APPLICATION FOR PERSONAL BLUE℠

1. Complete the application and sign PART THREE.
2. Please include a check for your first month's premium — you'll have 30 days to review coverage with no obligation.

P.O. Box 61153, Columbia, SC 29260-1153
www.SouthCarolinaBlues.com

PART ONE (Please PRINT IN INK)

SECTION A - APPLICANT INFORMATION

GO PAPERLESS – Would you like to receive your explanations of benefits electronically? ☐Yes ☐No If "Yes," an e-mail address is required.

Requested Effective Date:____/____/____

(Effective dates must be either the 1st or the 15th of the month.)

☐ Optional Family Coverage – must have family members at time of application.
This coverage is available to applicants age 19 and older. Applicants under age 19 may only be added if the Optional Family Coverage is purchased.

As of the requested effective date, will you and every person listed on the application be a resident of South Carolina? ☐ Yes ☐ No
(Only South Carolina residents are eligible for coverage.)

Are you and every person listed on the application a United States Citizen? ☐ Yes ☐ No
If no, provide a copy of your Green Card or parent/guardian/spouse Green Card or Visa.

Last Name: _____ First Name:_____ M.I.:_____ ☐ Male ☐ Female

Date of Birth: ____/____/____ Telephone Number: Home/Cell: (____)_____ Work: (____)_____

Social Security Number: ☐☐☐- ☐☐- ☐☐☐☐

Street Address: _____

City: _____ State: _____ ZIP: _____ E-mail Address:_____

Billing Address for Premium Notices. (Complete only if different from above).

Street Address: _____

City: _____ State: _____ ZIP: _____

Place of Employment: _____Occupation:_____

Personal BluePlan℠ SE

☐ Plan 1 ☐ Plan 2

Coinsurance Options (Select One): ☐ 90%/70% ☐ 70%/50% ☐ 80%/60% ☐ 60%/40%

Deductible Options (Select One): ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $3,000 ☐ $5,000 (N/A with Plan 1)

Out-of-Pocket Maximums (Select One): ☐ $1,500/$3,000 ☐ $2,500/$5,000 ☐ $3,000/$6,000 ☐ $5,000/$8,000

Choose Optional Benefit: ☐ Dental

Personal BluePlan℠ High Deductible SE

Select your Benefit Period:

☐ Begins on date coverage goes into effect and lasts 365 days except for a leap year. ☐ Calendar Year (January 1 – December 31)

Select your plan:

Single Coverage:

Deductible:	Coinsurance:	Out-of-pocket Maximum: In-network	Out-of-Network
☐ $1,500	100%/60%	$1,500	$3,000
☐ $2,600		$2,600	$5,200
☐ $3,500		$3,500	$5,500
☐ $5,000		$5,000	$10,000
☐ $1,500	80%/60%	$3,000	$4,500
☐ $2,600		$5,200	$7,800
☐ $3,500		$5,500	$7,500
☐ $1,500	70%/50%	$3,000	$4,500
☐ $2,600		$5,200	$7,800
☐ $3,500		$5,500	$7,500

Family Coverage:

Deductible:	Coinsurance:	Out-of-Pocket Maximum: In-network	Out-of-network
☐ $3,000	100%/60%	$3,000	$6,000
☐ $5,200		$5,200	$10,400
☐ $7,000		$7,000	$11,000
☐ $10,000		$10,000	$20,000
☐ $3,000	80%/60%	$6,000	$9,000
☐ $5,200		$10,400	$15,600
☐ $7,000		$11,000	$15,000
☐ $3,000	70%/50%	$6,000	$9,000
☐ $5,200		$10,400	$15,600
☐ $7,000		$11,000	$15,000

