

# **Blue Cross Blue Shield of Delaware** **BlueAdvantage Individual Application Checklist**

Thank you for your interest in Blue Cross Blue Shield of Delaware's BlueAdvantage Individual insurance plans. To apply for coverage, please follow the instructions below.

1. Print the following application form.
2. Please complete all fields of this form in black or blue ink.
3. In Section I. of the application labeled "Applicant Information," please indicate the date that you would like the coverage to begin under the question "If you are approved, please provide the date you would like your coverage to begin." Please note that coverage can begin on the first or the fifteenth of a month provided that all paperwork is received fifteen days early (for example, to obtain a first of a month start date, paperwork must be received prior to the fifteenth of the prior month). Additionally, coverage is dependent upon health underwriting.
4. Please be certain to sign the application.
5. If you are selecting the Health Savings Account with Bancorp Bank, please complete and sign the "MyAdvantageHSA™ Health Savings Account Addendum" and "Authorization for Release of Information." Please note that these 3 pages are only necessary if you are opening the Health Savings Account.
6. Once complete, please mail this application along with a voided check and completed Easy Pay form authorizing Blue Cross to draft your first and future month's premium payments to the following address (if you do not want Blue Cross to draft premiums from your bank account, please select quarterly billing. Blue Cross will not mail a monthly bill. Additionally, please mail a check payable to Blue Cross along with your application for your first premium payment if you are paying quarterly):

Health Insurance Associates  
260 Chapman Road, Suite 107  
Newark, DE 19702  
Attention: Nick

If you have any questions regarding the plans or the application process, please don't hesitate to contact us at 1-800-725-8862.



**Instructions:**

- Complete this form and send to the address above.
- Form must be signed. An updated application will be required if the entire application process is not completed within 90 days of the date you signed this form.
- Incomplete applications will be returned. If additional information is needed from a physician, please allow four to six weeks to complete the process.
- Use a separate sheet of paper if more space is needed.
- To add a dependent, complete entire application. To cancel a dependent or change coverage level — complete applicable sections on page 1.
- If you select monthly billing, please complete and return an *EasyPay Authorization* form. If you select quarterly billing, please submit payment with application.

**Important Information:** Please read carefully.

- **Do not cancel your current health care coverage until you have been informed of your approval.**
- Coverage is not guaranteed. Some or all persons on this application may be denied.
- The oldest applicant accepted will be the contract holder.
- **Please Note:** Benefits include a 12-month preexisting waiting period. If you have prior BCBS coverage (with no lapse), please submit your Certificate of Coverage to reduce this waiting period (with this application or send to the address above.)

**Eligibility. To apply for coverage you must be:**

- A Delaware resident between the ages of 18 to 64,
- Not enrolled in or eligible for Blue Cross Blue Shield of Delaware (BCBSD) group coverage,
- Not enrolled in or eligible for Medicare, and
- If a non-citizen resident of the US, must have resided in the US for six consecutive months

**I. APPLICANT INFORMATION.** List all persons applying for coverage.

Last Name	First Name	M.I.	Date of Birth	Relationship	Social Security Number	Height	Weight
				Self: <input type="checkbox"/> Male <input type="checkbox"/> Female			
				<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
				<input type="checkbox"/> Son <input type="checkbox"/> Daughter			

Mailing Address \_\_\_\_\_  
(Number) (Street) (City) (State) (Zip Code)

Home Phone ( ) \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_ Are you married? Yes  No

May we contact you by email? If yes, email address: \_\_\_\_\_

Are you now enrolled in or eligible for BCBSD Group coverage through any current or previous employer (including your spouse's)? Yes  No

If yes, please explain: \_\_\_\_\_

Employment information **must** be completed for you **and** your spouse even if spouse is not applying for coverage.

Applicant's Employer \_\_\_\_\_ Self-Employed? Yes  No  Occupation \_\_\_\_\_ Full-time  Part-time

Spouse's Employer \_\_\_\_\_ Self-Employed? Yes  No  Occupation \_\_\_\_\_ Full-time  Part-time

If you are approved, please provide the date you would like your coverage to begin: \_\_\_\_\_ 1<sup>st</sup> or \_\_\_\_\_ 15<sup>th</sup>

I am only interested in coverage if all persons on this application are approved. \_\_\_Yes \_\_\_No

**II. COVERAGE LEVEL.** Check one option. Information shows single/family deductible amounts, and the level of coverage once the deductible is met.

