APPLICATION FOR INDIVIDUAL COVERAGE

Please note: The underwriting process can take several weeks. Do not cancel your current health care coverage until you have received notice in writing that coverage has been approved.

Instructions:

1. Please complete all sections and print clearly in black ink.
2. Read carefully and sign the enclosed *Authorization for Release of Medical Information*.
3. Read carefully and sign the enclosed *Declarations and Conditions of Enrollment*.
4. Provide information about your spouse and dependents only if they are also applying for coverage. If you need additional space, attach a separate sheet with your signature and date.
5. Choose a payment option in Section A. Payment options are:
   a. monthly billing (you must include a check for the first month's premium)
      - for HMO plans, make your check payable to Keystone Health Plan East
      - for PPO plans, make your check payable to Independence Blue Cross

   b. monthly ACH — monthly automatic payment from your bank account
      - Complete the *Electronic Payments* form included in your packet and enclose it along with a voided check or savings deposit slip.

   Important: Receipt of your initial payment does not constitute enrollment in this program. Your coverage will not begin until this application has been approved, an effective date assigned, and your payment received. Failure to provide all information requested may result in a delay in the processing of your application. If you are not approved for coverage, your check or voided check/savings deposit slip will be returned by mail.
6. Once your materials are complete, be sure to make a copy for your records. Mail your application and check or *Electronic Payments* form to:

   Independence Blue Cross
   P.O. Box 41474
   Philadelphia, PA 19101-1474
7. If you are approved and enroll in an HSA-Qualified plan (PPO 5000 HSA or PPO 3000 HSA), you may be qualified to open a Health Savings Account (HSA) to help you save for future qualified medical expenses on a tax-free basis. Independence Blue Cross has a preferred relationship with The Bancorp Bank, an independent company, to provide HSA services. If you would like to open an HSA through Bancorp, in Section A, be sure to check "Yes, I'd like an HSA account set up through Bancorp, please send Bancorp my information." Visit the Department of the Treasury website at **www.treas.gov/offices/public-affairs/hsa** to learn more about HSA accounts and eligibility.

If you have any questions or need help completing this application, contact Independence Blue Cross at 1-800-263-1410, Monday through Friday, between 9 a.m. and 9 p.m.

Independence Blue Cross

Keep this page for your records.

Preexisting Condition Information

Please note: These plans exclude coverage for preexisting conditions for the first 12 months of your coverage *except for applicants under age 19 and dependent children under age 19.* However, if you meet the requirements for creditable coverage, you may be able to reduce or waive the waiting period for your preexisting condition.

What is a preexisting condition exclusion?
A preexisting condition exclusion excludes coverage for a certain period of time for charges related to any medical condition or illness for which medical advice or treatment was recommended or received within a stated "look-back" period that precedes the effective date of coverage.

If you have prior creditable coverage, you may be eligible for a waiver of the preexisting condition exclusion.

What is creditable coverage?
Creditable coverage refers to health coverage that you have now or that you have had previously that meets certain conditions. The previous health plan must have been in force for a specified time period (12 months for a Blue Cross® and Blue Shield® plan and 18 months for other carriers' plans). If the prior coverage was with a Blue Cross and Blue Shield plan it must have been in force continuously without a break prior to your current application. For other carriers' plans the prior coverage must have been in force continuously without a break of more than 63 days prior to your current application.

Prior creditable coverage does not guarantee acceptance into this medically underwritten program. All applications are subject to underwriting approval. For more information, go to www.ibx.com and visit the Individual & Family plans section.

What kind of plans qualify as creditable coverage?
- group or individual health plans including governmental plans
- COBRA continuation coverage
- state high-risk pools
- Indian Health Service
- public health plans (such as a plan offered by a state)
- federal or state employee benefits
- Medicare
- Medicaid

Plans that do not count as creditable coverage include:
- accident only
- dental or vision only
- disability or liability plans
- auto or homeowners plans
- hospital indemnity
- Workers' compensation
- specified disease policies (e.g., cancer policies)

What is needed to be considered for a reduction or waiver of the preexisting condition exclusion period?
- Be sure that you have fully completed all parts of Section G — Other Insurance.
- You must also submit a Certificate of Creditable Coverage for each applicant.

