

APPLICATION AND QUESTIONNAIRE FOR INDIVIDUAL HMO COVERAGE

Keystone Health Plan East (KHPE) HMO Plans

HOW TO COMPLETE THIS APPLICATION

- Any person eligible for Medicare or Medicare Disability benefits is not eligible to enroll in this coverage.
- If any family member is pregnant, an expectant parent, or in the process of adoption or surrogacy, the expectant parents are ineligible.

To avoid processing delays, we ask that you take your time to carefully and accurately complete all appropriate sections. Please print clearly in black ink.

You must select a primary care physician (PCP) from the directory. Indicate the name and the PCP Code Number (listed in the directory as the "HMO ID") for yourself and each of your covered dependents. Each of you can choose a different PCP. Indicate if you are currently a patient of the PCP you choose. You can access the PCP directory at www.ibx4you.com, or call 215-241-3367 for information.

Please note that 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.

1. Keep this page and a copy of the application form for your records. You may want to refer to it if you have a question about your application. If your application is approved but is changed because additional information was added during the underwriting process, you will be sent a copy of the revised form for a current signature and date.
2. Provide all the information requested on the Application/Change form. **If applying for Individual & Spouse or Family Coverage, primary applicant must be older spouse.** Provide information about your spouse and dependents only if they are also applying for coverage.
3. Provide answers to the health questions in Sections K, L, and M. Provide information about yourself and any other applicant(s). For all questions answered "Yes," please provide complete details. If additional space is needed, attach a separate sheet and sign and date this addendum before attaching and submitting it with your application form.
4. Read carefully and sign the enclosed "**Authorization for Release of Medical Information**" section before signing and dating the application. If your spouse and/or adult dependent children (18 through 22) are applying for coverage they must also sign and date the authorization. Keep a copy for your records. Your application will be returned if the Authorization page has not been signed and dated.
5. Read carefully and completely the "**Declarations and Conditions of Enrollment**" section before signing and dating the application. If your spouse is applying, he/she must also sign and date the application.
6. Payment options are (1) monthly billing or (2) monthly bank automatic withdrawals through Automated Clearing House (ACH). **A check for the first monthly premium must be submitted with your application. It should be made payable to Keystone Health Plan East.** If selecting monthly payment by ACH, a completed authorization form and a voided check or savings deposit slip must be sent with the application.

Mail the Application and ACH form or check to:

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

Please note: Receipt of your initial payment does not constitute enrollment under this program. Your Individual coverage will not begin until this application has been approved with an effective date of coverage assigned and payment has been received.

Failure to provide all information requested may result in a delay in the processing of your application.

If you have any questions, or require assistance in completing this application, please contact Independence Blue Cross at **1-800-263-1410** between 9 a.m. and 9 p.m.

Keep this page for your records.

Date: _____ Check Number: _____ Amount Paid: _____



Application ID: _____

Account ID: _____

Applicant's Social Security Number: _____ - _____ - _____

Keystone Health Plan East (KHPE) — Individual HMO

Application/Change Form and Health Questionnaire

- ☞ Application and Health Questionnaire must be completed in black ink.
- ☞ If applying for Individual & Spouse or Family coverage, applicant must be older spouse.
- ☞ Any person eligible for Medicare or Medicare Disability benefits is not eligible to enroll for coverage.
- ☞ If any family member is pregnant, an expectant parent, or in the process of adoption or surrogacy, the expectant parents are ineligible.
- ☞ Primary applicant (and spouse and adult dependent children if applying) must sign and date the Authorization for Release of Medical Information and keep a copy of it.
- ☞ Primary applicant (and spouse if applying) must sign and date the Declarations and Conditions of Enrollment.

Use "Family Code" from first column of section "B" ENROLLMENT INFORMATION to indicate appropriate person in other sections where requested.

A	Choice of Plan	Type of Coverage	Reason for Application	Payment Mode	For Office Use Only
	<input type="checkbox"/> HMO \$5000 Deductible <input type="checkbox"/> HMO \$2500 Deductible <input type="checkbox"/> HMO \$1500 Deductible <input type="checkbox"/> HMO \$20 Copay <input type="checkbox"/> HMO \$15 Copay <input type="checkbox"/> HMO \$10 Copay	<input type="checkbox"/> Individual <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> Individual and Child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Add Spouse/Dependent Child(ren) <input type="checkbox"/> Add Dependent Child(ren) Only <input type="checkbox"/> Change Benefit Plan	<input type="checkbox"/> Monthly Billing <input type="checkbox"/> Monthly ACH	Approved Effective Date _____

B Enrollment Information

Family Code Primary Applicant (Oldest person to be covered; must be 18 or older.)