**BlueAdvantage Individual PPO Options:**

- \$1,800 / \$3,600 Deductible / 100% / 80% Coinsurance
- \$2,700 / \$5,400 Deductible / 100% / 80% Coinsurance

**Maternity Option?**  Yes  No *(There is an additional cost for this option, and benefits are subject to a twelve-month waiting period.)*

**Choose Billing Cycle:**  Monthly (EasyPay Authorization Form only)  Quarterly (Direct Billing - January, April, July, October)

**Please Note:** Benefits include a 12-month preexisting waiting period. If you have prior BCBS coverage (with no lapse), please submit your Certificate of Coverage to reduce this waiting period. We do not credit coverage from other health benefits companies.

### III. INSURANCE INFORMATION Check answer that best applies.

1.  I have no health insurance coverage now and am applying for new coverage.
- I am an existing BCBSD Individual customer and want to change my coverage.  add a dependent  cancel a dependent  
 change coverage level
- I am currently enrolled with BCBSD through a group or association. ID Number: \_\_\_\_\_
- I am currently enrolled with another carrier. Name of carrier: \_\_\_\_\_
- I am currently enrolled with another Blue Cross and Blue Shield plan. Name of plan: \_\_\_\_\_ ID Number: \_\_\_\_\_

My current health care coverage will end on \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_. If approved, will this policy replace current coverage?  Yes  No

2. Is anyone listed on this application eligible for Medicare?  Yes  No. If yes, please provide the following:  
 Name of family member(s): \_\_\_\_\_
3. Please list below anyone on this application who:
- has **not** had any health insurance for the past 12 months: \_\_\_\_\_
  - previously applied for health insurance in the past three years and was denied for medical reasons: \_\_\_\_\_

### IV. HEALTH STATEMENT

Because this coverage is medically underwritten, we need your complete and accurate answers to all of the following health questions. BCBSD has a duty to report insurance fraud to the Fraud Bureau of the Delaware Department of Insurance. For each family member applying, list all of the information below for the last visit with his/her physician.

Applicant Name	Date of Visit	Symptom or Condition	Results of Visit – Provide Details	Complete Physician Name and Address

Has any person included on this application had any known indication, diagnosis or treatment **within the last seven years** of any of the conditions listed below? **Please check “Yes” or “No”** for each question. If “Yes,” **circle the appropriate condition**. Answering yes will not necessarily result in rejection of your application.

	Yes	No	Relevant Person Applying:
1. Any cancer, cysts, tumors or unusual growths? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Any metabolic or endocrine conditions/disorders (examples: diabetes, adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, chronic fatigue syndrome, AIDS or any immune disorder)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Any alcohol, drug or substance abuse or dependency, or been advised to reduce alcohol or drug intake? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Any disorder of the circulatory system or heart (examples: aneurysm, chest pain, elevated cholesterol level, heart attack, heart murmur, high blood pressure, irregular heart beat, phlebitis, rheumatic fever, stroke or varicose veins)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Any emotional or psychological disorders (examples: adjustment disorder, anxiety, attention deficit disorder, depression, obsessive-compulsive disorder, schizophrenia or attempted suicide)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Any disorder of the lungs or respiratory system (examples: allergy, asthma, chronic obstructive pulmonary disease, emphysema or tuberculosis)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Any disorder of the kidney or urinary system (examples: cystitis, renal failure, kidney stones, nephritis, prostatitis or recurring bladder infections)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Any disorder of the brain or nervous system (examples: epilepsy, seizures, head trauma, migraines, multiple sclerosis or paralysis)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Any disorder of the digestive system (examples: cirrhosis, chronic constipation, colitis, esophagitis, gall bladder/stones, hemorrhoids, chronic acid reflux, hepatitis or ulcer)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Any disorder of the muscles or skeletal system (examples: arthritis, bursitis, carpal tunnel syndrome, gout, back or spine trouble, external deformity, osteomyelitis, osteoporosis, rheumatism, or scoliosis)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Any disorder of the skin (examples: collagen disorder, eczema or psoriasis)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Any disorder of the blood (examples: anemia, hemophilia, leukemia or sickle cell)? .....	<input type="checkbox"/>	<input type="checkbox"/>	_____