Independence Blue Cross

For office use only
Application ID: _____
Account ID: _____

Application/Change Form for Individual Coverage

Keystone Health Plan East (KHPE) HMO Plans and QCC Insurance Company PPO Plans*

In order to be eligible for coverage, the following must be true:

- The primary applicant must be between the ages of 18 and 64.
- You, your spouse, or dependents are not pregnant, an expectant parent, or in the process of adoption or surrogacy.
- Applicants are residents of Bucks, Chester, Delaware, Montgomery, or Philadelphia counties in Pennsylvania.
- Applicants are not eligible for Medicare or Medicare Disability.
- Dependents must be under age 26.

SECTION A — Plan Selections

Type of Coverage	Reason for application	Payment mode	For office use only
☐ Individual ☐ Individual and spouse ☐ Individual and child(ren) ☐ Family	☐ New enrollment ☐ Add spouse ☐ Add dependent child(ren) ☐ Change benefit plan	☐ Monthly billing ☐ Monthly ACH	Approved Effective Date _____

Choice of Plan

Keystone Health Plan East plans:

☐ HMO 5000 Deductible ☐ HMO 30 Copay
☐ HMO 2500 Deductible ☐ HMO 20 Copay
☐ HMO 1500 Deductible ☐ HMO 15 Copay
☐ HMO 10 Copay

QCC Insurance Company Personal Choice plans:

☐ PPO 8000 Deductible
☐ PPO 5000 Deductible
☐ PPO 2500 Deductible
☐ PPO 30 Copay

☐ PPO 5000 HSA
☐ PPO 3000 HSA
☐ Yes, I'd like an HSA account set up through Bancorp. Please send Bancorp my information.

SECTION B — Primary Applicant Information (must be between the ages of 18 and 64)

Primary applicant name: Last, First, M.I.		Social Security Number			
Employer name	Birth date _____/_____/_____	Age	Gender: ☐ M ☐ F	Height ___ft. ___in.	Weight _____lbs.
Primary care office name (HMO only)†	PCP office code (HMO ID#, HMO only)†			Current patient? (HMO only)† ☐ Yes ☐ No	

* The Keystone Health Plan East HMO Plans are underwritten by Keystone Health Plan East and the QCC Insurance Company. PPO Plans are underwritten by QCC Insurance Company.

† **Required for all HMO plans. Use our website www.ibx4you.com to find a primary care physician (PCP) or call 215-241-3367 to request a PCP directory (HMO plans only).**

SECTION C — Family Information (if applying)

Spouse name: Last, First, M.I.		Social Security number			
Employer name	Birth date _____/_____/_____	Age	Gender: ☐ M ☐ F	Height ___ft. ___in.	Weight ______lbs.
Primary care office name (HMO only)†	PCP office code (HMO ID#, HMO only)†			Current patient? (HMO only)† ☐ Yes ☐ No	

Dependent name: Last, First, M.I.		Social Security number			
Relationship (e.g., son, stepdaughter)	Birth date _____/_____/_____	Age	Gender: ☐ M ☐ F	Height ___ft. ___in.	Weight ______lbs.
Primary care office name (HMO only)†	PCP office code (HMO ID#, HMO only)†			Current patient? (HMO only)† ☐ Yes ☐ No	

Dependent name: Last, First, M.I.		Social Security number			
Relationship (e.g., son, stepdaughter)	Birth date _____/_____/_____	Age	Gender: ☐ M ☐ F	Height ___ft. ___in.	Weight ______lbs.
Primary care office name (HMO only)†	PCP office code (HMO ID#, HMO only)†			Current patient? (HMO only)† ☐ Yes ☐ No	

Dependent name: Last, First, M.I.		Social Security number			
Relationship (e.g., son, stepdaughter)	Birth date _____/_____/_____	Age	Gender: ☐ M ☐ F	Height ___ft. ___in.	Weight ______lbs.
Primary care office name (HMO only)†	PCP office code (HMO ID#, HMO only)†			Current patient? (HMO only)† ☐ Yes ☐ No	

†**Required for all HMO plans. Use our website www.ibx4you.com to find a primary care physician (PCP) or call 215-241-3367 to request a PCP directory (HMO plans only).**

SECTION D — Personal Information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Are any applicants 'non-U.S. citizen' residents? ☐ Yes ☐ No

If "yes," provide the information below for 'non-U.S. citizen' residents:

Name(s)______________________________ Length of time in U.S.__________________

Non-U.S. citizens must have resided within the United States for the past six (6) consecutive months and must provide a copy of their green card or student/work visa.

