Print

Health/Dental PPO/Life

Health/Dental PPO

Health Only

Dental PPO Only

Dental HMO Only

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Physical Questionnaire

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Blue Options TIP

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Life Insurance

# For Internal Data Entry Use Only - Do Not Print Page

## Enrollment Type

☐ New Business ☐ Upgrade ☐ Add-On ☐ Reinvite

## Applicant Information

First Name MI Last Name

Home Address

City St Zip

*Washington*

County

Home Phone Work/Cell Phone Email Address

Date of Birth Age Ht Wt

SSN

Applicant Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of FL Residence

Date of US Residence

| First Name, MI, Last Name (Last Name if Different from Applicant | Social Security Number | Age | Date of Birth Mo./Day/Yr. | Ht | Wt | Sex | Relationship to Applicant |
|---|---|---|---|---|---|---|---|
| | | | | | | ☐ M ☐ F | ☐ Spouse ☐ Domestic |
| | | | | | | ☐ M ☐ F | ☐ Son ☐ Daughter ☐ Other |
| | | | | | | ☐ M ☐ F | ☐ Son ☐ Daughter ☐ Other |
| | | | | | | ☐ M ☐ F | ☐ Son ☐ Daughter ☐ Other |

## Product Selection

☐ BlueOptions Plan # _____

☐ BlueSelect Plan # _____

☐ MyBasic Plan # _____

☐ BlueChoice Plan # _____

☐ Miami-Dade Plan # _____

Deductible _____

Out of Pocket _____

Coinsurance _____

Maternity: ☐ Yes ☐ No

If Yes: ☐ Copay ☐ Deductible ($1,500)

Integrated Rx (HSA) ☐ Yes ☐ No

## Premium/Billing Information

Select Billing Mode (Months):

☐ APO

☐ 1 ☐ 3 ☐ 6

☐ 2 ☐ 4 ☐ 12

Applicant Premium _____

Spouse Premium _____

Dependent Premium _____

Dependent Premium _____

Dependent Premium _____

Months Premium Collected for: 2

## Additional Information

Has the Applicant, Spouse/ Domestic Partner, or any dependent age 18 or older used tobacco in any form (e.g., cigarettes, cigars, pipes, snuff or chewing tobacco) in the past 12 months? in any form? ☐ Yes ☐ No

If yes, please identify person: ☐ Applicant ☐ Spouse ☐ Dependent

Name(s):

Will this policy replace any other hospital or medical insurance or HMO coverage (including group coverage) currently in force? ☐ Yes ☐ No

Will this policy replace any dental insurance currently in force? ☐ Yes ☐ No

Do you currently have or are you applying for a temporary insurance policy with Blue Cross and Blue Shield of Florida? ☐ Yes ☐ No

## Agent Information

Agent Name Agent Number License Number Keycode

Agency Name Agent Phone Ext. Fax Number

Agency Address

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

Dear:

Thank you for your interest in Blue Cross Blue Shield of Florida, Inc. ***This package contains time sensitive material and it is important for you to promptly review your application forms for accuracy and return immediately in the enclosed, pre-paid envelope.***

**In the event you need to change any of the information on the application forms, do not use any correction fluid such as whiteout as this will invalidate the application.** Simply draw a single line through the incorrect information and write the correct information above, below or beside it. Note: Application signatures and dates cannot be altered or changed. You, the applicant, must initial and date all corrections. If an interpreter is used, the interpreter must sign and date beneath the applicant's signature. Follow the checklist below during the review of your application so that we may expedite its processing once received back in our office.

- **USING BLUE OR BLACK INK**, sign and date the enclosed enrollment application forms where indicated by the Xs. **PLEASE NOTE:** All signatures and dates must be the same and cannot be altered.

- **OTHER:**_____

  _____

  _____

- **PLEASE ENCLOSE A CHECK OR MONEY ORDER** for $0.00 plus a voided check if applicable based on the period of coverage selected, adding your Social Security to the memo line of the check. Also include a check for $0.00 if applicable for the Temporary Insurance premium. A rate calculation sheet for one month's premium amount is included in this package.

- Your check or money order should be **payable to Blue Cross Blue Shield of Florida, Inc.**

- For your convenience and due to the time sensitive nature of the application process, we have included a pre-paid, pre-addressed US Postal service envelope or Return Fed Ex package.

**To help you understand the application process we have included information below to explain how it works.**

**Step 1: Underwriting Review**
Our individual under 65 products are *medically underwritten* which means we review your medical information to determine risk. Coverage and premiums are based on that assessment which is part of what enables us to offer our products to a broad spectrum of the population. Many applicants and their dependents qualify for coverage on a standard basis.

**IT IS IMPORTANT TO REMEMBER THE UNDERWRITING PROCESS CAN TAKE ANYWHERE FROM SIX TO EIGHT WEEKS, DEPENDING ON HOW SOON INFORMATION NEEDED IS RECEIVED.**

**Step 2: The Decision**
We will notify you of our decision and any premium rate change if applicable. Those accepted can expect to receive their contract and identification cards approximately seven days after their application is approved. If a medical exclusion rider is required as a result of our risk assessment, you will be asked to sign a rider form. If an additional rating is required, your contract will include the Rate Modification Endorsement and your billing notices will reflect the additional premium. If your application is not accepted, your premium check will be returned.

If you need assistance of have any questions prior to returning your signed application, please call us at ext: from 8 a.m. to 6 p.m., Monday through Friday.

Sincerely,

# RATE CALCULATION SHEET - INDIVIDUAL PRODUCTS

BlueCross BlueShield of Florida

**Applicant Name:** **SSN:**

**Applicant Address:**

**Agent's Name:** **Agent #:**

**County Code:** *Washington* 69

**Deductible Option:**

**OOP Option:**

**Child Only:**

**Maternity Benefit:** ☐ Yes ☐ No

If Yes: ☐ Copay ☐ Deductible ($1,500)

**Product:**
- ☐ BlueOptions Plan # _____
- ☐ BlueSelect Plan # _____
- ☐ MyBasic Plan # _____
- ☐ BlueChoice Plan # _____
- ☐ Miami-Dade Plan # _____

**Integrated Rx (HSA):** ☐ Yes ☐ No

**Tobacco Status Indicator:** ☐ Applicant ☐ Spouse ☐ Dependent Name(s) _____

*Home*

*Application*

| First Name, MI, Last Name (Last Name if Different from Applicant) | Age | Sex | Relationship to Applicant | Basic Premium |
|---|---|---|---|---|
| | | ☐ Male ☐ Female | Self | |
| | | ☐ Male ☐ Female | ☐ Spouse ☐ Domestic | |
| | | ☐ Male ☐ Female | ☐ Son ☐ Daughter ☐ Other | |
| | | ☐ Male ☐ Female | ☐ Son ☐ Daughter ☐ Other | |
| | | ☐ Male ☐ Female | ☐ Son ☐ Daughter ☐ Other | |

| | |
|---|---|
| **Total Monthly Premium:** | $0.00 |
| 2 **Months Total:** | $0.00 |

This information is intended solely for _____.
If you are not _____, this information does not apply to you. The rate shown, which is based on the information provided by _____, is subject to change and is not a guarantee of coverage. Also, coverage is not effective until after your application has been approved by BCBSF, a contract has been issued and the initial premium has been paid. No agent can make or change a contract term or waive any of the company's rights. The precise coverage afforded by any BCBSF insurance policy is subject to the terms and conditions of the policies as issued.