**ALL QUESTIONS MUST BE CHECKED "YES" OR "NO."**

Yes

No

Relevant Person Applying:

13. Any breast or gynecological disorders?  
(examples: endometriosis, infertility, irregular menstruation, or breast condition) .....  Yes  No \_\_\_\_\_
14. Any venereal disease (examples: gonorrhea, herpes or syphilis)? .....  Yes  No \_\_\_\_\_
15. Any disorders of the eye, ear, nose or throat (examples: allergy, deafness or cataracts)? .....  Yes  No \_\_\_\_\_
16. Any of the following conditions or procedures: Alzheimer's disease, cystic fibrosis, Hodgkin's disease, muscular dystrophy, myasthenia gravis, palsy, Parkinson's disease or polio? .....  Yes  No \_\_\_\_\_
17. Any congenital conditions? .....  Yes  No \_\_\_\_\_
18. Any premature births, caesarean deliveries or miscarriages? .....  Yes  No \_\_\_\_\_
19. Is any person named on this application currently pregnant, expecting a baby or in the process of adoption or surrogacy? .....  Yes  No \_\_\_\_\_  
Expected delivery or adoption date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
20. Any motor vehicle accident involvement in the last three years? .....  Yes  No \_\_\_\_\_
21. Is any applicant an organ transplant recipient or currently on a transplant waiting list? .....  Yes  No \_\_\_\_\_
22. Any abnormal test or physical exam results or is any applicant currently awaiting test results? .....  Yes  No \_\_\_\_\_
23. Any advice by a physician to undergo additional testing or treatment that has not yet been sought? .....  Yes  No \_\_\_\_\_
24. Any scheduled surgery or hospital admission within the next six months? .....  Yes  No \_\_\_\_\_  
Please list the condition : \_\_\_\_\_  
Date of scheduled service : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Attending physician : \_\_\_\_\_
25. Any tobacco use (smoked, snuffed or chewed tobacco) at any time during the past 24 months?  
(Please name each applicant who has.) .....  Yes  No \_\_\_\_\_
26. Any health issue not previously mentioned on this application for which advice, diagnosis, care or treatment (including medical, surgical, hospital, emergency or urgent care) was sought? .....  Yes  No \_\_\_\_\_
27. Any health issue not previously mentioned on this application for which advice, diagnosis, care or treatment was **not** sought? .....  Yes  No \_\_\_\_\_

- If you have checked "yes" to any of the questions above, enter details below. (If more space is required, use a separate sheet of paper.)
- All questions must be checked "yes" or "no," or your application will be returned.
- Failure to disclose conditions may result in voiding of coverage and denial of benefits.

Name of Family Member Applying	Ques. No.	Illness or Condition	Last Treatment	Operation?	Complete Name and Address of Attending Physician
			Month / Year	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			Month / Year	<input type="checkbox"/> Yes <input type="checkbox"/> No	
			Month / Year	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Has anyone included in this application been prescribed medications in the last 12 months?  No  Yes If yes, please provide the following information:

Name of Family Member Applying	Drug and Daily Dosage	Illness or Condition

## V. TERMS OF AGREEMENT

I hereby apply on behalf of myself, my spouse and my dependent children (if listed on this application) for a Blue Cross Blue Shield of Delaware (BCBSD) health insurance contract.