Residence address			**Mailing address (if different from residence address)**		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			Note: Confidential medical information may be mailed to the mailing address.		

SECTION E — Contact Information

Home phone # ( )	Business phone # ( )	Best time to call: ☐ Morning ☐ Afternoon
Mobile phone # ( )	Email address	Best location to call: ☐ Home ☐ Business ☐ Mobile

SECTION F — Household Information

A. Do all applicants reside in the same household? ☐ Yes ☐ No

If no, provide reason: _____ Address: _____

B. Do all applicants reside in one of the following counties: Bucks, Chester, Delaware, Montgomery, or Philadelphia? ☐ Yes ☐ No

If no, provide reason: _____ Address: _____

SECTION G — Other Insurance

A. Are you or any applicants currently insured with Independence Blue Cross or an affiliate of Independence Blue Cross, or another Blue Cross and Blue Shield plan?	☐ Yes ☐ No
B. Have you or any applicants been insured under any other group or individual health plan for the last 18 months without a break of more than 63 days?	☐ Yes ☐ No
C. Do you have any other accident and health insurance in force?	☐ Yes ☐ No
D. Are you replacing the accident and health insurance plan listed in A, B, or C above? If "yes," termination date: _____/_____/_____	☐ Yes ☐ No

Important: Do not cancel any existing coverage until you have received notification that your application has been approved. Attach a Certificate of Creditable Coverage for each applicant (if applicable). If approved, you may be eligible for preexisting credit.

If you answered "yes" to question A,B, or C provide the following information for each applicant.

Name	Health care carrier	Policy number	Term/ Renewal date

SECTION G, continued

Have any applicants been rejected for life or health insurance? ☐ Yes ☐ No

If "yes," provide the following:

Name: _____ Date: _____/_____

Reason: _____

Are you or any applicants enrolling or eligible for Medicare or Medicaid due to age and/or disability? ☐ Yes ☐ No

If "yes," provide the following:

Name: _____ Eligibility date: _____/_____

Any person eligible for Medicare or Medicare disability benefits is not eligible for this coverage.

SECTION H — Travel and Residence Outside the U.S.A.

A. Have you or any applicants resided or traveled outside of the U.S.A. for the past six consecutive months? ☐ Yes ☐ No

If "yes," please provide name, country and explain: _____

B. Is any applicant planning to travel or work outside the U.S.A. within the next two years? ☐ Yes ☐ No

If "yes," name of person: _____ Country: _____

Reason: _____ Length of stay:_____

SECTION I — Expectant Parent Information (including adoption and surrogacy)

Females: Have you or any dependents (whether applying for coverage or not) been diagnosed and/or are currently under the care of a licensed health care practitioner for an existing pregnancy? ☐ Yes ☐ No

If "yes," name of person:_____ Expected delivery date: _____/_____/_____

Males: Are you expecting a child with anyone, even if the birth mother with a diagnosed pregnancy is not listed on the application? ☐ Yes ☐ No

Females and males: Is any applicant in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this application? ☐ Yes ☐ No

If "yes," name of person:_____ Expected adoption/delivery date: _____/_____/_____