Personal Blue℠ Secure SE

Coinsurance Options (Select One): ☐ 80%/60% ☐ 70%/50% ☐ 60%/40% ☐ 50%/50%

Deductible Options (In-Network/Out-of-Network) (Select One):
☐ $1,250/$2,500 ☐ $1,750/$3,500 ☐ $2,250/$4,500 ☐ $3,250/$6,500 ☐ $4,250/$8,500 ☐ $5,250/$10,500

Out-of-Pocket Maximum (In-Network/Out-of-Network) (Select One):
☐ $1,750/$3,500 ☐ $2,250/$4,500 ☐ $3,750/$7,500 ☐ $5,250/$10,500

Choose Optional Benefit: ☐ Dental/Vision

Personal Blue℠ Basic SE

Single Coverage:

Deductible: (In/Out)	Coinsurance:	Out-of-pocket Maximum: In-network	Out-of-Network
	80%/60%		
☐ $500/$1,500		Unlimited	Unlimited
☐ $1,000/$3,000		$5,000	$10,000
☐ $1,500/$4,500		$6,000	$12,000
☐ $2,500/$5,000		$7,500	$15,000
	70%/50%		
☐ $5,000/$10,000		Unlimited	Unlimited
	60%/40%		
☐ $500/$1,500		$5,000	$10,000
☐ $1,000/$3,000		$5,000	$10,000
☐ $1,500/$4,500		$6,000	$12,000

Family Coverage:

Deductible: (In/Out)	Coinsurance:	Out-of-Pocket Maximum: In-network	Out-of-network
	80%/60%		
☐ $1,500/$4,500		Unlimited	Unlimited
☐ $3,000/$9,000		$10,000	$20,000
☐ $4,500/$13,500		$12,000	$24,000
☐ $5,000/$10,000		$15,000	$30,000
	70%/50%		
☐ $10,000/$20,000		Unlimited	Unlimited
	60%/40%		
☐ $1,500/$4,500		$10,000	$20,000
☐ $3,000/$9,000		$10,000	$20,000
☐ $4,500/$13,500		$12,000	$24,000

Choose Optional Benefit: ☐ Dental/Vision

SECTION B – BANKING INFORMATION

☐ Monthly Bank Draft - Voided Check (not deposit slip) and Authorization Form required.
☐ Monthly Direct Bill
☐ List Bill: (through your employer): List Bill Account Number: _____
☐ Monthly Credit Card

FOR USE BY BLUECROSS ONLY	
Bank Number	
Account Number	

SECTION C - FAMILY INFORMATION – IF OPTIONAL FAMILY ENDORSEMENT IS SELECTED

Coverage is available for Dependent children through age 25.
List dependents to be insured

Last Name	First Name	M.I.	Social Security Number	Sex	Birthdate	For Office Use Only Rider
Spouse:			☐☐☐-☐☐-☐☐☐☐		/ /	
Child:			☐☐☐-☐☐-☐☐☐☐		/ /	
Child:			☐☐☐-☐☐-☐☐☐☐		/ /	
Child:			☐☐☐-☐☐-☐☐☐☐		/ /	

☐ **Check here if others are to be insured. List all pertinent information on another sheet.**

PART TWO

SECTION A - HEALTH HISTORY

Applicant's Height:	Applicant's Weight:	Spouse's Height:	Spouse's Weight:
Any weight change in the last 12 month? ☐ Yes ☐ No		Any weight change in the last 12 month? ☐ Yes ☐ No	
Lbs. Gained:	Lbs. Lost:	Lbs. Gained:	Lbs. Lost:
Reason:		Reason:	

SECTION B - DETAILS TO HEALTH HISTORY

In the last 10 years, have you or any person listed on the application had a diagnosis of, advice for, testing for, indication of, symptoms related to, treatment or surgery for, or any injury related to any of the following?