AP	Name: Last, First, M.I.	Relationship	Sex	Age	Birth Date	Social Security No.	Height (ft.in.)	Weight (lbs)	PCP Office Code (HMO ID #)	Primary Care Office Name	Current Patient?
		Self	M / F		/ /						<input type="checkbox"/> Yes <input type="checkbox"/> No

Spouse (if applying)

SP	Name: Last, First, M.I.	Relationship	Sex	Age	Birth Date	Social Security No.	Height (ft.in.)	Weight (lbs)	PCP Office Code (HMO ID #)	Primary Care Office Name	Current Patient?
		Spouse	M / F		/ /						<input type="checkbox"/> Yes <input type="checkbox"/> No

Dependent Children (if applying)

In the RELATIONSHIP box below, please indicate son, daughter, stepson, or stepdaughter beside each dependent's name.

Dependents age 19 and under 23 must be full-time students in an accredited school or university.

D1	Name: Last, First, M.I.	Relationship	Sex: M / F	Age	Birth Date	Social Security No.	Height (ft.in.)	Weight (lbs)	PCP Office Code (HMO ID #)	Primary Care Office Name	Current Patient?
					/ /						<input type="checkbox"/> Yes <input type="checkbox"/> No
					/ /						<input type="checkbox"/> Yes <input type="checkbox"/> No
					/ /						<input type="checkbox"/> Yes <input type="checkbox"/> No

*Use our web site www.ibx4you.com to find a Primary Care Physician (PCP), or call 215-241-3367 to request a PCP directory to be mailed to you. Use the "HMO ID" Number in the Directory.

Family Code Student Information (For Dependents from Age 19 to Under 23)

Family Code	Dependent	School Attending	Semester Hours	Expected Graduation Date

Application ID: _____

Account ID: _____

Applicant's Social Security Number: _____ - _____ - _____

C Personal Information

Proposed Insured Marital Status: Single Married Divorced Separated Widowed

Proposed Insured Resident Status: U.S. Citizen? Yes No If no, please explain _____

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.

D Telephone Information

Home Phone No. _____ Business Phone No. _____ Best Time to call: Morning Afternoon Evening
() () Best Location to call: Home Business Mobile

Mobile Phone No. _____ Email Address: _____
()

E Household Information

A. Do all proposed insureds reside in the same household? Yes No
If no, provide reason: _____ Address: _____

B. Do all proposed insureds reside in one of the following counties: Bucks, Chester, Delaware, Montgomery, or Philadelphia? Yes No Address: _____
If no, provide reason: _____

C. Are all family members being covered? Yes No
If no, provide reason: _____

F Proposed Insured's Employment Information (required)

Employer Name and Address: _____ Job Duties: _____

G Spouse's Employment Information (if applicable)

Employer Name and Address: _____ Job Duties: _____

H Other Insurance

Family Code Do you or any applicants currently have health care coverage? Yes No
If "Yes," provide name of current (or most recent) Health Care Carrier and coverage termination date (if applicable).

Health Care Carrier name and policy no.: _____ Termination/Renewal Date: ____/____/____ Yes No

Are you replacing existing health insurance? Yes No
If "Yes," Termination Date: ____/____/____

Are you or any applicants enrolling or eligible for Medicare or Medicaid due to age and/or disability? Yes No
If "Yes," Name: _____ Eligibility Date: ____/____/____

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

Have you or any applicants ever applied and been rejected for any:
Health Care Coverage: Yes No Name of Person(s) rejected, date and reason: _____

Life Insurance Coverage: Yes No _____

Application ID: _____

Account ID: _____

Applicant's Social Security Number: _____ - _____ - _____

9) Has any person to be covered 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 the answer is "Yes," list below the name of the person, substance used, and date stopped

Name of Person _____ Name of Drug/Substance _____ Date Stopped ____/____/____

10) Has any person to be covered, smoked or used any form of tobacco within the last 5 years?