# INDIVIDUAL APPLICATION FOR HEALTH INSURANCE

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

**DO NOT WRITE IN SHADED AREA – FOR HOME OFFICE USE ONLY**

☐ AA ☐ NAA ☐ DEC

| Div. Code | Eff. Date | Cov. Code | Rider Code | U/W Date |
|---|---|---|---|---|
| | | | | |

| MEMBER # | SMOKER | RATING – CODE | RIDER # – CODE | DECLINE – CODE | COMMENTS |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**SUBMITTED BY:**

Writing Agent Name (please print) _____ Writing Agent Signature _____

Agency Name _____ Agency Address _____

Agency Telephone Number _____ Agency Code / Agent Code _____ Keycode _____

## PART I: ENROLLMENT INFORMATION

☐ NEW BUSINESS ☐ PRODUCT CHANGE ☐ RESUBMIT/INVITED
☐ ADD-ON ☐ UPGRADE (INVITATION MUST BE ATTACHED)

1. PRODUCT TYPE:
☐ BlueOptions Plan # _____
☐ BlueSelect Plan # _____
☐ Miami-Dade Blue (MDB) Plan # _____
☐ BlueChoice
☐ Dimension IV
☐ Essential Network
☐ MyBasic Plan # _____

BENEFIT OPTION SELECTED:
Deductible $ _____
Out-of-Pocket $_____
Coinsurance _____

MATERNITY: If BlueOptions, BlueSelect, MDB or MyBasic
☐ Yes ☐ No
If Yes: (Check One)
☐ Maternity Ded. $_____
☐ Copay Option (Additional Premium Required)

If HSA, Integrated Rx
☐ Yes ☐ No (Additional Premium Required)

2. BILLING MODE (Months):
☐ (Automatic Payment Option)
☐ 1 (Automatic Payment Option Only)
☐ 2, ☐ 3, ☐ 4, ☐ 6, ☐ 12

APPLICANT TO BE CONSIDERED FOR COVERAGE: Home Telephone | Work/Cell Telephone | E-mail Address:

This information is optional and is for data collection only. It will not determine eligibility, rating or claim payment.
Language Preference: ☐ English ☐ Spanish ☐ Other: _____

*Home*

| Social Security No. | LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE OF BIRTH |
|---|---|---|---|---|
| 3. | | | | |

| HOME ADDRESS (Include Apartment #, Lot # or Route #) P.O. Box should NOT be indicated | CITY |
|---|---|
| 4. | |

| COUNTY NAME | COUNTY CODE | STATE | ZIP | DATE OF RESIDENCY IN FLORIDA |
|---|---|---|---|---|
| *Washington* | 69 | | | |

OTHER MAILING ADDRESS IF DIFFERENT THAN IN QUESTION #4: ☐ Billing Only or ☐ Correspondence & Billing

5. Address: City: State: Zip:

6. MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed | Sex of Applicant: ☐ Male ☐ Female | Sex of Domestic Partner: ☐ Male ☐ Female

7. **LIST PERSONS TO BE CONSIDERED FOR COVERAGE:** Any person not listed below will not be considered. If Spouse/Domestic Partner is to be covered, list in 7.B. Domestic Partner coverage is available only on BlueOptions products.

| | FIRST NAME, MIDDLE INITIAL, LAST NAME (Last Name if Different from Applicant) | SOCIAL SECURITY NUMBER | AGE | DATE OF BIRTH Mo. / Day / Yr. | HEIGHT | WEIGHT | RELATIONSHIP TO APPLICANT | ZIP (if other than #4) |
|---|---|---|---|---|---|---|---|---|
| 7.A. | Applicant | Above | | Above | | | Self | |
| 7.B. | | | | | | | ☐ Spouse ☐ Domestic Partner | |
| 7.C. | | | | | | | ☐ Son ☐ Daughter ☐ Other | |
| 7.D. | | | | | | | ☐ Son ☐ Daughter ☐ Other | |
| 7.E. | | | | | | | ☐ Son ☐ Daughter ☐ Other | |

8. Has the Applicant, Spouse/Domestic Partner, or any dependent age 18 or older used tobacco in any form (e.g., cigarettes, cigars, pipes, snuff or chewing tobacco) in the past 12 months? ☐ Yes ☐ No
If "Yes", please identify person: ☐ Applicant ☐ Spouse/Domestic Partner ☐ Dependent

9.A. Will this policy replace any other hospital or medical insurance or HMO coverage (including group coverage) currently in force? ☐ Yes ☐ No
**(If "Yes", please complete and submit a Replacement of Insurance notice, form #8422, along with all applicable Certificates of Creditable Coverage.)**

9.B. Will this policy replace any dental insurance currently in force? ☐ Yes ☐ No **(If "Yes", please complete and submit a Replacement of Insurance notice, form #8422.)**

10. Do you currently have or are you applying for a temporary insurance policy with Blue Cross and Blue Shield of Florida? ☐ Yes ☐ No

Home

11. Are you or your spouse/domestic partner eligible for group coverage or are you or your spouse/domestic partner in an eligibility waiting period for group coverage?
Applicant: ☐ No ☐ Yes – Please explain: _____ ☐ BCBSF/HOI group ☐ Other Company
Spouse/Domestic Partner: ☐ No ☐ Yes – Please explain: _____ ☐ BCBSF/HOI group ☐ Other Company

12. APPLICANT'S EMPLOYMENT STATUS:
☐ Employed ☐ Not Employed* ☐ Self-Employed ☐ Fulltime Student ☐ Retired / Date of Retirement Mo. _____ Year _____
☐ Retired Early - Under Age 55 ☐ Yes* ☐ No
* Please explain: _____
* Are you seeking employment? ☐ No ☐ Yes - Explain _____

| A. Name of Employer (Company) or School (If Fulltime Student) | B. Occupation / Title |
|---|---|
| C. Employer or School Address | D. Give Type of Business and list Specific Duties |

13. SPOUSE/DOMESTIC PARTNER'S EMPLOYMENT STATUS:
☐ Employed ☐ Not Employed* ☐ Self-Employed ☐ Fulltime Student ☐ Retired / Date of Retirement Mo. _____ Year _____
☐ Retired Early - Under Age 55 ☐ Yes* ☐ No
* Please explain: _____
* Are you seeking employment? ☐ No ☐ Yes - Explain _____

| A. Name of Employer (Company) or School (If Fulltime Student) | B. Occupation / Title |
|---|---|
| C. Employer or School Address | D. Give Type of Business and list Specific Duties |

14. If any dependent applying for coverage is over the age of 18, provide:
Currently employed? ☐ Yes ☐ No; If yes, occupation: _____

## PART II: MEDICAL HISTORY

**If the response to any question is "YES", please indicate details in the space provided in Question #26. Be sure to reference the question number, identify the person, the condition, provide the date and duration of the condition, and the name and address of the hospital or doctor.**

| | | YES | NO |
|---|---|---|---|
| 15. | In the past 2 years, did any person, including children, listed in Question #7 consult a doctor or practitioner and have a complete examination performed (including gyn exam)? Please provide the date (Mo./Yr.) and indicate details in Question #26. | ☐ | ☐ |
| 16. | Has any person, including children, listed in Question #7 been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? | ☐ | ☐ |
| 17. | Has any person, including children, listed in Question #7 ever had, currently have or received treatment (including but not limited to the seeking of advice, taking medication including herbal supplements for or receiving counseling for) from a physician or member of the medical profession for: | | |
| | A. High blood pressure, elevated cholesterol and/or triglycerides, low blood pressure, chest pain, palpitations, heart attack, angina, any disorder of the heart, arteries, veins, or circulatorysystem? | ☐ | ☐ |
| | B. Any disease, disorder or surgery of the brain including but not limited to stroke, TIA, seizures or convulsions? | ☐ | ☐ |
| | C. Any disease or disorder of the endocrine system, including but not limited to, the thyroid or diabetes? | ☐ | ☐ |
| | D. Malignant tumor, cancer, Hodgkin's disease, malignant melanoma, or multiple myeloma? Give location in Question #26. | ☐ | ☐ |
| | E. Benign cyst, tumor or lesion? Give location in Question #26. | ☐ | ☐ |
| | F Any disease or disorder of the lungs or respiratory system? | ☐ | ☐ |
| | G. Any disease, disorder or surgery of the kidney, bladder, or urinary tract? | ☐ | ☐ |
| | H. Any disease or disorder of the blood including but not limited to anemia or leukemia? | ☐ | ☐ |
| | I. Any disease, disorder or surgery of the back, joints, or disc(s) including a fixation device, prosthesis or chiropractic care? | ☐ | ☐ |
| | J. Any mental or nervous disorder, including anxiety, stress or depression, or counseling history? | ☐ | ☐ |
| | K. Any gynecological disorder, abnormal pap smears, infertility, menstrual disturbances, uterine fibroids, cesarean section, or other complications due to pregnancy or childbirth? | ☐ | ☐ |
| | L. Any disease, disorder or surgery involving the breast(s) including but not limited to breast implants? | ☐ | ☐ |
| | M. Any disease, disorder or surgery involving the male reproductive organs including but not limited to erectile dysfunction, testicular disorder, prostate disorder or infertility? | ☐ | ☐ |
| | N. Any ulcers, stomach, gastrointestinal tract, colon, rectum or other internal disorders? | ☐ | ☐ |
| | O. Any disease or disorder of the liver, including but not limited to cirrhosis or hepatitis? Specify type of hepatitis in Question #26. | ☐ | ☐ |
| | P. Any fixation device or prosthesis present, including but not limited to pins, plates, screws, rods, wires, or implants? Specify location and type in Question #26. | ☐ | ☐ |