	YES	NO
A. Heart or circulatory system, high blood pressure, heart attack, chest pain, stroke, heart murmur, irregular heartbeat, varicose veins, phlebitis, poor circulation or high cholesterol or triglycerides.	☐	☐
B. Lung, respiratory system, shortness of breath, sleep apnea, asthma, hay fever or other allergies, sinusitis, persistent cough, tuberculosis, emphysema, pneumonia, recurrent or persistent bronchitis or cystic fibrosis.	☐	☐
C. Genital or urinary system, kidney stones, prostate, urinary tract infection, blood in urine, infertility, sexual/reproductive organs, sexually transmitted disease, complications of pregnancy, breast condition, endometriosis, fibroids, abnormal Pap smear or menstrual disorder.	☐	☐
D. Digestive system, gallbladder, pancreas, hepatitis (type), liver, spleen, colon, reflux, gastritis, intestinal condition, colitis, stomach, intestinal or rectal bleeding, hemorrhoids, hernia (type) or ulcer (type).	☐	☐
E. Muscular or skeletal system, fibromyalgia, connective tissues, lupus, polio, back, joints, bones, muscles, gout, arthritis, amputation or fracture (indicate location, joint involved and location of any screws, pins or plates).	☐	☐
F. Nerves or nervous system, frequent or severe headaches, migraines, seizures, convulsions, fainting, dizziness, multiple sclerosis, cerebral palsy, paralysis, insomnia, stress, anxiety, depression, obsessive compulsive disorder, attention deficit/hyperactivity disorder or any other mental or emotional condition.	☐	☐
G. Eye, ear, nose, throat, tonsils, mouth, palate, teeth or jaw.	☐	☐
H. Any type of cancer, tumor, cyst, polyp, skin condition or rash, thyroid, goiter, endocrine disorder, spleen, anemia, hemophilia, bone marrow, leukemia or any other blood condition. ☐ Benign ☐ Malignant	☐	☐
I. Diabetes, elevated blood sugar, insulin resistance, metabolic syndrome, gestational diabetes or presence of any protein, albumin or sugar in the urine.	☐	☐
J. Alcohol or drug dependency or abuse, use of any illegal drugs or substances (includes counseling) or use of prescription drugs not prescribed to you.	☐	☐
K. Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex or ever tested positive for the HIV virus.	☐	☐
L. Unexplained, sudden or surgical weight loss, eating disorders, night sweats, persistent fever, fatigue, persistent infection or lymph node enlargement.	☐	☐
M. Any other abnormality, surgery, deformity, developmental defect or delay, anomaly, congenital disorder, or any abnormal lab or test results.	☐	☐

1. In the last 5 years, has any person listed on this application:
   A. Had any symptoms of or concern with any physical, mental or emotional condition for which a doctor has not been seen, or for which treatment, follow-up or testing has been advised or discussed but not already disclosed in this application?..... ☐ Yes ☐ No
   B. Seen a doctor (including physical exams, lab work or testing), been hospitalized, institutionalized or had an accident or injury not already disclosed on this application?..... ☐ Yes ☐ No
2. Is person applying for coverage expecting a child or in the process of adoption, whether or not the mother is listed on the application?..... ☐ Yes ☐ No
3. In the last 12 months, has any person on this application taken any prescription drugs or daily non-prescribed drugs? ..... ☐ Yes ☐ No
4. In the last 5 years, has any person on this application smoked tobacco, used any tobacco product, or used any product containing nicotine? ..... ☐ Yes ☐ No
   Date started:_____ Packs per day:_____ Date Stopped:_____

NOTE: If you answered, "Yes" to any questions in Part Two, Section B, complete the chart below. For more room, attach a sheet of paper, sign and date it.

Question Letter/ Number	Patient's Name	Condition, Injury, Symptom or Diagnosis	Date of Onset	Date of Recovery	Date Last Seen	Treatment, X-ray, Labs, Surgery, Medication & Dosage	Physician Name, Address, Telephone Number

SECTION C - OTHER INSURANCE INFORMATION

1. Do you or does any member of your family to be insured have other health insurance coverage, including Medicare, Medicare Advantage or TRICARE in force within the last six months? ☐Yes ☐ No
   A. If you answered "Yes" to 1, will this policy replace that health insurance? ☐Yes ☐ No
   B. Other Coverage Effective Date:_____ Other Coverage Termination Date:_____
   C. Provide a copy of the other carrier's Certificate of Creditable Coverage as soon as possible.