SECTION J — Health Related Questions

1. Does any applicant use medical equipment (such as a walker, cane, hospital bed)?	☐ Yes ☐ No
2. Is any applicant currently receiving home health care?	☐ Yes ☐ No
3. Has any applicant received occupational, physical, or speech therapy, or chiropractic treatments in the past 5 years?	☐ Yes ☐ No
4. In the past five years, has any applicant been advised by a licensed health care practitioner of any abnormal lab results, X-rays, MRI, or physical exams results?	☐ Yes ☐ No
5. In the past five years, has any applicant been medically advised to undergo further medical testing, treatment, or surgery which has not yet been completed?	☐ Yes ☐ No
6. Has any applicant consulted any physician or other health care provider, been a patient in a hospital, surgical center, or other medical facility in the last five years?	☐ Yes ☐ No
7. Has any applicant taken prescription medications or been advised to take prescription medications in the past 2 years?	☐ Yes ☐ No
8. Has any applicant been medically treated or diagnosed for alcohol, chemical, or substance abuse or been advised to reduce alcohol intake at any time during the last five years?	☐ Yes ☐ No

SECTION J, continued

Below provide dates and details for "yes" responses in Section J questions 1 – 8. Attach a separate sheet if needed, and sign and date.

Question #	Name of person	Start and end dates MM/YY to MM/YY	Explanation
		___/___ to ___/___	
		___/___ to ___/___	
		___/___ to ___/___	
		___/___ to ___/___	
		___/___ to ___/___	

9. Has any applicant used controlled substances including but not limited to cocaine, heroin, LSD, marijuana, or methamphetamines at any time during the last 5 years? ☐ Yes ☐ No

If "yes," provide the following:

Name of person: _____ Name of drug/substance: _____ Date last used: _____/_____

10. Has any applicant smoked or used any form of tobacco within the last five years? ☐ Yes ☐ No

If "yes," list below the name of person(s) and type and amount of tobacco used per day.

Name of person: _____ Type and amount: _____ Date last smoked or used tobacco: _____/_____

Name of person: _____ Type and amount: _____ Date last smoked or used tobacco: _____/_____

SECTION K — Health History Questionnaire

Answer all questions and provide complete details to all "yes" answers in Section L1 — Additional Detailed Medical Information.

In the last 10 years, has any applicant consulted a health care provider, been diagnosed, received treatment, or been hospitalized for any of the following conditions or diseases?

1. Birth Defects/Congenital Abnormalities ☐ **Yes** ☐ **No**

☐ Cerebral palsy	☐ Developmental delay	☐ Kidney disorder	☐ Skull or facial deformities
☐ Cleft palate/lip	☐ Down's syndrome	☐ Lung disorder	☐ Webbed fingers/toes
☐ Club foot	☐ Heart disorder	☐ Mental retardation	☐ Other_____

2. Brain/Nervous System Conditions/Disorders ☐ **Yes** ☐ **No**

☐ Alzheimers	☐ Head injury	☐ Muscular dystrophy	☐ Parkinson's disease
☐ Convulsions	☐ Headaches – chronic	☐ Narcolepsy	☐ Seizures
☐ Dementia	☐ Headaches – migraine	☐ Nervous disorder	☐ Stroke
☐ Dizziness	☐ Loss of consciousness	☐ Neuritis	☐ Tremors
☐ Epilepsy	☐ Memory loss	☐ Numbness/tingling	☐ Vertigo
☐ Fainting	☐ Multiple sclerosis	☐ Paralysis	☐ Other_____

3. Cancer/Tumors ☐ **Yes** ☐ **No**

☐ Abnormal growth/neoplasm	☐ Hodgkin's disease	☐ Tumors
☐ Cysts	☐ Leukemia	☐ Other cancer_____

SECTION K, continued

4. Digestive Conditions/Disorders ☐ Yes ☐ No

- ☐ Acid or gastric reflux (GERD)
- ☐ Chronic diarrhea
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Colon polyps
- ☐ Crohn's disease
- ☐ Gallbladder disease
- ☐ Gastric bypass/banding
- ☐ Esophagus disorder
- ☐ Heartburn/Indigestion
- ☐ Hemorrhoids
- ☐ Hepatitis (type _____)
- ☐ Hernia
- ☐ Intestines disorder
- ☐ Irritable bowel syndrome
- ☐ Jaundice
- ☐ Jaw or chewing problems
- ☐ Liver disease
- ☐ Rectal disorder
- ☐ Stomach disorder
- ☐ Ulcers
- ☐ Unexplained weight gain or loss
- ☐ Other_____