| | | YES | NO |
|---|---|---|---|
| 18. | A. Is any person listed in Question #7, or any immediate family member not listed in Question #7, now pregnant? | ☐ | ☐ |
| | B. Are you an expectant father? | ☐ | ☐ |
| 19. | Is any person, including children, listed in Question #7 currently taking or have taken in the last 6 months any medication, herbal supplements or receiving any treatment? If yes, provide specific details in Question #26. | ☐ | ☐ |
| 20. | Has any person listed in Question #7 ever had an angioplasty or cardiac catherization? | ☐ | ☐ |
| 21. | In the past 10 years, has any person listed in Question #7 had or been advised by a physician or member of the medical profession to have any of the following: | | |
| | A. Electrocardiogram and/or other cardiac work-up, x-rays, or blood, urine, or other medical tests? | ☐ | ☐ |
| | B. Any surgery, observation, testing or treatment either on an inpatient or outpatient basis? | ☐ | ☐ |
| 22. | In the past 10 years, has any person listed in Question #7: | | |
| | A. been treated by a doctor or a member of the medical profession for the use of alcohol or drugs? This includes but is not limited to the seeking of advice, taking of medication for, or receiving counseling for alcohol or drug use? | ☐ | ☐ |
| | B. had any DUI conviction, drunken driving conviction or license revocation? | ☐ | ☐ |
| | C. used or is now using barbiturates, amphetamines, marijuana, cocaine, heroin opiates, or other narcotics except as prescribed by a doctor or a member of the medical profession? | ☐ | ☐ |
| | D. had life or health insurance declined, postponed, changed, rated up, or withdrawn? Date:_____ Reason: _____ Company Name: _____ | ☐ | ☐ |
| | E. received disability benefits, compensation or pension because of sickness or injury? | ☐ | ☐ |
| 23. | In the past year, has the weight of any person listed in Question #7 increased or decreased by more than 10 pounds? If YES, what was weight 3 months ago? _____ lbs., 6 months ago? _____ lbs., 12 months ago? _____ lbs. Provide reason for weight change in Question #26. | ☐ | ☐ |
| 24. | Has any person, including children listed in Question #7 had any other diagnosis or received treatment from a physician or member of the medical profession for (including but not limited to the seeking of advice, taking medication for, or receiving counseling for) any manifested physical or mental disorder, disease or defect or any other condition(s), injury, or problem(s) not listed above? | ☐ | ☐ |
| 25. | Is any person, including children, listed in Question #7 recently had or anticipate having any testing or surgery, elective or non-elective, or have not been released from physician's care? | ☐ | ☐ |

**26. MEDICAL HISTORY ADDITIONAL DETAILS - For additional space, use Medical History Addendum, form #10909.**

| Name & Question Number | Reason / Diagnosis | Dates First &Last Seen | Full Names & Address of Doctors & Hospitals |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**26A. PRESCRIPTION DRUG ADDITIONAL DETAILS - For additional space, use Prescription Drug Addendum, form #19020.**

| Name & Question Number | Name of Drug or Herbal Supplement & Strength | Daily Dosage | Reason Drug Prescribed | Name & Address of Prescribing Doctor |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## PART III: SUPPLEMENTAL INFORMATION

1. Has the last name of any person to be covered changed in the last 5 years due to marriage, court order, etc.? ☐ Yes ☐ No
   If "YES", please advise the complete former name: _____
2. A. Have all persons named in Part I, Question #7 been a United States resident for at least 6 months? ☐ Yes ☐ No
   B. Date of United States Residency. _____
   C. Are all persons listed in Part I, Question #7 United States citizens? ☐ Yes ☐ No
   D. If "No" to 2.C., do all persons listed in Part I, Question #7 have a resident alien card? ☐ Yes ☐ No
   E. If "No" to 2.D., do all persons listed in Part I, Question #7 have a VISA? ☐ Yes ☐ No

| Member Name | Type of VISA | VISA Expiration Date |
|---|---|---|
| | | |
| | | |
| | | |

   F. Are all persons named in Part 1, Question 7.A & B legally domiciled residents of the State of Florida? ☐ Yes ☐ No
   G. Are the Applicant and Sales Agent related? ☐ Yes ☐ No
3. Agent Remarks: _____

## PART IV: ADDITIONAL INFORMATION

The Sales Agent thoroughly explained the following matters to me:

A. The Conditional Receipt and/or Cash Receipt process ☐ Yes ☐ No
B. The pre-existing clause ☐ Yes ☐ No
C. For benefit upgrades, the primary applicant and any covered dependents desiring upgrade must reapply on their anniversary date and are subject to current evidence of insurability. ☐ Yes ☐ No
D. Downgrades may be subject to re-underwriting and are not restricted to the Anniversary Date. ☐ Yes ☐ No
E. A rate change will occur when the insured moves to a different rating area and is effective as of the paid to date of the contract. Rate changes may occur on the anniversary date due to an increase in the age of covered members. ☐ Yes ☐ No
F. From time to time, rate adjustments may be necessary for all contract holders of a particular product (i.e., BlueOptions, Miami-Dade Blue, etc.) ☐ Yes ☐ No
G. Exclusion riders may be applied for certain conditions on applicants age 19 and older. ☐ Yes ☐ No
H. If BlueChoice, penalties are involved if Admission Certification is not obtained prior to a hospital admission. ☐ Yes ☐ No
I. If BlueChoice or BlueSelect, this coverage may not be available in all areas of the state. ☐ Yes ☐ No
J. If applicable, applicant agrees to pay directly to providers of health care such copayments as are required by the contract under which they are enrolled. ☐ Yes ☐ No
K. If Essential or Hospital Surgical, this product provides Hospital and Surgical coverage only and is not a major medical contract. ☐ Yes ☐ No
L. Paramedical Examination Disclosure Statement and Paramedical Exam process. ☐ Yes ☐ No
M. A rate modification may be imposed for certain conditions which will increase the premium rate quoted at the time of application. ☐ Yes ☐ No
N. The optional maternity/obstetrical endorsement is only available for purchase by the primary applicant or the primary applicant's spouse/domestic partner. Election of the optional maternity/obstetrical care endorsement requires an additional premium and to be eligible for maternity benefits, the maternity endorsement must be in effect continually for a period of 30 days immediately preceding the conception of the pregnancy as determined by a licensed obstetrical provider. ☐ Yes ☐ No
O. If I reach age 65 prior to my proposed effective date of coverage: (1) I am not eligible to apply for this coverage; and (2) my application for coverage will be declined. ☐ Yes ☐ No
P. If MyBasic, this product has an Office Services maximum and an Annual Benefit maximum that are both per person, per calendar year that is applicable to individuals applying for coverage on an existing member's MyBasic contract. ☐ Yes ☐ No
Q. If BlueSelect, there is no coverage for services subject to Exclusive Provider Provision(s) received outside of BCBSF's BlueSelect Network of EPO providers in non-emergency situations. ☐ Yes ☐ No
R. If applying for Miami-Dade Blue, there is no participating provider network outside of Miami-Dade County. I will be responsible for all charges that exceed BCBSF's payment amount for services received from non-participating providers. ☐ Yes ☐ No

Applicant's Signature: **X** _____ Date: _____

## PART V: AUTHORIZATIONS / ACKNOWLEDGEMENTS

**CANCELLATION PROVISION**

I understand that Blue Cross and Blue Shield of Florida, Inc. may cancel this coverage for all insureds covered by it after giving 90 days notice, and that any unearned premiums will be returned to me. I also understand that such action will not be taken solely because of the amount of claims paid under this policy.