### I UNDERSTAND AND AGREE TO THE FOLLOWING:

- I have the authority to act for myself, my spouse and all of my dependent children; including those who have reached the age of 18.
- The contract will be effective only for those applicants approved by BCBSD.
- If BCBSD accepts this application, I will receive a copy of the contract and an identification card. The contract will state plan benefits for insureds and define the conditions under which the benefits will be available. If I am a new member, the carrier holding my ID card will specify the effective date of my coverage.
- BCBSD has a 12-month waiting period before preexisting conditions will be covered under this contract. BCBSD will apply this waiting period to any physical or mental condition of a covered person (a) for which medical advice, diagnosis, care or treatment was received within the 12 months prior to this contract being effective, or (b) that manifested symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis or treatment within the 12 months prior to this contract being effective.
- The contract, application and any attached amendments shall constitute the entire agreement and shall supersede any previous agreements.
- I will pay the premiums to BCBSD when due.
- In the event there is an error made in any payment of benefits, I agree to refund to BCBSD the amount of any overpayment of benefits to which I am not entitled.
- I will notify BCBSD in writing if there have been any changes to the health of any person listed on this application, that occur prior to acceptance of this application by BCBSD.
- All statements made on this application are complete, true, and correctly stated to the best of my knowledge. I intend for BCBSD to rely on these representations in deciding to issue the contract, and for them to be part of this contract.
- Failure to enter accurate and complete medical information in writing, as well as failure to update that information prior to the acceptance of the application by BCBSD, may be a material or fraudulent misrepresentation. If so, BCBSD may void or cancel your contract, deny benefits for the affected individual or condition, and report fraud to the Delaware Department of Insurance.
- If BCBSD accepts this application, I accept complete and sole responsibility, and BCBSD has no responsibility, for payment of any tax obligations I may incur should any individuals I cover under a BCBSD health insurance contract not meet the definition of spouse or dependent child under the Internal Revenue Code and IRS published rulings. Such tax obligations include, but are not limited to, federal, state and local income tax obligations, and any interest and penalties that may result from such tax obligations.
- If BCBSD accepts this application, the BCBSD health insurance policy that will be issued to me is intended to qualify as a high-deductible health plan (HDHP) under Section 223 of the Internal Revenue Code and IRS published rulings. I should obtain professional legal advice before I establish or contribute to a Health Savings Account (HSA) now and in the future.

I have carefully read this application and agree to the terms and conditions specified. All applicants have signed below, except for dependent children under the age of 18.

\_\_\_\_\_  
Signature (DO NOT PRINT)

\_\_\_\_\_  
Printed Name

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse or Child Age 18 or Older (DO NOT PRINT)

\_\_\_\_\_  
Printed Name of Spouse or Child Age 18 or Older

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Child Age 18 or Older (DO NOT PRINT)

\_\_\_\_\_  
Printed Name of Child Age 18 or Older

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

## VI. AUTHORIZATION TO PROVIDE HEALTH INFORMATION TO BROKER

If you are submitting this application through a broker, complete this section to indicate if you authorize BCBSD to discuss this application, including related health information, with that broker. PLEASE NOTE: This authorization applies to all applicants signing below.

\_\_\_\_ Yes, I do want BCBSD to discuss this application with my broker. Please write your broker's name in the blank below.

\_\_\_\_ No, I do not want BCBSD to discuss this application with my broker.

I authorize BCBSD, Inc. to release my Protected Health Information (PHI) to \_\_\_\_\_ (name of your broker) for any and all purposes related to this application for coverage, including discussion of BCBSD's decision to accept or reject the application. My signature below authorizes the disclosure of all PHI in BCBSD's possession, specifically including the following: HIV/AIDS, Substance Abuse, Behavioral Health and Genetic Testing. I understand that I may revoke this authorization at any time by notifying BCBSD in writing. My revocation will not affect any action that BCBSD took before receiving my notice. I understand that if the person I have authorized to receive my PHI is not subject to federal health information privacy laws, the information will no longer be protected by those laws and may be re-disclosed. I understand that giving this authorization is not a condition of eligibility for benefits, enrollment in a health plan or payment of claims.