5. Eyes, Ears, Nose, and Throat Conditions/Disorders ☐ Yes ☐ No

Eyes/Sight:
- ☐ Blindness
- ☐ Cataracts
- ☐ Crossed eyes
- ☐ Detached retina
- ☐ Glaucoma
- ☐ Infections
- ☐ Other_____

Ears/Hearing:
- ☐ Deafness
- ☐ Eustachian tube dysfunction
- ☐ Infections
- ☐ Loss of hearing
- ☐ Other_____

Nose/Breathing:
- ☐ Adenoiditis
- ☐ Deviated septum
- ☐ Polyps
- ☐ Sinusitis
- ☐ Other_____

Throat/Swallowing:
- ☐ Sleep apnea
- ☐ Strep throat
- ☐ Tonsillitis
- ☐ Other_____

6. Heart and Circulatory Conditions/Disorders ☐ Yes ☐ No

- ☐ Anemia
- ☐ Aneurysm
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Bleeding/Clotting disorder
- ☐ Bypass surgery/angioplasty
- ☐ Chest pain
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Heart attack
- ☐ Heart murmur
- ☐ High cholesterol/lipids
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphadenitis
- ☐ Pacemaker or defibrillator
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Raynauds disease/Phenomenon
- ☐ Stroke
- ☐ Thrombosis
- ☐ Valve replacement
- ☐ Varicose veins
- ☐ Other_____

7. Metabolic and Endocrine Conditions/Disorders ☐ Yes ☐ No

- ☐ Adrenal/Pituitary disorder
- ☐ AIDS/ARC/HIV positive
- ☐ Chronic fatigue syndrome
- ☐ Diabetes
- ☐ Epstein-Barr
- ☐ Goiter
- ☐ Immune disorder
- ☐ Lupus
- ☐ Mononucleosis
- ☐ Pancreatic disorder
- ☐ Scleroderma
- ☐ Thyroid disorder
- ☐ Other glandular disorder
- ☐ Other_____

8. Musculoskeletal Conditions/Disorders ☐ Yes ☐ No

- ☐ Arthritis
- ☐ Back disorder
- ☐ Dislocations
- ☐ Fibromyalgia
- ☐ Fracture
- ☐ Gout
- ☐ Herniated disc
- ☐ Internal fixation/hardware
- ☐ Joint or bone disorder
- ☐ Paraplegic/Quadriplegic
- ☐ Spinal curvature
- ☐ Strain/Sprain
- ☐ Tendon injury
- ☐ Other_____

9. Nervous, Mental and Behavioral Conditions/Disorders ☐ Yes ☐ No

- ☐ Anxiety/Panic disorders
- ☐ Attention deficit hyperactivity disorder
- ☐ Bipolar disorder
- ☐ Chemical imbalance
- ☐ Counseling/Support group
- ☐ Depression
- ☐ Eating disorders
- ☐ Manic depressive disorder
- ☐ Mental disease
- ☐ Obsessive-compulsive disorder
- ☐ Psychosis
- ☐ Schizophrenia
- ☐ Substance abuse
- ☐ Other_____

10. Female Reproductive Conditions/Disorders ☐ Yes ☐ No

- ☐ Abnormal menstrual bleeding
- ☐ Abnormal Pap smear
- ☐ Absence of menstruation
- ☐ Breast cysts/lumps/adenomas
- ☐ Breast disorders/implants
- ☐ Endometriosis
- ☐ Genital warts/herpes
- ☐ Infertility
- ☐ Miscarriage/abortion
- ☐ Ovarian cysts
- ☐ Pelvic pain/pelvic inflammatory disease
- ☐ Polycystic ovary syndrome
- ☐ Sexually transmitted diseases
- ☐ Uterine fibroids
- ☐ Other_____

11. Male Reproductive Conditions/Disorders ☐ Yes ☐ No

- ☐ Genital herpes/warts
- ☐ Infertility
- ☐ Low sperm count
- ☐ Prostate disorder
- ☐ Sexual dysfunction
- ☐ Sexually transmitted diseases
- ☐ Undescended testes
- ☐ Other_____

