program under state or federal law.  
**I agree to notify ValueCare immediately if an employer begins contributing in any way to the premium or treats this as an employer-sponsored plan. I further understand and agree that this individual insurance policy may be terminated retroactively to the date of employer involvement under such circumstances.**
14. I understand that binding arbitration is available as the final step for the resolution of any dispute arising under or out of the Health Care Agreement. Arbitration shall be conducted pursuant to the rules of the American Arbitration Association, a copy of which is available upon request from ValueCare or the American Arbitration Association.
15. **I, THE APPLICANT, CERTIFY THAT I COMPLETED THIS APPLICATION IN ITS ENTIRETY.**

Date \_\_\_\_\_ Signature of **APPLICANT** \_\_\_\_\_

**NOTE: Careful consideration should be given before any existing health coverage is cancelled since your acceptance is not guaranteed and this program has a waiting period for pre-existing conditions.**

**AGENCY AGREEMENT**

(This section to be completed by Insurance Agent when applicable.)

**In order to receive proper credit for business written and to receive policy communications, please complete all applicable areas.)**

Agent/Agency Name _____	RBCBSU Appointment No. _____ Utah Lic. No. _____
Social Security Number (if Agent) _____	Tax I.D. Number (if Agency) _____
Print Name of Agent _____	Business Address _____
Signature of Agent _____	City, State, ZIP _____
Date of Signature _____	Telephone Number _____
	FBL Agent No. (if applicable) _____

- I understand and agree that in acting as agent for this applicant:
- a. **Application must be completed by the Applicant.**
  - b. I am in possession of a valid license issued by the State of Utah authorizing me to sell and service life insurance and health care service contracts.
  - c. I have no authority to: (1) make, alter, interpret, or discharge a contract in the name of VALUECARE, or (2) waive any of the terms or conditions of the contract.
  - d. I have no authority to assign effective dates or to effect membership changes.
  - e. Cancellation of this Health Care Agreement by either the subscriber or ValueCare will terminate this Agency Agreement.

**THIS SECTION IS TO BE COMPLETED BY VALUECARE**

Subscriber Name _____	Contract No. _____
Effective Date _____	Group No. _____
Agent No. _____	