2. Have you or any member of your family to be insured been insured by Blue Cross and Blue Shield of South Carolina or BlueChoice® HealthPlan of South Carolina, Inc., in the last 3 years? ☐Yes ☐ No
   If "Yes," who and under what identification number? _____

Remarks: _____

PART THREE

SECTION A - AUTHORIZATION AND AGREEMENTS – READ CAREFULLY BEFORE SIGNING

The undersigned authorize(s) release to Blue Cross and Blue Shield of South Carolina (Corporation) or its representatives of (1) All past and future medical records and other information deemed necessary by the Corporation to underwrite this application and to process claims and (2) All Medicare Part A and Part B claims information from the effective date of any coverage which may be approved pursuant to this application until the termination of such coverage for the purpose of processing claims.

It is fully understood and agreed (1) That the Corporation has the right to accept, rider, charge an additional premium to or reject any person applying for coverage in this application, subject to the Patient Protection and Affordable Care Act and (2) If the Corporation approves coverage, the Corporation will determine the effective date of such coverage, and (3) That no insurance coverage shall be in force until the Corporation receives the application, approves coverage and assigns the date on which coverage shall become effective, and (4) If coverage is approved, the undersigned will receive a certificate and identification card(s) from the Corporation, and (5) That any premium submitted herewith may be retained by the Corporation pending approval of coverage. If any coverage is approved, the Corporation will retain the premiums thereof. If no coverage is approved, the Corporation will return any premium.

The undersigned hereby expressly acknowledges understanding this policy constitutes a policy solely with Blue Cross and Blue Shield of South Carolina, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The "Association" permits Blue Cross and Blue Shield of South Carolina to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and Blue Cross and Blue Shield of South Carolina is not contracting as an agent of the Association. The undersigned further acknowledges and agrees to have not entered into this policy based on representations by any person other than Blue Cross and Blue Shield of South Carolina. No person, entity or organization other than Blue Cross and Blue Shield of South Carolina shall be held accountable or liable to the undersigned for any of Blue Cross and Blue Shield of South Carolina's obligations created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of South Carolina other than those obligations created under other provisions of this agreement.

The undersigned hereby represent(s) that the information on this application and any other information furnished by the undersigned is complete, true and correctly recorded.

SECTION B - SIGNATURE(S)

I have read and I fully understand each and every part of this application for insurance. Applications received more than 10 days after the signature date may not be considered.

X _____

Applicant's Signature Date Signed

NOTE: If Applicant Is A Minor, A Parent Or Legal Guardian Must Sign. If Legal Guardian Is Signing, Please Attach Legal Documents.

X _____

Spouse's Signature *(Only Required If Applying For Coverage)* Date Signed

_____

Agent's Name (Please Print)

X _____ ☐☐☐ - ☐☐☐

Agent's Signature Date Signed Agent's Code

AUTHORIZATION AGREEMENT FOR BANK DRAFT PAYMENTS

☐ **Bank Draft** Bank Name:_____ Bank Routing Number:_____

City:_____ State:_____ ZIP:_____

My Account No.:_____ Name on Account:_____

☐ **Credit Card** ☐ Visa ☐ Master Card ☐ Discover Expiration Date:_____

My Account No.:_____ Name on Account:_____

If you choose Bank Draft/Credit Card Payments, complete the authorization agreement below and attach a voided check, if applicable.

Corporation Name: Blue Cross and Blue Shield of South Carolina Corporation ID Number: 320396492

I authorize Blue Cross and Blue Shield of South Carolina to initiate debit/charge entries to my checking account/credit card below and the Bank/Corporation named to debit/charge my account.