12. Respiratory Conditions/Disorders ☐ Yes ☐ No

- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic cough
- ☐ COPD
- ☐ Cystic fibrosis
- ☐ Emphysema
- ☐ Fungal infections
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Pneumothorax
- ☐ Sarcoidosis
- ☐ Shortness of breath
- ☐ Tuberculosis
- ☐ Other_____

SECTION K, continued

13. Skin Conditions/Disorders			☐ Yes ☐ No
☐ Acne	☐ Fungal infections	☐ Pre-cancerous lesions	☐ Skin cancer or melanoma
☐ Dermatitis	☐ Keratosis	☐ Psoriasis	☐ Other__________
☐ Eczema	☐ Moles/warts		
14. Urinary Conditions/Disorders			☐ Yes ☐ No
☐ Bladder infections	☐ Kidney/bladder stones	☐ Sugar in urine	
☐ Blood in urine	☐ Kidney infections/nephritis	☐ Urinary tract disorder	
☐ Incontinence	☐ Protein in urine	☐ Other__________	
15. Has any applicant been diagnosed or treated for any other condition or disorder not listed in questions 1 through 14?			☐ Yes ☐ No
If "yes," write the condition below.			
☐ Other__________	☐ Other__________	☐ Other__________	☐ Other__________

SECTION L1 — Additional Detailed Medical Information

Provide full details to *all* questions answered "yes" in Section K. Attach a separate sheet if needed, and sign and date it.

Question #_____	Person treated: __________	Start and end dates: ___/___ to ___/___	Degree of recovery: ☐ None ☐ Partial ☐ Full
Explain nature of illness/condition: __________ __________ __________			Physician or hospital Name: __________ Specialty: __________ Phone: (______) __________
Describe treatment received/recommended: __________ __________ __________			

Question #_____	Person treated: __________	Start and end dates: ___/___ to ___/___	Degree of recovery: ☐ None ☐ Partial ☐ Full
Explain nature of illness/condition: __________ __________ __________			Physician or hospital Name: __________ Specialty: __________ Phone: (______) __________
Describe treatment received/recommended: __________ __________ __________			

Question #_____	Person treated: __________	Start and end dates: ___/___ to ___/___	Degree of recovery: ☐ None ☐ Partial ☐ Full
Explain nature of illness/condition: __________ __________ __________			Physician or hospital Name: __________ Specialty: __________ Phone: (______) __________
Describe treatment received/recommended: __________ __________ __________			

SECTION L1, continued

Question #_____	Person treated: _____	Start and end dates: ___/___ to ___/___	Degree of recovery: ☐ None ☐ Partial ☐ Full
Explain nature of illness/condition: _____ _____			Physician or hospital Name: _____ Specialty: _____ Phone: (_____) _____
Describe treatment received/recommended: _____ _____			

Question #_____	Person treated: _____	Start and end dates: ___/___ to ___/___	Degree of recovery: ☐ None ☐ Partial ☐ Full
Explain nature of illness/condition: _____ _____ _____			Physician or hospital Name: _____ Specialty: _____ Phone: (_____) _____
Describe treatment received/recommended: _____ _____ _____			

SECTION L2 — Additional Detailed Medical Information

Have any applicants taken any prescription drugs or medications within the last 12 months? ☐ Yes ☐ No

If "yes," list all below. Attach a separate sheet if needed, and sign and date it.

Name of person	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Reason/Condition for which medication is prescribed	Date prescribed to date discontinued	Physician or hospital
			___/___ to ___/___	Name: _____ Phone: (_____) _____
			___/___ to ___/___	Name: _____ Phone: (_____) _____
			___/___ to ___/___	Name: _____ Phone: (_____) _____
			___/___ to ___/___	Name: _____ Phone: (_____) _____
			___/___ to ___/___	Name: _____ Phone: (_____) _____

SECTION L3 — Last Doctor Visit

List the last doctor visit for all applicants, including routine check-ups. Attach a second sheet if needed, and sign and date it.