Applicant's Signature: **X** _____ Date: _____

### PLEASE READ AND SIGN THE APPLICATION

I hereby apply for individual health care coverage for myself and eligible dependents under the Blue Cross and Blue Shield of Florida, Inc. product indicated in Question #1 of this application. I acknowledge that any coverage is contingent upon the complete and accurate disclosure of the information requested in this application. **I UNDERSTAND THAT BCBSF MAY DECLINE COVERAGE TO ME, OR ANY OF MY DEPENDENTS BASED UPON THE INFORMATION CONTAINED IN THIS APPLICATION AND/OR A PARAMEDICAL EXAM REQUESTED AT THE OPTION OF BCBSF, AND BCBSF MAY OFFER COVERAGE ONLY TO THOSE INDIVIDUALS ACCEPTABLE TO BCBSF.**

I understand that this policy has a 24-month limitation of coverage for pre-existing conditions. I understand and agree that if the contract is issued to me it will not cover benefits for me or any dependents age 19 and older covered under this contract for any condition which manifested itself in a manner which would cause a reasonable person to seek diagnosis or treatment, or which was the subject of medical advice or treatment by a provider during the 24 month period immediately preceding the effective date of this contract. I understand that this 24-month limitation may be lessened or waived if prior creditable coverage exists and appropriate Certificates of Creditable Coverage are provided with this application pursuant to applicable Florida Statutes. If the product applied for includes dental coverage, I understand this 24-month limitation of coverage for pre-existing conditions does not apply to dental benefits.

I understand that the product applied for provides **NO** coverage for services rendered in conjunction with a non-complicated pregnancy/delivery unless the **optional** Maternity Benefits endorsement has been purchased.

If I am applying for BlueSelect, I acknowledge that I have received (1) a description of the exclusive providers; (2) a description of the exclusive provider provisions including coinsurance and deductible levels if providers other than exclusive providers are used; (3) a description of coverage for emergency and urgently needed care and other out-of-service area coverage; (4) a description of limitations on referrals to restricted exclusive providers and to other providers; and (5) a description of BCBSF's quality assurance program and grievance procedure. I further acknowledge that I understand the restrictions of the BlueSelect product.

*No coverage will start unless your application is approved by BCBSF, a contract is issued, accepted by you, the initial premium is paid, and the statements in Parts I and II continue to be complete and true as of the effective date of the contract. No agent can make or change a contract or waive any of the company's rights.*

I understand that I am applying for a medical insurance plan that is not intended by BCBSF to be a small employer health plan.

I have read this application carefully and I represent that the statements and answers I am submitting on this application are entirely true and complete to the best of my knowledge and belief. No information has been withheld or omitted concerning the past and present state of health of myself and any dependents applying for this coverage. **I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.** I understand and agree that any misstatements or omissions may result in denial of benefits and/or termination or recision of coverage. I understand that if I am accepted for coverage, I will have ten (10) days after my policy is received by me to review it and submit any information that is missing or incorrect, including any past medical history which may have been left out of the application. If I am enrolling in a high-deductible health plan designated for use with a Health Savings Account (HSA) under Internal Revenue Service Code section 223, I understand that BCBSF will exchange certain limited information obtained from this application with its preferred financial partner(s) for the purposes of initial enrollment in and administration of HSAs.

Applicant's Signature: **X** _____ Date: _____

Parent / Guardian Name: _____ Relationship: _____

Spouse / Domestic Partner's Signature: **X** _____ Date: _____

### FOR AGENT USE ONLY:

**Agent Certification:** I hereby certify that I have seen and personally asked the applicant all questions set forth above and that I have accurately recorded answers supplied by the applicant. I further certify that I have explained exclusions and limitations of this plan. I also verified that no person named in Question #7 is now eligible or to become eligible in the next six months for a group type health plan.

Agent Name: _____ Agent's Identification No.: _____
(Please Print)

Agent Signature: _____ Date: _____

**Telemarketing Sales Agent Certification:** I hereby certify that I personally asked the applicant during a telephone call all questions set forth above and that I have accurately recorded answers supplied by the applicant. I further certify that I have explained exclusions and limitations of the plan selected. I also verified that no person named in Question #7 is now eligible or to become eligible in the next six months for a group type health plan.

Sales Agent Name: _____ Agent's Identification No.: _____
(Please Print)

Sales Agent Signature: _____ Date: _____ Time: _____

BlueCross BlueShield of Florida
Health Options®

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

# ADDENDUM TO THE MEDICAL HISTORY

Applicant: _____ SS# _____

| Name and Question # | Reason/Diagnosis | Dates First & Last Seen | Full Names & Address of Doctors & Hospitals |
|---|---|---|---|
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**Signatures:**

X _____
Signature of Applicant

X _____
Signature of Spouse/Domestic Partner (if proposed for coverage)

X _____
Signature of Agent

X _____
Date

BlueCross BlueShield of Florida
Health Options®

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Blue Cross and Blue Shield of Florida, Inc., Individual Medical Underwriting, PO Box 44026, Jacksonville, FL 32231

# NOTICE OF MEDICAL UNDERWRITING PROCESSES AND AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

By making application for this product, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or any other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, or any of my dependents to release such information to Blue Cross and Blue Shield of Florida, Inc. ("BCBSF"), Health Options, Inc. ("HOI") or their subsidiaries or affiliates or contracted representatives acting on behalf of BCBSF, HOI or their subsidiaries or affiliates for the purpose of obtaining medical records, exams, and/or reports. This authorization includes the use of any medical records, paramedical examination reports and testing, pharmacy records, results of laboratory testing and referrals including the use of records obtained by BCBSF, HOI or their subsidiaries or affiliates for a purpose other than this application for health coverage.

This authorization includes medical records, paramedical examination reports and testing, pharmacy records, results of laboratory tests and referrals ordered by a referring physician or facility other than the primary provider. This authorization specifically includes, but is not limited to, authorization to release any and all medical records and testing and information associated with (or in reference to) the following conditions: Positive exposure to HIV infection, AIDS, alcohol or drug dependency, mental and nervous disorders.

This authorization includes the use of any historical medical, pharmaceutical and referral files maintained by BCBSF, HOI or their subsidiaries or affiliates or another Blue Cross and Blue Shield Plan. This authorization includes the use of any prior medical records, paramedical examination reports and testing, pharmacy records, results of laboratory testing and referrals obtained by BCBSF, HOI or their subsidiaries or affiliates for the purpose of claim review and adjudication. This authorization includes the use of any prior health product application files of BCBSF, HOI or their subsidiaries or affiliates, including admitted medical history, medical records, paramedical examination reports and testing, pharmacy records, results of laboratory testing and referrals made part of the prior file, whether or not the requested coverage was offered by BCBSF, HOI or their subsidiaries or affiliates.