Yes No

If the answer is "Yes," list below the name of person(s) and type and amount of tobacco used per day

Name of Person _____ Type _____ Amount _____

Name of Person _____ Type _____ Amount _____

L Health History Questionnaire for Each Person Applying for Coverage

Answer all questions & provide complete details to all "Yes" answers in the "ADDITIONAL DETAILED MEDICAL INFORMATION" Section below. **Include the "Family Code" for the person(s) with the condition opposite the condition.**

In the last 10 years, has any person applying for coverage in this application 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 (such as but not limited to): Yes No

Cerebral Palsy	Developmental delay	Kidney Disorder(s)	Skull or facial deformities
Cleft palate/lip	Down syndrome	Lung Disorder(s)	Webbed fingers/toes
Club foot	Heart Disorder(s)	Mental retardation	Other

2. Brain/Nervous System Conditions/Disorders (such as but not limited to): Yes No

Convulsions	Headaches – Migraine	Nervous Disorder(s)	Seizures
Dizziness	Loss of Consciousness	Neuritis	Stroke
Epilepsy	Memory Loss	Numbness/Tingling	Tremors
Fainting	Multiple Sclerosis	Paralysis	Vertigo
Head Injury	Narcolepsy	Parkinsonism	Other
Headaches – Chronic			

3. Cancer/Tumors (such as but not limited to): Yes No

Abnormal Growth/Neoplasm	Hodgkin's Disease	Tumors
Cysts	Leukemia	Other Cancer

4. Digestive Conditions/Disorders (such as but not limited to): Yes No

Chronic Diarrhea	Esophagus Disorder(s)	Intestines Disorder(s)	Rectal Disorder(s)
Cirrhosis	Hemorrhoids	Irritable Bowel Syndrome	Stomach Disorder(s)
Colitis	Hepatitis (Type _____)	Jaundice	Ulcers
Colon Polyps	Hernia	Jaw or Chewing Problems	Unexplained Weight Gain or Loss
Gallbladder Disease(s)	Indigestion	Liver Disease(s)	Other
Gastric Bypass			

Application ID: _____

Account ID: _____

Applicant's Social Security Number: _____ - _____ - _____

L Health History Questionnaire for Each Person Applying for Coverage (continued)						
5. Eyes, Ears, Nose, and Throat Conditions/Disorders (such as but not limited to):			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Eyes/Sight:		Ears/Hearing:		Nose/Breathing:		Throat/Swallowing:
Blindness		Deafness		Adenoiditis		Sleep Apnea
Cataracts		Eustachian Tube Dysfunction		Deviated Septum		Strep Throat
Crossed Eyes		Infections		Polyps		Tonsillitis
Detached Retina		Loss of Hearing		Sinusitis		Other
Glaucoma		Other		Other		
Infections						
Other						
6. Heart and Circulatory Conditions//Disorders (such as but not limited to):			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Anemia		Chest Pain		High Blood Pressure		Raynauds Disease/Phenomenon
Aneurysm		Congestive Heart Failure		Low Blood Pressure		Stroke
Angina		Coronary Artery Disease		Lymphadenitis		Thrombosis
Arteriosclerosis		Heart Attack		Pacemaker or Defibrillator		Valve Replacement
Bleeding/Clotting Disorder(s)		Heart Murmur		Palpitations		Varicose Veins
Bypass Surgery/Angioplasty		High Cholesterol		Phlebitis		Other
7. Metabolic and Endocrine Conditions/Disorders (such as but not limited to):			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Adrenal/Pituitary Disorder(s)		Epstein-Barr		Mononucleosis		Other Glandular Disorder(s)
AIDS/ARC/HIV positive		Goiter		Pancreatic Disorder(s)		Other
Chronic Fatigue Syndrome		Immune Disorder(s)		Scleroderma		
Diabetes		Lupus		Thyroid Disorder(s)		
8. Musculoskeletal Conditions/Disorders (such as but not limited to):			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Arthritis		Fracture		Internal Fixation/Hardware		Prosthesis
Back Disorder		Gout		Joint or Bone Disorder		Strain/Sprain
Fibromyalgia		Herniated Disc		Paraplegic/Quadriplegic		Other
9. Nervous, Mental and Behavioral Conditions/Disorders (such as but not limited to):			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Anxiety/Panic Disorders		Chemical Imbalance		Manic Depressive Disorder		Schizophrenia
Attention Deficit Hyperactivity Disorder		Counseling/Support Group		Mental Disease		Substance Abuse
		Depression		Obsessive-Compulsive Disorder		Other
Bipolar Disorder		Eating Disorders		Psychosis		