Primary applicant name	Date of last doctor visit ______/______/______
Purpose of last visit: ____________________ ____________________	Physician information Name: ____________________ Phone: (________) ________________
Findings ☐ normal ☐ abnormal (if abnormal, provide details): ____________________ ____________________	Address:____________________ ____________________ ____________________

Spouse name	Date of last doctor visit ______/______/______
Purpose of last visit: ____________________ ____________________	Physician information Name: ____________________ Phone: (________) ________________
Findings ☐ normal ☐ abnormal (if abnormal, provide details): ____________________ ____________________	Address:____________________ ____________________ ____________________

Dependent name	Date of last doctor visit ______/______/______
Purpose of last visit: ____________________ ____________________	Physician information Name: ____________________ Phone: (________) ________________
Findings ☐ normal ☐ abnormal (if abnormal, provide details): ____________________ ____________________	Address:____________________ ____________________ ____________________

Dependent name	Date of last doctor visit ______/______/______
Purpose of last visit: ____________________ ____________________	Physician information Name: ____________________ Phone: (________) ________________
Findings ☐ normal ☐ abnormal (if abnormal, provide details): ____________________ ____________________	Address:____________________ ____________________ ____________________

Dependent name	Date of last doctor visit ______/______/______
Purpose of last visit: ____________________ ____________________	Physician information Name: ____________________ Phone: (________) ________________
Findings ☐ normal ☐ abnormal (if abnormal, provide details): ____________________ ____________________	Address:____________________ ____________________ ____________________

Independence Blue Cross

Application ID: _____

Account ID: _____

Authorization for Release of Medical Information

Keystone Health Plan East (KHPE) HMO Plans
QCC Insurance Company PPO Plans

As part of the process of determining eligibility, and for the purpose of underwriting this insurance application, I authorize the release of my protected health information (PHI) and that of my dependent children under the age of 18. This includes information and/or medical records relating to past, present, and future health care examinations, prescription drugs, treatment and diagnosis, including those involving mental health (excluding psychotherapy notes, unless specifically and separately authorized), substance abuse, and HIV/AIDS. I do authorize any physician, medical practitioner, hospital, medical or medically related facility, insurer, pharmacy benefits manager, or any other health care organization to release the information as described above to Keystone Health Plan East or QCC Insurance Company ("the companies") and their subsidiaries.

This authorization shall remain in force for 18 months following the date of the signature(s) below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notice to Independence Blue Cross, Medical Underwriting Department, 1901 Market Street, Philadelphia, PA 19103-1480. I understand that a revocation is not effective to the extent that the companies or any other person have already relied on this authorization to disclose or collect information, or to the extent the companies and their subsidiaries have a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that the PHI disclosed based on this authorization may be subject to re-disclosure and may then be no longer protected by the federal privacy rule. However, the companies are required to comply with the HIPAA Privacy Rules and any re-disclosure of information will be done under the privacy rule. I understand that I will receive a copy of this signed authorization. A copy of this authorization is as valid as the original. I understand that if I refuse to sign this authorization the companies may refuse to enroll me or may determine that I am not eligible for benefits.

SIGN HERE X_____ _____/____/_____
Signature of proposed primary insured — Date

SIGN HERE X_____ _____/____/_____
Signature of spouse (if applying for coverage) — Date

SIGN HERE X_____ _____/____/_____
Signature of adult dependent child, age 18 - 25 (if applying for coverage) — Date

SIGN HERE X_____ _____/____/_____
Signature of adult dependent child, age 18 - 25 (if applying for coverage) — Date

SECTION M — Declarations and Conditions of Enrollment *Please read carefully before signing below.*

By applying to Keystone Health Plan East or QCC Insurance Company ("the companies") for coverage for myself and the dependents listed in Section C, I understand and agree as follows:

***Coverage may be denied (with the exception of applicants under age 19 and dependent children under age 19), or a premium adjustment made, based on information provided to the companies during the underwriting process.**