This authority is to remain in force until the Bank/Corporation has received written notification from me of its termination in such time and such manner as to afford the Bank/Corporation a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notifying the Bank/Corporation prior to charging the account. If Blue Cross and Blue Shield of South Carolina initiates an erroneous debit entry to a customer's account, the customer shall have the right to have the amount of the entry credited to his/her account by the Bank/Corporation. If, within 15 calendar days following the date on which the Bank/Corporation sent to the customer a statement of account or written notice pertaining to the entry or 46 days after posting, whichever occurs first, the customer shall have sent to the Bank/Corporation a written notice identifying the entry, stating that the entry was in error and requesting the Bank/Corporation to credit the amount to his/her account.

Your Name:_____ I.D.#_____

Signed: X_____ Date:_____

FOR USE BY BLUECROSS

Effective Date	Approved	Ridered

For additional applications, or answers to any questions, please call toll free:

1-800-868-2500, ext. 46401

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FOR UNDERWRITING

This authorization is only needed if you are applying for a Personal Blue℠ Policy.

Please complete this form and send it to the following address if you have been seen by a licensed medical provider within the last 10 years:

Group & Individual Privacy Underwriting (AX-H05)
BlueCross® BlueShield® of South Carolina
I-20 East at Alpine Road
Columbia, SC 29219-0001
Fax: (803) 264-0251

Section 1: Authorization – I authorize my past or present treating physicians/hospitals/clinics, licensed medical providers, pharmacies, and/or pharmacy-related service organizations to disclose to BlueCross BlueShield of South Carolina ("BlueCross"), or its designated agent, my protected personal health information concerning symptoms or conditions for which I may have been treated or given advice for, but does not include psychotherapy notes, in the 10 years prior to my signing this authorization. I further authorize BlueChoice® HealthPlan of South Carolina to disclose to BlueCross, my electronic claims history for the same time period, if any. I understand this authorization is voluntary. However, BlueCross reserves the right to deny enrollment or eligibility for benefits if I refuse to sign this form.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

Section 2: Purpose – The purpose of this authorization is for BlueCross to obtain copies of documents related to my medical history in order to determine eligibility before enrollment, and the requested use or disclosure does not include psychotherapy notes.

Section 3: Options for Disclosures – Disclosure may occur by sending copies of documents concerning my medical history in the 10 years prior to my signing this form by U.S. mail, by fax, hand delivery or by an electronic transmission.

Section 4: Expiration and Revocation – **Expiration**: This authorization will expire: 1) upon the effective date of my enrollment with BlueCross; or 2) upon BlueCross' denial of coverage; or 3) upon my written revocation, whichever occurs first. **Revocation**: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above.

BlueCross will condition my eligibility for insurance based on whether or not I sign this form. I understand that revocation of this authorization will not affect any action BlueCross took in reliance on this authorization before BlueCross received my notice of revocation.

Section 5: Signature – I, the undersigned, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction.

Print Applicant's Name:_____

Applicant's Social Security No.: ☐☐☐-☐☐-☐☐☐☐ Spouse's Social Security No.: ☐☐☐-☐☐-☐☐☐☐

List Dependents to be included in this Authorization to Disclose Protected Health Information for Underwriting:

Name:_____D.O.B.____/___/____Name:_____D.O.B.___/___/____

Name:_____D.O.B.____/___/____Name:_____D.O.B.___/___/____

Signature:_____Print Name:_____Date: ____/___/____

Spouse's Signature:_____Print Name:_____Date:____/___/____
(If Applying for Coverage)

Please Note: If this authorization is for a Dependent age 16 or over, that dependent must sign below.

Dependent's Signature:_____Print Name:_____Date:____/___/____
(If Applying for Coverage and Age 16 or Over)

You are entitled to a copy of this Authorization Form