BCBSD USE ONLY	Sub-Group No.:	Package No.:	Contract Type:	Effective Date:
AGENT/GENERAL USE ONLY	Agent Name: Atlantic States United Brokerage, Inc.	Agent No.: 241	Broker/Producer Name: Nicholas Moriello	Broker/Producer No.: 5339
BROKER/PRODUCER USE ONLY	1) Did you review the completed application with the applicant(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, please explain:	2) Are you aware of any undisclosed or misrepresented information on this application that would have an impact on BCBSD's decision to approve or deny the applicant(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please explain:

\_\_\_\_\_  
Signature of Broker (DO NOT PRINT)

\_\_\_\_\_  
Printed Name of Broker

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

## AUTHORIZATION

I authorize any medical professional, hospital, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, health plan, or other medical or medically-related facility, governmental agency or other person or firm, to disclose to Blue Cross Blue Shield of Delaware or BCBSD's authorized representative, information (including copies of records) concerning advice, care or treatment provided to me and/or my dependents. That information may include, without limitation, information relating to HIV/AIDS, mental health, or abuse of drugs or alcohol. In addition, I authorize BCBSD to use its own records for information.

I understand that such information will be used by BCBSD to evaluate my application for health coverage, to decide whether or not to offer me coverage, and to determine whether I am eligible for benefits. Further, I understand that my authorization is required for BCBSD to consider my application and to determine my eligibility for benefits. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by BCBSD as permitted or required by law and that upon such re-disclosure, it may no longer be protected by federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid for two years from the date signed unless (a) revoked by me in writing, which I may do at any time, or (b) BCBSD declines this application. Any revocation will not affect the activities of BCBSD prior to the date such revocation is received by BCBSD.

**IMPORTANT:** This authorization 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.

All applicants have signed below, except for dependent children under the age of 18 on whose behalf I have the authority to act.

I understand and agree to the above.

_____ Signature (do not print)	_____ Printed Name	_____ Date
_____ Signature of Spouse or Child Age 18 or Older (do not print)	_____ Printed Name	_____ Date
_____ Signature of Child Age 18 or Older (do not print)	_____ Printed Name	_____ Date



# Authorization Agreement for EasyPay Automatic Withdrawals

By signing below, I deem all information to be true solely with respect to withdraws of my individual health insurance premium. I authorize Blue Cross Blue Shield of Delaware and the financial institution designated below to initiate automatic deductions by direct debit from my bank account for payment of my health insurance premiums. I understand the automatic withdrawal of the amount billed will be debited (withdrawn) on the billing due date I have selected.

INVALID/RETURNED DIRECT DEPOSIT TRANSMISSIONS: I understand and agree to pay \$20.00 for any invalid or returned deposit transmissions due to incorrect bank information supplied by me or if my payment is returned due to insufficient funds.

Subscriber Name: \_\_\_\_\_ Joint Account Name (if applicable): \_\_\_\_\_

Subscriber Identification Number: \_\_\_\_\_

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

Bank Address: \_\_\_\_\_

Bank Transit/ABA Routing Nine-Digit Number (numbers only, no symbols)\*: \_\_\_\_\_

Account Number: \_\_\_\_\_

Type of Account: (checking, savings, money market, etc): \_\_\_\_\_

Monthly Withdraw Date (circle one): 27<sup>th</sup> of the previous month, 3<sup>rd</sup> or 5<sup>th</sup> \_\_\_\_\_

Frequency of Current Payments (circle one): annually, semi-annually, quarterly or monthly \_\_\_\_\_

**\*The first nine digits in the lower left-hand corner of a check represent your Bank Transit/ABA Routing Number.**

Subscriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Joint Account Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please attach a copy of a voided check — not your deposit slip — for verification purposes. (See check facsimile below.)

If at anytime you wish to be removed from the *EasyPay* system, you must notify us in writing at the address below.