Application ID: _____

Account ID: _____

Applicant's Social Security Number: _____ - _____ - _____

L Health History Questionnaire for Each Person Applying for Coverage (continued)							
10. Female Reproductive Conditions/Disorders (such as but not limited to):				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Abnormal Menstrual Bleeding		Endometriosis		Ovarian Cysts		Uterine Fibroids	
Absence of Menstruation		Genital Warts/Herpes		Pelvic Pain/Pelvic Inflammatory Disease		Other	
Breast Cysts/Lumps/Adenomas		Infertility					
Breast Disorders/Implants		Miscarriage/Abortion		Sexually Transmitted Diseases			
11. Male Reproductive Conditions/Disorders (such as but not limited to):				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Enlarged Prostate		Low Sperm Count		Sexual Dysfunction		Undescended Testes	
Genital Herpes/Warts		Prostatitis		Sexually Transmitted Diseases		Other	
Infertility							
12. Respiratory Conditions/Disorders (such as but not limited to):				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Allergies		Cystic Fibrosis		Pneumonia		Shortness of Breath	
Asthma		Emphysema		Pneumothorax		Tuberculosis	
Bronchitis		Fungal Infections		Sarcoidosis		Other	
Chronic Cough		Pleurisy					
13. Skin Conditions/Disorders (such as but not limited to):				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Acne		Fungal Infections		Pre-cancerous Lesions		Skin Cancer or Melanoma	
Dermatitis		Keratosis		Psoriasis		Other	
Eczema		Moles/Warts					
14. Urinary Conditions/Disorders (such as but not limited to):				<input type="checkbox"/> Yes <input type="checkbox"/> No			
Bladder Infections		Kidney/Bladder Stones		Protein in Urine		Urinary Tract Disorder(s)	
Blood in Urine		Kidney Infections/Nephritis		Sugar in Urine		Other	
Incontinence							
15. Other Conditions/Disorders not listed in this Section (L): List below:				<input type="checkbox"/> Yes <input type="checkbox"/> No			

Application ID: _____

Account ID: _____

Applicant's Social Security Number: _____ - _____ - _____

M Additional Detailed Medical Information

1. Provide full details to ALL questions answered "Yes" in Section L. Attach a separate sheet if needed and sign and date it.

Ques. No.	Person Treated	Dates	Explain Nature of Illness/Condition	Describe Treatment Received/Recommended	Degree of Recovery
					Indicate None, Partial %, or Full
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			

2. List all medications, prescription drugs, taken by any person to be covered within the past 12 months. If none, please state "None."

Family Code	Name of Person	Dates of Use	Name of Medication	Dosage & Frequency	Reason/Condition
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			
		From ___/___/___ To ___/___/___			

Application ID: _____

Account ID: _____

Applicant's Social Security Number: _____ - _____ - _____

M Additional Detailed Medical Information (continued)

3. For details and medications indicated above, please list all doctors, medical attendants, or practitioners that any person to be covered consulted. If none, please state "None."

Family Code	Question Number and/or Reason	Name, Address and Phone Number of Attending Physician(s) or other Practitioner(s)	Physician's Specialty

4. List last doctor visit for all persons to be covered, including routine check-ups.

Family Code	Purpose of Visit	Dates of Visit	Findings		Name, Address and Phone Number of Physician
			Abnormal: Details	Normal	
AP					
SP					
D1					
D2					
D3					

Authorization for Release of Medical Information

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 healthcare 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, (KHPE) and its 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 KHPE or any other person has already relied on this authorization to disclose or collect information, or to the extent KHPE and its 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, KHPE is 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 KHPE may refuse to enroll me or may determine that I am not eligible for benefits.