This authorization allows for BCBSF, HOI or their subsidiaries or affiliates to share received medical records, paramedical examination reports and testing, pharmacy records, results of laboratory testing and referrals internally for the purpose of claims review and adjudication as well as for the evaluation of insurability for health products. The following persons or entities are authorized to disclose health information about me: A physician medical practitioner; hospital; clinic; medical or medically-related facility; or any insurance or reinsurance company (including BCBSF); any consumer reporting agency such as Medical Information Bureau, Inc. (MIB); or any other organization, institution, or person having personal health information about me.

Health information about me may be disclosed to BCBSF and its affiliates; service providers; reinsurers, agents and representatives; and to any consumer reporting agency such as MIB. By signing this authorization, I understand that the responses to the application questions will be contained on one application form for all dependents who are applying for this coverage, including but not limited to the responses to all medical history questions.

Based upon the information obtained in the medical underwriting evaluation, the following underwriting activity may occur and the undersigned hereby authorizes the use and disclosure as described herein:

1. If application is made for an Insurance product, Medical Exclusion Rider(s) may be imposed for pre-existing conditions and/or for other reasons arising from information obtained from any medical records, paramedical examination reports and testing, pharmacy records, results of lab testing and referrals of any person age 19 and above listed on this application. The Medical Exclusion Rider may contain health information of a sensitive nature. The Medical Exclusion Rider will require the signature of the proposed Contract Holder to validate acceptance of the underwriting offer with respect to the undersigned person(s).
2. Rate Modification(s) may be imposed for pre-existing conditions and/or for other reasons arising from information obtained from any medical records, paramedical examination reports and testing, pharmacy records, results of lab testing and referrals of any person listed on this application. The Rate Modification Endorsement may contain health information of a sensitive nature. The Rate Modification affects the total premium charged and the endorsement does not require the signature of the proposed Contract Holder.
3. Any person(s) listed on this application may be denied coverage. This action will require an Exclusionary Rider and will require the signature of the proposed Contract Holder to validate acceptance of the underwriting offer. A formal letter will be provided to the proposed Contract Holder and may contain health information of a sensitive nature.
4. Complete denial of the application for which a formal rejection letter will be provided to the proposed Contract Holder.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state regulations governing the privacy of health information.

**Failure to fully complete, sign and date, this authorization by all applicants, age 18 and above, will result in denial of coverage.** Individuals may have the right under Federal law to revoke this authorization by written notice to the post office address at the top of this form. Please note this may impact the obligation of BCBSF or HOI to extend coverage and may not apply to the extent of reliance on this authorization. **A photographic copy of this authorization shall be as valid as the original. This authorization will expire two years from the date signed.**

| Signature of Proposed Insured | Date | Social Security Number | Signature of Spouse/Domestic Partner (if applicable) | Date |
|---|---|---|---|---|
| | | | | |

If coverage is requested for dependent children age 18 and above, signature of each child age 18 and above is required below:

| Signature of Dependent Child | Date | Signature of Dependent Child | Date |
|---|---|---|---|
| | | | |



HOME OFFICE COPY

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

4800 Deerwood Campus Parkway
Jacksonville, Florida 32246

# CONDITIONAL RECEIPT

**Payment of Initial Binder Must Accompany this Application. Check or Money Order Must be Made Payable to Blue Cross and Blue Shield of Florida, Inc.**

1. If your application is approved and accepted, your effective date must be greater than 14 days from application signature date and will be the first allowable effective date (1st or 15th).
2. If you are replacing existing health coverage, and this application is approved and accepted, your effective date will be coordinated with your prior coverage paid to date, provided this is a future date. The earliest effective date assigned to the Blue Cross Blue Shield of Florida, Inc. ("BCBSF") coverage will be your application signature date. Under no circumstances can your effective date be more than 90 days in advance of your application signature date. It is important that you advise your agent of any payments made on your existing health coverage while this application is being considered. You should maintain your existing coverage until you have been advised of and accepted BCBSFs decision regarding your application.
3. If your application is approved and accepted, your initial binder will be applied to your contract, however, it may be necessary to send you a supplemental bill to pre-pay your contract and place it on the appropriate BCBSF billing date before the billing mode you selected can commence. BCBSF billing dates are the 1st, 8th, 15th and 23rd of each month.
4. This receipt is issued on the condition that any check or other order of payment or money is good and collectible. The deposit of your payment to the account of BCBSF does not guarantee acceptance for insurance.
5. If your application is approved by BCBSF, you will be entitled to benefits in accordance with the provisions of your policy. If you are not satisfied with the policy, you may return the policy and identification cards to BCBSF within 10 days of their delivery to you. The policy will be void from the effective date of coverage and your premium payment will be refunded.
6. If your application is denied, you will receive **NO** coverage and your premium payment will be refunded to you.

I have read and explained this **Conditional Receipt** to the applicant. I have received an application for a health insurance policy and an initial premium payment of $ _____ from _____ .

Signature of Agent: _____

Date: _____

I have personally completed an application for an Individual Medically Underwritten product and the Agent has read and explained this **Conditional Receipt** to me. I understand that I will not receive any insurance coverage UNLESS my application is accepted by BCBSF and a policy is issued.

Applicants Signature: X_____

Date: _____

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**COMPLETE ONLY ONE RECEIPT**

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

4800 Deerwood Campus Parkway
Jacksonville, Florida 32246

# CASH RECEIPT

**Payment of Initial Binder Must Accompany this Application. Check or Money Order Must be Made Payable to Blue Cross and Blue Shield of Florida, Inc.**

1. If you are not replacing coverage and your application is approved and accepted, the effective date of your coverage will be assigned by BCBSF. The effective date will be the 1st or the 15th of the month after your application is accepted by BCBSF. Under no circumstances will you effective date be less than 14 days from your application signature date.
2. If you are replacing existing health coverage, and this application is approved and accepted, your effective date will be coordinated with your prior coverage paid to date, provided this is a future date. The earliest effective date assigned to the Blue Cross Blue Shield of Florida, Inc. ("BCBSF") coverage will be on the date of final underwriting approval. Under no circumstances can your effective date be more than 90 days in advance of your application signature date. It is important that you advise your agent of any payments made on your existing health coverage while this application is being considered. You should maintain your existing coverage until you have been advised of and accepted BCBSF's decision regarding your application.
3. If your application is approved and accepted, your initial binder will be applied to your contract, however, it may be necessary to send you a supplemental bill in order to place your contract on the appropriate BCBSF billing date before the billing mode you selected can commence. BCBSF billing dates are the 1st, 8th, 15th and 23rd of each month.
4. If your application is approved and accepted, there is **NO** coverage between the date of your application and the effective date of the policy.
5. This receipt is issued on the condition that any check or other order of payment or money is good and collectible. The deposit of your payment to the account of BCBSF does not guarantee acceptance for insurance.
6. If your application is approved by BCBSF, you will be entitled to benefits in accordance with the provisions of your policy. If you are not satisfied with the policy, you may return the policy and identification cards to BCBSF within 10 days of their delivery to you. The policy will be void from the effective date of coverage and your premium payment will be refunded.
7. If your application is denied, you will receive **NO** coverage and your premium payment will be refunded to you.

I have read and explained this **Cash Receipt** to the applicant. I have received an application for a health insurance policy and an initial premium payment of $ _____ from _____ .

Signature of Agent: _____ Date: _____

I have personally completed an application for an Individual Medically Underwritten product and the Agent has read and explained this **Cash Receipt** to me. I understand that I will not receive any insurance coverage UNLESS my application is accepted by BCBSF and a policy is issued.

Applicant's Signature: X_____ Date: _____

18442-1210 R SR

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# PREMIUM VALIDATION STATEMENT

## PLEASE COMPLETE EITHER **PART I** OR **PART II**, WHICHEVER IS APPLICABLE.

The State of Florida has enacted legislation governing Small Group health plans. This legislation impacts how insurers provide coverage to employees of small companies whose employees number from 1 to 50.