1. a) **The requested Effective Date of Coverage is the _____ 1st or the _____ 15th day of _____ (month).**
   b) **There is no guarantee that your requested Effective Date can be met.**
   c) **Coverage does not begin until this application is approved by the companies with an Effective Date of coverage assigned and payment has been received.**
   d) If selecting monthly payment, a check for the first monthly premium must be submitted with your paper application. If selecting automatic monthly bank withdrawal through Automatic Clearing House (ACH), a completed authorization form and a voided check or savings deposit slip must be submitted with the application.
   e) Receipt of the initial payment (check or ACH) does not constitute enrollment under any program.
   f) This coverage is provided only to residents of the geographical area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, Pennsylvania, served by the companies. The companies reserve the right to investigate and confirm your residence.
2. a) The companies may require me and/or my family member(s) applying to provide additional medical history. The companies may also require a medical examination, blood test or other applicable medical test prior to acceptance of the application.
   b) The companies may telephone me or my dependents for additional information that may help with timely application processing.
   c) Except for applicants under age 19, the companies may deny this application, in which case any premium submitted will be returned to me.
   d) The companies may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by intentionally supplying a material misrepresentation of fact, except in the case of fraud, for which there is no time limit for voiding the policy.
3. **HMO:** I understand that benefits will not be payable during the 12-month period following the Effective Date on which I and my covered dependents become enrolled under the non-group benefit policy for any condition, illness, or injury for which medical advice or treatment was recommended by or received from a physician or other professional provider within a 90-day period prior to the Effective Date of the policy. This exclusion will not apply to applicants under age 19 or dependent children under age 19.
4. **PPO:** I understand that benefits will not be payable during the 12-month period following the Effective Date on which I and my covered dependents become enrolled under the non-group benefit policy for any condition, illness, or injury for which medical advice or treatment was recommended by or received from a physician or other professional provider within a 12-month period prior to the Effective Date of the policy. This exclusion will not apply to applicants under age 19 or dependent children under age 19.
5. I understand that I and any dependents may be eligible for insurance coverage without a preexisting condition exclusion if I (we) have been enrolled in a Blue Cross and Blue Shield plan, or an affiliate of Independence Blue Cross during the 12 months immediately preceding without a break in coverage. Applicants under age 19 or dependent children under age 19 are not subject to the preexisting condition exclusion.
6. The terms and conditions of the coverage will be controlled by the written agreement with the companies, and the companies may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.
7. **HMO Plans Only:**
   a) As a condition of coverage, each applicant must select a participating primary care physician.
   b) As a condition of coverage, (with the exception of emergency procedures and certain direct access services as defined in the Subscriber Agreement) all services, in order to be covered by KHPE, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy (if applicable), or other provider as authorized by a referral, or pre-certification, from a participating primary care physician or KHPE.
8. I understand that benefits under this policy will be coordinated with other coverage any covered person may have which is subject to coordination.
9. By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-Group policy, the companies will use and disclose PHI (protected health information) for purposes of Treatment, Payment and Operations (TPO) as this term is defined by federal law.
10. I understand that any medical condition or treatment that occurs after the signature date and before the effective date of any approved coverage will be considered in the final underwriting decision. I agree to advise the companies of any condition or treatment occurring during such period.
11. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature(s) Required

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

SIGN HERE X _____ ___/___/_____
Applicant/Parent or Legal Guardian signature — Date

SIGN HERE X _____ ___/___/_____
Applicant spouse signature (if applying for coverage) — Date

SECTION N — Statement of Accountability (if applicable)

To be completed if the applicant cannot complete or has not completed the application:

I, _____, have read and completed the application form for the primary applicant for the following reason(s):

☐ Applicant does not speak English
☐ Applicant does not read English
☐ Applicant does not write in English
☐ Other (explain)_____

I translated and fully explained the "Declarations and Conditions of Enrollment." I also translated the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by: _____

_____ _____/_____/_____

Signature of translator (required) Date (required)

Relationship to applicant: _____

SECTION O — Broker Information (if applicable)

Primary broker code	Producer broker code
Primary broker name	Producer name
Telephone number	Telephone number

IBC Sale Representative (if applicable)

Sales representative code	Name of sales representative

Mail your application and check or *Electronic Payments* form to:

Independence Blue Cross
P.O. Box 41474
Philadelphia, PA 19101-1474

If you have any questions, contact Independence Blue Cross at **1-800-263-1410** between 9 a.m. and 9 p.m.

#15621 2011-0124 10/11