Signature of Proposed Primary Insured

Date

Signature of Spouse

Date

Signature of Adult Dependent Children (18 through 22)

Date

Signature of Adult Dependent Children (18 through 22)

Date

N	Declarations and Conditions of Enrollment — Please Read Carefully Before Signing Below			
	<p>By applying to Keystone Health Plan East (KHPE) for coverage for myself and the dependents listed in Section B, I understand and agree as follows: *Coverage may be denied, or a premium adjustment made, based on information provided to KHPE during the underwriting process.</p> <ol style="list-style-type: none"> 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 KHPE 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 KHPE. KHPE reserves the right to investigate and confirm your residence. 2. a) KHPE may require me and/or my family member(s) applying to provide additional medical history. KHPE may also require a medical examination, blood test or other applicable medical test prior to acceptance of the application. b) KHPE may telephone me or my dependents for additional information that may help with timely application processing. c) KHPE may deny this application, in which case any premium submitted will be returned to me. d) KHPE 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 supplying materially incorrect or misleading enrollment eligibility information, except in the case of fraudulent statements or omissions, for which there is no time limit for voiding the policy. 3. 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. 4. The terms and conditions of the coverage will be controlled by the written agreement with KHPE and KHPE 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. 5. 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. 6. I understand that benefits under this policy will be coordinated with other coverage any covered person may have which is subject to coordination. 7. 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, KHPE will use and disclose PHI for purposes of Treatment, Payment and Operations (TPO) as this term is defined by federal law. 8. 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 of any condition or treatment occurring during such period. 9. 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. 			
O	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.			
	Applicant/Parent or Legal Guardian Signature	Date	Applicant Spouse Signature (if applying for coverage)	Date
P	Broker Information (if applicable)			
	Primary Broker Code		Producer Broker Code	
	Primary Broker Name		Producer Name	
	Telephone Number		Telephone Number	
Q	IBC Sales Representative (if applicable)			
	Sales Representative Code		Name of Sales Representative	



Independence Blue Cross offers a **free** electronic premium payment service. You authorize the withdrawal of your total amount due from your checking or savings account, and Independence Blue Cross will deduct your payment through the ACH (Automated Clearing House) process. With the electronic premium payment service, there's no need to wait for your invoice to come or mail payments each month. Payment is automatic and always on time.

Why should I sign up for electronic payments?

- no checks to write
- no missed due dates
- no worrying about paying premiums when away from home
- no stamps to buy
- no sign-up fees
- no transaction fees

Sign up for electronic payments today and make paying your premium easy.

ACH Authorization Form

Important instructions:

1. Complete and sign this form.
2. Attach a voided check (for checking accounts) or deposit slip (for savings accounts).
3. Return this form with your application in the postage-paid reply envelope provided.

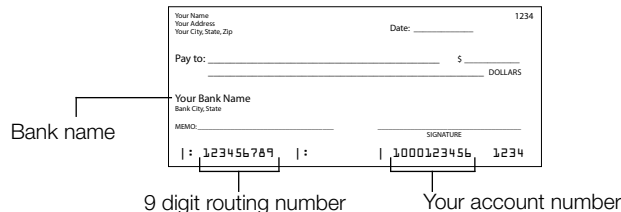
Note: Your payment will not be processed until your coverage is approved.*

I (we) authorize my bank or savings institution to make payments to Independence Blue Cross from the account listed below. I (we) understand this authorization may be revoked by me at any time, by written notification, to discontinue my automatic payment. I (we) agree to maintain sufficient funds in the account to permit these deductions. If the account does not maintain sufficient funds, electronic payments will be cancelled and I (we) will be billed through the postal service (regular mail). All plan termination notices should be sent to: Independence Blue Cross, Billing Department, P.O. Box 13828, Philadelphia, PA 19101-3828.

Name on bank account: _____ Bank routing/transfer number: _____

Relationship to applicant: _____ Bank account number: _____

Name of financial institution: _____



The diagram shows a voided check with the following fields and labels:

- Your Name
- Your Address
- Your City, State, Zip
- Date: _____
- 1234
- Pay to: _____ \$ _____ DOLLARS
- Your Bank Name
- Bank City, State
- MEMO: _____
- SIGNATURE _____
- 1234
- 9 digit routing number
- Your account number

Type of account: Checking Statement savings (No passbook accounts)

Bank account usage: Personal Business

Account holder signature: _____ Date: _____

Additional signature (if joint account): _____ Date: _____

Signature of applicant: _____ Date: _____
(if different than account holder)

*Final rate quote and approval of coverage is dependent on medical underwriting. Approval is not guaranteed, and some applications may not be approved based on medical conditions.