**PART I:** *No portion paid by employer*

I UNDERSTAND that I am applying for a health care coverage plan that is not intended by Blue Cross and Blue Shield of Florida, Inc., (herein "BCBSF") or Health Options, Inc., (herein "HOI") to be a small employer health plan and that no portion of my BCBSF premium payment or HOI prepayment fee shall be paid for by my or my spouse/domestic partner's (if applicable) employer. Further, if my employer is submitting payment on my behalf, I understand that my employer may not provide any administrative support for the billing and/or submission of my individual BCBSF premium payment or HOI prepayment fee, unless the payments are being submitted in accordance with BCBSF's or HOI's list billing agreement with my employer and Florida Statutes sec. 627.6699(4)(a) or any successor statutes.

Applicant's Name *(printed)* and Signature _____ Date _____

Applicant's Social Security Number _____

Spouse/Domestic Partner's Signature (if applicable) _____ Date _____

Writing Agent's Name *(printed)* and Signature _____ Date _____

Agency Number _____

**PART II:** *Employer-paid coverage exempted from small group reform*

I UNDERSTAND that I am applying for a health care coverage plan that is not intended by BCBSF or HOI to be a small employer group health plan. A portion of my BCBSF premium payment or my HOI prepayment fee is paid by my employer on my or my spouse/domestic partner's (if applicable) behalf based on the following condition:

- ☐ I am a part-time employee working less than 25 hours per week and am not eligible for a group plan.
- ☐ I am an employee working under an independent contractor agreement.
- ☐ I am self-employed and elect to purchase individual insurance or HMO coverage.
- ☐ I am a temporary or substitute employee.

Home

Applicant's Name *(printed)* and Signature _____ Date _____

Applicant's Social Security Number _____

Spouse/Domestic Partner's Signature (if applicable) _____ Date _____

Writing Agent's Name *(printed)* and Signature _____ Date _____

Agency Number _____

BlueCross BlueShield of Florida
Health Options®

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*BCBSF Corporate Compliance*
*Privacy Compliance Unit*
*P.O. Box 44283*
*Jacksonville, FL 32203-4283*

# GRAMM- LEACH- BLILEY ACT PRIVACY NOTICE

To Our Customers:

Health insurers such as Blue Cross and Blue Shield of Florida (BCBSF) and Health Options, Inc. (HOI) are affected by the privacy provisions of two federal privacy laws, the Gramm-Leach-Bliley Act (GLBA) and the Health Insurance Portability and Accountability Act – Administrative Simplification (HIPAA-AS). Both require that we provide you with Privacy Notices that explain our privacy practices.

This GLBA Privacy Notice is provided to help you better understand how we obtain, use, share, and protect your non-public personal financial information even after our customer relationship with you has ended. Our HIPAA-AS Privacy Notice explains how we use and share your non-public personal health information and how you can access it. You may obtain a copy of our HIPAA-AS Privacy Notice by contacting us at the address noted above.

## What Kind Of Non-Public Personal Financial Information Do We Obtain and How Do We Obtain It?

Generally, we obtain your name, address, phone number, social security number, date and place of birth, age, sex, and other demographic information. Depending on the product or service in which you are enrolled and whether that product or service is group or individual, we may also obtain your occupation, salary, transactional information, billing preferences, beneficiary information, and work history.

We obtain non-public personal financial information about you from:

- You, on your application for insurance or other service;
- You, concerning your transactions with us and other companies;
- Your physician or other health care provider;
- Your employer, if you are enrolled in a group health plan; and
- Other third parties within and outside our family of companies, depending on the product or service in which you are enrolled.

## How Do We Use Your Non-Public Personal Financial Information?

We use your non-public personal financial information to perform transactions and functions necessary to implement and administer the product or service in which you are enrolled. These functions include enrollment, premium payment processing, customer service, claim payment, health care benefit management, fraud and abuse protection, and other similar activities. We also use your non-public personal financial information to determine if you might be interested in any of our other health products or services.

**What Non-Public Personal Financial Information Do We Share About You and With Whom?**
We may share all of the non-public personal financial information we obtain about you, as described above, with our affiliates when the sharing is in accordance with the HIPAA-AS Privacy law. Our affiliates include, for example, our family of companies that provide life insurance, dental insurance, and long term care insurance.

We may share any of your non-public personal financial information we obtain with our affiliates as well as non-affiliates as necessary to provide our products and services to you. For example, we may share such information with companies and individuals with whom we contract to assist with administration of the product or service in which you are enrolled. Those companies and individuals may help us mail benefit booklets and other communications to you, process your claims, collect delinquent accounts, conduct satisfaction surveys, manage your benefits, or perform other activities. We require each unaffiliated third party with whom we contract to assist in administering a product or service to agree in writing to abide by the same privacy standards we do.

We may share any of your non-public personal financial information we obtain with affiliated and unaffiliated third parties as otherwise permitted or required by law. For example, we may share information with an insurance regulatory authority, a government agency, or a law enforcement official to comply with a regulatory examination or investigation, a state statute, a subpoena, or a court order.

We may share all of the non-public personal financial information we obtain about you, as described above, with unaffiliated third parties that act on our behalf to market the products and services we offer when the sharing is in accordance with the HIPAA-AS Privacy law.

**How Do We Protect Your Non-Public Personal Financial Information?**
We maintain physical, electronic, and procedural safeguards to protect your non-public personal financial information. We use and share your non-public personal financial information to the extent minimally necessary to administer the products and services in which you are enrolled. We restrict our employees' access to your non-public personal financial information to those employees who need to know the information to administer the product or service in which you are enrolled.

**How to Contact Us?**
You do not need to reply to this GLBA Privacy Notice. However, please feel free to call us at 1-888-574-2583 or contact us at the address listed above if you have any questions about the notice. Hearing impaired enrollees may contact us by dialing the Florida Relay Service at 711 via TTY. Our office hours are Monday through Friday from 9:00 A.M. - 4:00 P.M.

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

# Automatic Payment Form for Individuals Under 65

## How it works

- Your premium is deducted on the date it is due. However, if your due date is the 1st of the month, your payment will be deducted on the 3rd.
- Please allow up to four weeks to start the automatic payment process. If you receive a bill during this time, please pay it as you normally would and your account will be adjusted to include that payment.
- You may cancel automatic withdrawal of your premium payment by notifying us and your financial institution 15 days prior to the date your premium is due.
- Once your automatic payment account is active, you'll receive a confirmation letter in the mail.

## Signing up is easy

1. Complete and sign the authorization form below.
2. Mail to: Blue Cross and Blue Shield of Florida, Attn: Direct Membership & Billing, PO Box 45074, Jacksonville, FL 32232-9830

_____
Member Name

_____
Member Number (found on your ID card)

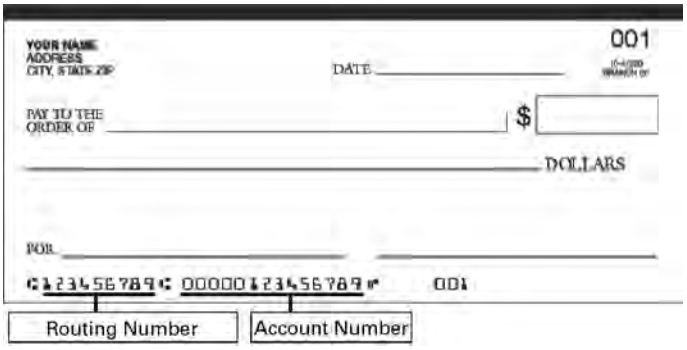
_____
Financial Institution Name

_____
Financial Institution Address City State Zip

_____
Name on Account

_____
Routing Number

_____
Account Number




By signing up for the automatic Payment Option, you can decide the frequency of your premium payments. Please choose from one of the following options:

☐ Monthly (pay every month) ☐ Bi-monthly (pay every other month)

☐ Quarterly (pay every three months) ☐ Semi-annually (pay twice a year) ☐ Annually (pay one a year)

I authorize Blue Cross and Blue Shield of Florida, to initiate debits to the financial institution account for the premium amount. This authority will remain in effect until canceled by me or with the my consent by the financial institution. This authorization is automatically revoked upon cancellation of my coverage. I understand that by revoking the Automatic Payment Option, my health care coverage payments will change to bi-monthly (every other month) premium billing.

