INDIVIDUAL COVERAGE PERSONAL CHOICE
APPLICATION FORM
PLEASE TYPE OR PRINT

1. ENROLLMENT INFORMATION (Please complete your name and address if information below is missing or incorrect.)

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

Requested Effective Date of Coverage*: ___ ___ / ___ ___ / ___ ___ ___ ___

*The requested effective date cannot be guaranteed and cannot be more than 30 days prior to the receipt of the application.

Last name | First name | MI

Email: ______________________ Street address

Home phone: (_____) ______________________ City | State | ZIP

If you are a current member, please provide your identification number: ______________________

2. COVERAGE INFORMATION

Coverage underwritten by QCC Insurance Company.

Please check the coverage you want:

❑ **PPO Value HSA** ❑ Yes, I'd like an HSA account set up through Bancorp. Please send Bancorp my information.

❑ **PPO Basic I** ❑ **PPO Basic II** ❑ **PPO HospitalCare I** ❑ **PPO HospitalCare II** ❑ **PPO HospitalCare III**

3. PERSONS TO BE COVERED

Please complete the following information regarding yourself and dependents to be covered. Dependents include your spouse, dependent children (under age 26), and eligible handicapped children over age 26. **Attach a separate list for additional dependents, if needed.**

NAME (included last name if different from applicant) Last First MI	SEX		DATE OF BIRTH			SOCIAL SECURITY NUMBER	HANDICAPPED CHILDREN (Over Age 26)
			MM	DD	YY		
Self	❑ M	❑ F					N/A
Spouse	❑ M	❑ F					N/A
	❑ M	❑ F					
	❑ M	❑ F					
	❑ M	❑ F					

Please answer the questions below:

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

B. Do you have any other accident and health insurance in force? ❑ **Yes** ❑ **No**

C. If yes, do you intend to replace your current accident and health insurance with this insurance? ❑ **Yes** ❑ **No**

(Please see Section 1 on the reverse.)

4. PRIOR INSURANCE

Was your prior insurance through: ❑ Employer/group ❑ Individual plan

Who was your prior Insurer? ❑ No prior insurance ❑ Blue Cross/Blue Shield ❑ Aetna ❑ Assurant ❑ Celtic ❑ Coventry ❑ CIGNA ❑ Health America ❑ United HealthCare ❑ Other ______________________

How long has it been since you were insured? ❑ Currently insured ❑ 1 – 3 months ❑ 3 – 6 months ❑ 7 – 11 months ❑ 1 – 2 yrs ❑ 2+ yrs ❑ Never

What is your primary reason for applying for health care coverage?

❑ No longer covered under employer plan
❑ Unemployed
❑ Self-employed
❑ New job, waiting for benefit eligibility
❑ Dependent, no longer covered under parent's plan
❑ Employer doesn't offer health insurance
❑ Not satisfied with current plan
❑ Other

5. IMPORTANT! READ THE REVERSE SIDE OF THIS FORM, BEFORE SIGNING AND DATING BELOW

The information 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.

SIGNATURE OF APPLICANT: ______________________ DATE: _____/_____/_____

IMPORTANT — PLEASE READ CAREFULLY

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

QCC Insurance Company ("Company") 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 12-month period preceding the effective date of coverage. *This preexisting condition exclusion does not apply to you or to any of your dependents (a) previously enrolled in any Blue Cross or Blue Shield policy, or in a policy of an affiliate of the Company, for a period of 12 months and are transferring directly without a break in coverage and (b) to an enrollee under the age of 19.*

2. DECLARATION

I elect coverage under the plan specified on this application for the persons listed on the reverse side and agree to abide by the conditions of the policy and pay required premiums for the plan as selected. I and my listed eligible dependent(s) authorize any hospital, physician, or health care provider to furnish the Company, its assignee of designee, with such medical information about the applicant and dependent(s) listed on the application as the Company may require for claims payment, utilization review, quality assurance, or fulfillment of obligations imposed by applicable state or federal law. I understand that my coverage will become effective upon the approval of my Application. I understand and agree that: (1) the policy contains a pre-existing condition exclusion; (2) the policy shall be binding on the Company only if all of statement(s) are complete and true.

3. 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 purposes 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.

4. CONDITIONS OF ENROLLMENT

I understand that if I and my dependents receive care from Non-Network Providers (Non-Participating Health Care Facilities and Non-Participating Professional Providers), except for emergencies, I will be responsible for higher Non-Network deductibles and coinsurance, and in some cases, the entire cost of the care.

5. SUBSCRIBER INFORMATION

PLEASE NOTE: Most elective admissions require Pre-Admission Certification. Services that are rendered by Non-Network Providers are subject to deductible and coinsurance provisions. See your contract for details about your coverage, its limitations and exclusions, or call Personal Choice Customer Service at 1-800-ASK-BLUE (1-800-275-2583). Inquiries about your coverage should include your name, identification number, group number, and home address.

6. 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.

1901 Market Street, Philadelphia, PA 19103-1480

Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

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