Should you have any questions regarding your *EasyPay* process, please feel free to contact us:

**By email: [premiumbilling@bcbsde.com](mailto:premiumbilling@bcbsde.com)  
By phone: 302.421.3209 or 800.548.1050**

Your Name	1234
000 Any Street	Date: _____
Any City, USA 00000	\$ _____
Pay to the order of _____	_____ Dollars
Memo _____	_____
: 246824682 :1 088394827 1234	



## ADDENDUM

### MyAdvantageHSA™ Health Savings Account (HSA)

#### I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. If Blue Cross Blue Shield of Delaware (BCBSD) accepts this application, the BCBSD health insurance policy that will be issued to me is intended to qualify as a high deductible health plan (*HDHP*) under Section 223 of the Internal Revenue Code and IRS published rulings.
2. I should obtain professional legal or tax advice before I establish or contribute to a Health Savings Account (*HSA*) now and in the future. Eligibility for an HSA is based on the application of federal tax rules to each individual, and the determination of eligible individual status is made on a monthly basis. Also, federal, state, and local tax rules change from time to time. Generally, an individual is eligible to establish and contribute to an HSA for any month if
  - (a) he/she is covered by a high deductible health plan as of the first day of such month and is not covered by any other health plan not permitted by the HSA rules, (*see section 3. below*) or by the application of state coordination of benefits rules,
  - (b) he/she is not enrolled in Medicare, and
  - (c) he/she cannot be claimed as a dependent on someone else's tax return.
3. In accordance with section 2.(a) above, even if I am covered under a qualifying HDHP, I am not eligible to establish or contribute to an HSA if I am also:
  - (a) covered by another health plan (*including an HDHP*), where the application of state coordination of benefits rules would result in payment of benefits under the other health plan (*second plan*) that would satisfy all or part of the deductible under the BCBSD health insurance policy that will be issued to me (*first plan*); or
  - (b) covered by another health plan that is not an HDHP, whether as an individual, spouse, or dependent, unless such health plan is for permitted coverage or permitted insurance (*see section 4. below*), or unless such coverage is under an employee assistance, a disease management, or a wellness program, if the program does not provide significant medical care or treatment; or
  - (c) covered by my spouse's employer's health plan, where my spouse has family coverage or where my spouse participates in a general purpose health flexible spending account (*Health FSA*) that reimburses health care expenses of spouses and dependents; or
  - (d) eligible to receive medical benefits through the Department of Veterans Affairs (*VA*) and I actually received medical benefits from the VA at any time during the previous three (3) months; or
  - (e) covered under TRICARE, the health care program for active duty and retired members of the uniformed services, their families and survivors.
4. In accordance with section 3.(b) above:
  - (a) **permitted coverage** includes coverage under another plan (*whether through insurance or otherwise*) for accidents, disability, dental care, vision care, or long-term care; and
  - (b) **permitted insurance** includes coverage under an insurance policy if substantially all of the coverage relates to liabilities under workers' compensation laws, tort liabilities relating to ownership or use of property (*for example, automobile insurance*), insurance for a specified disease or illness, or insurance that pays a fixed amount per day (*or other period*) of hospitalization.
5. If I am also covered by a post-deductible health reimbursement arrangement (*HRA*) through my employer or my spouse's employer, with a deductible that satisfies the minimum annual deductible requirement for an HDHP, my annual HSA contribution is limited to the lower of the two deductibles.
6. If I have or my spouse has family coverage, or if both of us have family coverage, the HSA contribution limit is calculated as though we both have family coverage. If each of us has family coverage under a separate health plan, we both are treated as covered under the plan with the lowest deductible. The contribution limit for both of us is the lowest deductible amount, divided equally between us unless we agree on a different division.
7. I accept complete and sole responsibility, and BCBSD has no responsibility for payment of any tax obligations I may incur should I pay or reimburse any medical expenses from my HSA that:
  - (a) do not qualify as medical expenses under the Internal Revenue Code and IRS published rulings; or
  - (b) are for any individuals who do not meet the definition of spouse or dependent under the Internal Revenue Code and IRS published rulings. Such tax obligations include, but are not limited to, federal, state and local income tax obligations, and any interest and penalties that may result from such tax obligations.
8. I accept complete and sole responsibility for the terms and conditions of the following:

(over)