X_____ _____
Signature of Account Holder (Signatures required for all parties listed on account) Date

X_____ _____
Signature of Account Holder Date

BlueCross BlueShield of Florida
Health Options®

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# PARAMEDICAL EXAM DISCLOSURE STATEMENT

**APPLICANT NAME** _____

**SOCIAL SECURITY NUMBER** _____

I understand that this application for Blue Cross Blue Shield of Florida, Inc. (BCBSF) or Health Options, Inc. (HOI) coverage is subject to medical underwriting and that a paramedical examination may be necessary to determine insurability. If I am contacted by a paramedical examiner, I will make every effort to complete the exam in a timely manner, and I understand that this application will not be complete until I have completed the paramedical exam.

The paramedical exam includes height, weight, blood pressure, pulse. A urinalysis to include Continine (test for nicotine) and Cocaine testing and fasting blood work with HIV testing, and possible hepatitis screening. It will also include an overview of past and current medical history. (A Notice and Consent Form for AIDS-Related Blood Testing is required by Florida Law).

I recognize that this paramedical exam is conducted solely for underwriting purposes and does not constitute a diagnostic or clinical examination. I understand that the evaluation is not designed to diagnose or disclose any specific illness or health condition. Accordingly, I hereby waive any rights against BCBSF or HOI, its employees, agents, contractors, affiliated companies and reinsurers which may arise as a result of any failure to diagnose or disclose any such illness or condition.

I understand that if this application for coverage is rejected by BCBSF or HOI, I will not be advised of the cause for rejection or otherwise of the results of the paramedical evaluation unless required by law. Accordingly, I hereby waive any rights to be advised of any illness or condition revealed by the paramedical evaluation.

I also understand that if this application for coverage is rejected, I am hereby advised to consult the physician of my choice for a complete medical examination which would be at my expense.

I also certify that I have read this form and that I fully understand its contents and do not desire any further explanation.

_____ _____
*(applicants signature)* *(date)*

_____ _____
*(spouse/domestic partner's signature if also seeking coverage)* *(date)*

_____ _____
*(sales agents signature)* *(date)*

# Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

Mail to:
P.O. Box 37859
Jacksonville, FL 32236

## BlueDental Choice PPO Application for Individual Insurance

**All Fields Are Required**

| Applicant First Name 1 | Applicant Last Name 2 | Home Phone No. 3 | Social Security No. 4 |
|---|---|---|---|
| Home Address 5 | Suite/Apt No. 6 | Business/Other Phone No. 7 | Birth Date: (mm/dd/yyyy) 8 (Min. applicant age 18) |
| City 9 | State 10 / Zip Code 11 | Gender 12 ☐M ☐F | Requested Effective Date (within 90 days) 13 |

**Coverage Type Requested** *(check all that apply)*: ☐ Policyholder < 65 ☐ Policyholder Age 65+ ☐ Child(ren) 14
☐ Spouse < 65 ☐ Spouse Age 65+ ☐ Domestic Partner (DP) < 65 ☐ Domestic Partner (DP) Age 65+

**Plan Selection Choice:** ☐ **Individual BlueDental Choice Plus** ☐ **Individual BlueDental Choice Copayment** 15

**List All Eligible Dependents To Be Covered.** Children of a domestic partner may be covered when the domestic partner is also covered. Attach additional sheet of paper, if necessary. Sign and date it. 18 – 27, Check all that apply.

| 16 First Name, M.I., Last Name *(Please provide information in the corresponding numbered spaces below.)* 17 Social Security Number (Please provide in spaces below.) | 18 Relation to You (DP = Domestic Partner) | 19 Marital Status: Married | 19 Marital Status: Unmarried No Children | 20 Gender (M/F) | 21 Birth Date (mm/dd/yyyy) | 22 Disabled | 23 Lives with You | 24 You Support Financially | 25 Student FT/PT | 26 Florida Resident | 27 Covered by Medicaid |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | ☐ Spouse *or* ☐ DP | | | F | | ☐ | ☐ | ☐ | | | |
| 16 | ☐ Child *or* ☐ DP Child | ☐ | ☐ | F | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16 | ☐ Child *or* ☐ DP Child | ☐ | ☐ | F | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16 | ☐ Child *or* ☐ DP Child | ☐ | ☐ | F | | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Do you or any of your dependents have Dental insurance under another plan? ☐ Yes ☐ No 28
If "YES" complete the following: **Person's Name:** **Policy No.:**
**Insurance Co. Name/Address:**

**Replacement of Coverage.** Is this insurance intended to replace **ANY** dental insurance currently "in-force"? 29
☐ Yes ☐ No If "YES" complete the following:
**Insurance Company Name:** **Policy No.:**
**Effective Date:** **Termination Date:**
**(Also, read the Replacement of Insurance notice.)**

Have you been insured by a Florida Combined Life group or individual dental insurance policy within the last 90 days? ☐ Yes ☐ No 30

Are you also applying for Blue Cross and Blue Shield of Florida health insurance coverage? ☐ Yes ☐ No 31

## Acceptance of Coverage

I am a Florida resident, and I wish to enroll in the above selected plan. I understand the insurance applied for will not become effective until FCL has approved my application. I understand that waiting periods may apply for certain services.

I authorize FCL to exchange benefit information with any insurance company; organization; or individual to determine if coordination of benefits applies for me and my dependents. If an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I certify that the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

I understand that this application is hereby made a part of the policy. A photocopy of this application shall be as valid as the original.

**Fraud Notice: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

Applicant Signature **(Required)**: X 32 Date **(Required)**: 33

I understand that FCL may terminate this insurance at the end of any period for which the premium has been paid.

Applicant Signature **(Required)**: X 34 Date **(Required)**: 35

**Payment Information on Page Two Must be Completed.**

**Please Complete this Page, and Sign if applicable.**

| First Name 36 | Last Name 37 | Social Security No. 38 |
|---|---|---|
| | | |

**Agent Information: ALL INFORMATION MUST BE COMPLETED TO PROCESS APPLICATION**

| Agent Printed Name: 39 | Signature: 40 | Date: 41 |
|---|---|---|
| Agent Phone Number: 42 | Agent Fax Number: 43 | |
| Florida State License Number: 44 | BCBSF Agent Code: 45 | |

**Premium Payment Mode:** ☐ Monthly *Only payable by Bank Draft* 46
***(see rate sheet)*** ☐ Quarterly* ☐ Semi-Annual* ☐ Annual* **Payable by Bank Draft, Check or Credit Card*

**Payment Method: *(Choose One)***

**1. Bank Draft:** ☐ *For Monthly, Quarterly, Semi-Annual, and Annual Premium Payment Modes* 47

**You Must Include A Voided Check With This Application For Bank Draft and Complete the Section Below. We will Deduct your 1st and future premiums from your account.**

Policies effective on the 1st of the month will be drafted on the 28th of the previous month; policies effective on the 15th of the month will be drafted on the 12th of the month.

I authorize _____ to make a bank draft of $_____
***(Financial Institution/Bank Name)***

From Account No. _____ Bank Routing No. _____
and to remit the amounts deducted to FCL, upon instructions from FCL. The amount of deduction indicated above is approximate and may be corrected as instructed by FCL. This authorization will remain in effect until: (a) I/we cancel it in writing; (b) the above account is closed; (c) the deduction and remittance arrangements between the above financial institution and FCL are discontinued; or (d) the insurance policy is cancelled. I understand that this authorization does not waive or change any of the payment provisions of the policy issued to me by FCL, and if this authorization terminates for any reason, any further payments required under the policy will be made as provided in the policy. I agree that the above financial institution is acting gratuitously and for my sole accommodation and not as an agent for FCL.

