

# INDIVIDUAL COVERAGE APPLICATION FORM

PLEASE TYPE OR PRINT BOLD

## 1. ENROLLMENT INFORMATION

(Please complete your name and address if information below is missing or incorrect)

FOR OFFICE USE ONLY		
IDENT. No.		
GR NO	TR DT	REAS
BC EFF	PR ST	ORIG
BS EFF	TC	

Last Name	First Name	MI
Street Address		
City	State	Zip Code

HOME PHONE: (     ) \_\_\_\_\_ **If current member, please provide Identification Number:** \_\_\_\_\_

## 2. COVERAGE INFORMATION

Please check the coverage you want:

**Combinations: (see brochure for descriptions of each)**

- Premier     Standard  
 High         Basic

-or-

**Blue Cross Hospitalization Plans:**

- Co-Pay Preferred  
 \$500 Co-Payment  
 \$1000 Co-Payment

**Blue Shield Medical/Surgical Plans:**

- Plan 100     Plan 5000S  
 Plan C        Plan 1800S

**Major Medical**

- You must have both Blue Cross and Blue Shield coverages as an individual Subscriber to be eligible for Major Medical.

## 3. PERSONS TO BE COVERED

**(Please Print)** Please complete the following information regarding yourself and dependents to be covered.

Dependents include your spouse, dependent children (under age 19) and eligible handicapped children over 19. **Attach a separate list for additional dependents if needed.**

Name (include last name if different from applicant) Last      First      MI	SEX	DATE OF BIRTH			SOCIAL SECURITY NUMBER	HANDICAPPED Children (Over Age 19)
		Mo.	Day	Yr.		
Self	<input type="checkbox"/> M <input type="checkbox"/> F					N/A
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F					N/A
	<input type="checkbox"/> M <input type="checkbox"/> F					
	<input type="checkbox"/> M <input type="checkbox"/> F					
	<input type="checkbox"/> M <input type="checkbox"/> F					

Please answer the questions below:

**A. Do any of the persons listed above have health insurance with a Blue Cross & Blue Shield Plan, or any other insurance company?**     Yes     No

If YES, do you wish to replace this coverage with Independence Blue Cross and Highmark Blue Shield?

(Please see reverse side Section 1)     Yes     No

If NO, do you understand that the Company will not pay benefits during the first 12 months of the policy for any medical condition or illness for which medical advice or treatment was recommended or received within the 5 year period preceding the effective date of coverage?     Yes     No

**B. Do any of the persons listed above have any other health insurance?**     Yes     No

If you answered Yes to Questions A or B above, please provide:

Name of Insured	Name of Plan	Location of Plan (City, State)	Identification or Policy No.
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Please indicate if you or your spouse are enrolled in Medicare Part A or Part B:

	PART A	EFFECTIVE DATE	PART B	EFFECTIVE DATE	MEDICARE CLAIM NUMBER
Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	-   -	<input type="checkbox"/> Yes <input type="checkbox"/> No	-   -	
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	-   -	<input type="checkbox"/> Yes <input type="checkbox"/> No	-   -	

## 4. PRIOR INSURER

- No Prior Insurance     Mutual of Omaha     State Farm     Aetna/U.S. Healthcare     Prudential     Other  
 Blue Cross/Blue Shield NJ     Oxford     American Republic     Qual Med     Time

## 5. PLEASE READ THE REVERSE SIDE OF THIS FORM, THEN SIGN AND DATE BELOW:

*The data supplied on the application is accurate and complete to the best of my knowledge and I have read and agree to the terms set forth on the reverse side of this form.*

Sign Here → SIGNATURE OF APPLICANT: \_\_\_\_\_ DATE: \_\_\_\_\_

# IMPORTANT --- Please read carefully

## 1. NOTICE OF PRE-EXISTING CONDITION(S) EXCLUSION

Independence Blue Cross and Highmark Blue Shield will not pay benefits during the first 12 months of the policy for charges related to any medical condition or illness for which medical advice or treatment was recommended or received within a 5-year period preceding the effective date of coverage, unless you and your dependents have been enrolled in a Blue Cross and Blue Shield Plan, or an affiliate of Independence Blue Cross for a period of 12 months and are transferring directly without a break in coverage.

## 2. DECLARATION

*I elect coverage under the plan specified on the reverse side of this form for the persons listed on the reverse side and agree to abide by the conditions of the agreement and pay required premiums for the plan as selected. Applicant and my listed eligible dependent(s) authorize any hospital, physician, or other health care provider to furnish Independence Blue Cross and Highmark Blue Shield, its assignee or designee, with such medical information about the applicant and dependent(s) listed on the application as Independence Blue Cross and Highmark Blue Shield may require for claims payment, utilization review, quality assurance or in fulfillment of obligations imposed by applicable state or federal law. I understand that my coverage(s) will become effective upon the Corporations' approval of my Application. I understand and agree that: (1) the agreement(s) may contain(s) certain waiting periods; (2) the agreement(s) shall be binding on Independence Blue Cross and Highmark Blue Shield only if all of my statement(s) are complete and true.*

## 3. GENERAL INFORMATION

Please keep this copy as verification of your application until you receive an identification card. As soon as your enrollment becomes effective, you will be eligible for the benefits available under your benefit program.

## 4. NOTICE REGARDING FRAUDULENT INFORMATION

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.

## 5. PLEASE NOTE:

If you must provide coverage for a child not living with you due to a court order please contact us for the appropriate paperwork.

**Please return this Application  
in the Enclosed Postage-Paid Envelope!**

**Send No Money Now - We Will Bill You Later.**



**Independence  
Blue Cross  
Highmark  
Blue Shield**

**1901 Market Street, Philadelphia, PA 19103-1480  
Independent Licensees of the Blue Cross and Blue Shield Association.**