### BCBSD DISCLOSURES STATEMENTS

Blue Cross Blue Shield of Delaware receives no commissions or other financial incentives from **The Bancorp Bank** to encourage enrollment in HSAs offered by **The Bancorp Bank**. Blue Cross Blue Shield of Delaware does not guarantee the performance or solvency of **The Bancorp Bank**, or the availability of HSA funds on deposit with **The Bancorp Bank**. In the event that Blue Cross Blue Shield of Delaware, acting as an agent for an employer, transfers HSA contributions in the form of payroll deductions or otherwise from such employer to **The Bancorp Bank**, Blue Cross Blue Shield of Delaware shall not be obligated to pay interest on such contributions held during the transfer process. Neither contributions made to an HSA, nor HSA account balances constitute, or may be deemed to constitute, the assets of any ERISA plan or other benefit plan. Blue Cross Blue Shield of Delaware is not, and shall not be deemed to be, the fiduciary, custodian, or trustee of any HSA, or of any funds held or transferred in connection with an HSA. Each HSA offered by **The Bancorp Bank** is the responsibility of **The Bancorp Bank** and the respective account holder; all funds on deposit with **The Bancorp Bank** are liabilities solely of **The Bancorp Bank**. In the event that **The Bancorp Bank** offers HSA account holders, directly or indirectly through third party brokerage or mutual fund companies, the option of investing any portion of HSA balances in securities, account holders should carefully consider the risks associated with any such investment. Blue Cross Blue Shield of Delaware is not responsible for the selection of any brokerage or mutual fund company for such investment purpose, the appropriateness of any investment that may be available to account holders, or the performance of any such investment.

BCBSD and its employees are not securities brokers or dealers, and are not authorized to sell any securities to you, accept investment instructions from you, or provide investment advice to you in connection with any HSA account balances. BCBSD has not authorized licensed insurance producers (*agents and brokers*), to perform any such investment function or service in connection with HSA account balances, even if those producers are otherwise licensed to sell securities. Neither BCBSD nor its employees will receive commissions or any other forms of compensation based on securities transactions in connection with any investment of HSA account balances. BCBSD has not authorized the payment of any such form of investment related compensation to licensed insurance producers.

Blue Cross Blue Shield of Delaware is a health service corporation and is an independent licensee of the Blue Cross and Blue Shield Association. **The Bancorp Bank** (*Nasdaq NM:TBBK*) is an independent bank providing HSA custodian and trustee services and is a member of the FDIC.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant (*do not print*)

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse (*do not print*)

\_\_\_\_\_  
Printed Name of Spouse

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Child 18 or Older (*do not print*)

\_\_\_\_\_  
Printed Name of Child 18 or Older

Blue Cross Blue Shield of Delaware is an independent licensee of the Blue Cross and Blue Shield Association.

™ Blue Cross Blue Shield of Delaware has applied for registration of the trademark with the U.S. Trademark Office.



MyAdvantageHSA™
Authorization for Release of Information
for a Health Savings Account with The Bancorp Bank

Form with fields: Individual's Name, Date of Birth (mm/dd/yy), Social Security Number, Driver's License Number and State Issued, Address, Apt./Box #, City, State, Zip Code, Daytime Phone, Home Phone, E-mail

Authorization for Release of Protected Health Information to Establish and Maintain a Health Savings Account with The Bancorp Bank

I authorize Blue Cross Blue Shield of Delaware (BCBSD) to provide to The Bancorp Bank (Bancorp) any and all identifying information necessary for Bancorp to open a Health Savings Account (HSA) in my name, including but not limited to my Social Security number, address, phone number and date of birth. This information may be provided in any format or medium including but not limited to electronic and paper files.

This Authorization is being provided in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations issued there under.

This Authorization shall remain in effect for as long as I am enrolled in coverage with a BCBSD health insurance plan connected with the above-referenced HSA.

I have the right to revoke this Authorization at any time by providing written notice to BCBSD. Revocation of this Authorization shall have no effect on any action that BCBSD or others have taken prior to receipt of the written notice.

I understand that if I fail to sign this Authorization, BCBSD will not be able to provide information to the HSA Custodian, Bancorp, to open and maintain my HSA. I also understand that any and all information provided by BCBSD to Bancorp in accordance with this Authorization may be subject to re-disclosure by Bancorp, and may no longer be protected by HIPAA.

Individual's Signature: \_\_\_\_\_

Date (mm/dd/yy): \_\_\_\_\_