Blue Cross Blue Shield of Delaware
Blue Individual Application Checklist

Thank you for your interest in Blue Cross Blue Shield of Delaware's Blue 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 desired start date of coverage under the question of "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. In Section II. of the application labeled "Coverage Level," please select the option that you've chosen under the appropriate heading (either BlueIPA or BluePPO). Should you choose the BlueIPA, you must name a Primary Care Physician (PCP) in this section as well.
5. Please be certain to sign the application.
6. Once complete, please mail this application along with a voided check and completed Easy Pay authorization form to allow Blue Cross to draft your first month's premium payment to the following address (If you do not want to pay premiums via Easy Pay, you must select quarterly billing. Blue Cross will not mail a monthly bill. Additionally, please mail a check payable to Blue Cross for your first premium payment along with your application if you select quarterly billing.):

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.

Blue Cross Blue Shield of Delaware
ATTN: Underwriting Services 1-8-10
PO Box 1991, Wilmington, DE 19899-1991
Fax 302.421.2161

Blue*Individual*
APPLICATION FOR INDIVIDUAL COVERAGE
MEDICALLY UNDERWRITTEN — SUBJECT TO APPROVAL

BlueCross BlueShield of Delaware

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: ☐ Male ☐ Female			
				☐ Spouse ☐ Son ☐ Daughter			
				☐ Son ☐ Daughter			
				☐ Son ☐ 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: ________ 1st or ________ 15th

I am only interested in coverage if all persons on this application are approved. ____Yes ____No

II. COVERAGE LEVEL. Please check one option below.

BlueIPA Options: *(Complete Primary Care Physician information below.)*

☐ $20 Copay / $1,000 Deductible

BluePPO Deductible Options:

☐ $1,500 ☐ $2,500 ☐ $5,000

Maternity Option? ☐ Yes ☐ No *(There is an additional cost for this option, and benefits are subject to a 12-month waiting period.)*

Choose Billing Cycle: ☐ Monthly (*EasyPay Authorization* form is required) ☐ Quarterly *(January, April, July, October)*

Name (to be completed by BlueIPA applicants only)	Primary Care Physician (PCP) First and Last Name	PCP's Identification (ID) Number	Current PCP?
(Applicant)			☐ Yes ☐ No
(Spouse)			☐ Yes ☐ No
(Dependent)			☐ Yes ☐ No
(Dependent)			☐ Yes ☐ No

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?	☐	☐	________
2. Any metabolic or endocrine conditions/disorders *(examples: diabetes, adrenal/pituitary disorders, lupus, scleroderma, thyroid disorders, chronic fatigue syndrome, AIDS or any immune disorder)*?	☐	☐	________
3. Any alcohol, drug or substance abuse or dependency, or been advised to reduce alcohol or drug intake?	☐	☐	________
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)*?	☐	☐	________
5. Any emotional or psychological disorders *(examples: adjustment disorder, anxiety, attention deficit disorder, depression, obsessive-compulsive disorder, schizophrenia or attempted suicide)*?	☐	☐	________
6. Any disorder of the lungs or respiratory system *(examples: allergy, asthma, chronic obstructive pulmonary disease, emphysema or tuberculosis)*?	☐	☐	________
7. Any disorder of the kidney or urinary system *(examples: cystitis, renal failure, kidney stones, nephritis, prostatitis or recurring bladder infections)*?	☐	☐	________
8. Any disorder of the brain or nervous system *(examples: epilepsy, seizures, head trauma, migraines, multiple sclerosis or paralysis)*?	☐	☐	________
9. Any disorder of the digestive system *(examples: cirrhosis, chronic constipation, colitis, esophagitis, gall bladder/stones, hemorrhoids, chronic acid reflux, hepatitis or ulcer)*?	☐	☐	________
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)*?	☐	☐	________
11. Any disorder of the skin *(examples: collagen disorder, eczema or psoriasis)*?	☐	☐	________
12. Any disorder of the blood *(examples: anemia, hemophilia, leukemia or sickle cell)*?	☐	☐	________

ALL QUESTIONS MUST BE CHECKED "YES" OR "NO." — **Yes** — **No** — **Relevant Person Applying:**

	Question	Yes	No	Relevant Person Applying
13.	Any breast or gynecological disorders? *(examples: endometriosis, infertility, irregular menstruation, or breast condition)*	☐	☐	______
14.	Any venereal disease *(examples: gonorrhea, herpes or syphilis)*?	☐	☐	______
15.	Any disorders of the eye, ear, nose or throat *(examples: allergy, deafness or cataracts)*?	☐	☐	______
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?	☐	☐	______
17.	Any congenital conditions?	☐	☐	______
18.	Any premature births, caesarean deliveries or miscarriages?	☐	☐	______
19.	Is any person named on this application currently pregnant, expecting a baby or in the process of adoption or surrogacy? Expected delivery or adoption date: ______ / ______ / ______	☐	☐	______
20.	Any motor vehicle accident involvement in the last three years?	☐	☐	______
21.	Is any applicant an organ transplant recipient or currently on a transplant waiting list?	☐	☐	______
22.	Any abnormal test or physical exam results or is any applicant currently awaiting test results?	☐	☐	______
23.	Any advice by a physician to undergo additional testing or treatment that has not yet been sought?	☐	☐	______
24.	Any scheduled surgery or hospital admission within the next six months?	☐	☐	______

Please list the condition : ______________________________

Date of scheduled service : ______ / ______ / ______ Attending physician : ______________________________

	Question	Yes	No	Relevant Person Applying
25.	Any tobacco use (smoked, snuffed or chewed tobacco) at any time during the past 24 months? *(Please name each applicant who has.)*	☐	☐	______
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?	☐	☐	______
27.	Any health issue not previously mentioned on this application for which advice, diagnosis, care or treatment was **not** sought?	☐	☐	______

- 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	☐ Yes ☐ No	
			Month / Year	☐ Yes ☐ No	
			Month / Year	☐ Yes ☐ 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:

1. 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.
2. The contract will be effective only for those applicants approved by BCBSD.
3. 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.
4. 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.
5. The contract, application and any attached amendments shall constitute the entire agreement and shall supersede any previous agreements.
6. I will pay the premiums to BCBSD when due.
7. 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.
8. 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.
9. 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.
10. 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.

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)? ☐ Yes ☐ 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)? ☐ Yes ☐ No	If Yes, please explain:

Signature of Broker (DO NOT PRINT)	Printed Name of Broker	__/__/__ Date

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

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

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BlueCross BlueShield of Delaware

Authorization Agreement for EasyPay Automatic Withdraws

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): 27th of the previous month, 3rd or 5th

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
By phone: 302.421.3209 or 800.548.1050

Your Name 1234
000 Any Street Date: ____________
Any City, USA 00000
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Pay to the
order of ____________________________________
____________________________________ Dollars
Memo ____________________ ____________________
: 246824682 :1 088394827 1234

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