**Accountholder's Signature (Required): X** Date:

| **2. Check:** ☐ *For Quarterly, Semi-Annual, and Annual Premium Payment Modes* 48<br>**Payable to Florida Combined Life (FCL)** | Premium Payment: 49<br>$ | Check No.: 50 |
|---|---|---|

| **3. Credit Card:** 51<br>*For Quarterly, Semi-Annual, and Annual Premium Payment Modes*<br>☐ MasterCard ☐ Visa | Credit Card No.: 52 | Exp. Date: (mm/yy) 53 |
|---|---|---|
| I hereby authorize charging by Credit Card: 54<br>**Cardholder's Signature: X** | Amount Charged: 55<br>$ | Date: 56 |

Home

**Please attach your voided check here.**

## Did You Remember To:

- ❑ **Answer the question about replacement of insurance (Box 29)**
- ❑ **Sign and date the application in both places on page 1 (Boxes 32 - 35)**
- ❑ **Calculate your premium carefully, using the rate sheet**
- ❑ **For Bank Draft, send a voided check that includes the bank routing & account numbers, and sign/date authorization (Box 47). We will deduct your 1st and future premiums from your account.**
- ❑ **For Credit Card payment, complete all requested information, and sign/date authorization (Boxes 51 - 56)**

**For Internal Use Only**

| PSR No. | Date Processed | Group & Division No. | Policy Effective Date |
|---|---|---|---|
| | | | |

If you have any questions about completing this application, please call 888-753-4363.

**APPLICANT COPY**

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL DENTAL INSURANCE

**Florida Combined Life Insurance Company, Inc.**
**5011 Gate Parkway, Bldg. 200**
**Jacksonville, Florida 32256**

**SAVE THIS NOTICE. IT MAY BE IMPORTANT TO YOU IN THE FUTURE**

According to your application, you intend to lapse or otherwise terminate existing dental insurance and replace it with a Florida Combined Life Insurance Company, Inc., individual dental insurance policy. For your information and protection, you should be aware of and seriously consider certain factors, which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all dental insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this dental insurance is a wise decision.

**STATEMENT TO APPLICANT BY AGENT:**

I have reviewed your current dental insurance. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefit under the new policy, whereas a similar claim might have been payable under your present policy.
2. If you are replacing existing dental insurance, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right but is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all information you provide on the application is truthfully and completely answered. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded.
4. The new policy may be issued at an older age than the issue age under your present policy, therefore, the cost of the new policy may be higher than what you are paying for your present policy.
5. The renewal provision of the new policy should be reviewed so you know your rights regarding renewal of the policy.

Agent Printed Name _____ Agent Signature _____

Agent Address _____ Date _____

The above "Notice to Applicant" was delivered to me on:

Date _____ Applicant Signature _____



**FCL COPY**

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL DENTAL INSURANCE

**Florida Combined Life Insurance Company, Inc.**
**5011 Gate Parkway, Bldg. 200**
**Jacksonville, Florida 32256**

**SAVE THIS NOTICE. IT MAY BE IMPORTANT TO YOU IN THE FUTURE**

According to your application, you intend to lapse or otherwise terminate existing dental insurance and replace it with a Florida Combined Life Insurance Company, Inc., individual dental insurance policy. For your information and protection, you should be aware of and seriously consider certain factors, which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully, comparing it with all dental insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this dental insurance is a wise decision.

**STATEMENT TO APPLICANT BY AGENT:**

I have reviewed your current dental insurance. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions that you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefit under the new policy, whereas a similar claim might have been payable under your present policy.
2. If you are replacing existing dental insurance, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right but is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all information you provide on the application is truthfully and completely answered. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded.
4. The new policy may be issued at an older age than the issue age under your present policy, therefore, the cost of the new policy may be higher than what you are paying for your present policy.
5. The renewal provision of the new policy should be reviewed so you know your rights regarding renewal of the policy.

Agent Printed Name _____ Agent Signature _____

Agent Address _____ Date _____

The above "Notice to Applicant" was delivered to me on:

Date _____ Applicant Signature _____

50576-0905 Dental Replacement

# FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.

5011 GATE PARKWAY, BLDG. 200
JACKSONVILLE, FLORIDA 32256

## SIMPLIFIED APPLICATION FOR INDIVIDUAL LEVEL TERM LIFE INSURANCE

**INFORMATION ON THE PROPOSED INSURED (Please print.)**

1. Full legal name of proposed insured:
2. Social Security number:
3. Home Phone:
4. Mailing address: Street City State Zip
5. Date of Birth:
6. Sex: ☐ male ☐ female
7. Is the proposed insured a United States citizen? ☐ Yes ☐ No If **No**, explain:
8. Amount applied for: ☐ $25,000 ☐ $50,000
9. Term Period: ☐ 10 yrs ☐ 15 yrs ☐ 20 yrs ☐ 25 yrs ☐ 30 yrs
10. Billing Preference: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly – Check-O-Matic (complete authorization below)
11. Waiver of Premium: ☐ Yes ☐ No
12. Accidental Death: ☐ Yes ☐ No
13. Is this insurance intended to replace or change any life insurance currently "in-force"? ☐ Yes ☐ No
    If **Yes**, Company: Policy No.: Date of Termination:
14. Has the proposed insured **used** any tobacco products within the last twelve (12) months? ☐ Yes ☐ No
    If **Yes**, Type:
    Frequency:
15. Full legal name of primary beneficiary(s): Relationship to proposed insured: % of Share
    a.
    b.
    Full legal name of contingent beneficiary(s): Relationship to proposed insured: % of Share
    a.
    b.

**Complete this section if the policyholder is to be other than the proposed insured:**

16. Full legal name of policyowner:
17. Date of birth:
18. Social Security number:
19. Mailing Address: Street City State Zip
20. Relationship to Insured:

**Complete this section if you would like to name a secondary addressee. If you name one, Florida Combined Life Insurance Company, Inc. (FCL), may notify the secondary addressee and the policyowner that the insured's coverage may terminate due to failure to pay premium within the policy's specified time period.**

21. Full legal name of secondary addressee:
22. Mailing address: Street City State Zip

### COVERAGE REQUEST AND AGREEMENT

I hereby apply for the coverage amount indicated above on this form. I understand FCL must approve this application, and FCL (or other affiliated carrier) coverage is contingent upon the complete, accurate disclosure of the information requested. I may be required to furnish evidence of insurability. The original application is required to evaluate the request for insurance. A copy of it will be attached to the policy, when issued. A photocopy of this application will be as valid as the original.

**FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

I have read and accept the "Coverage Request and Agreement." I represent that the answers on this form, including any attachments to it, are true and complete to the best of my knowledge.

X _____ / _____
Proposed insured's signature Date

X _____ / _____
Proposed policyowner's signature (if policyowner is other than insured) Date

**AGENT USE ONLY:**

To the best of my knowledge, replacement ☐ is ☐ is not involved at this time.
Agent's name (typewritten or printed): _____
Agent's license number: _____ Agency Code/Agent Code: _____
Agent's signature: _____ Date: _____

**HOME OFFICE USE ONLY**

| Approved: | Declined: | Date (mm/dd/yyyy) | Reviewed by: |
|---|---|---|---|
| | | | |

### CHECK-O-MATIC AUTHORIZATION

**Instructions:**

1. Complete the section at the right, making sure to enter the date, and sign your name as it appears on your account.
2. Return this application, along with your check for the first month of coverage.
3. We will withdraw future premiums from the checking account listed on the check used for the initial premium, unless you direct us otherwise.
4. If you wish to have future premiums withdrawn from a checking account other than the one from which you paid the initial premium, please provide us with a voided check for that account.

NOTE: This section allows your financial institution to pay the monthly premium for you automatically from the checking account specified by you.

*I/We give permission for my/our financial institution to automatically make payments to Florida Combined Life Insurance Company, Inc. This authorization will remain in effect until: I/We cancel it in writing; the checking account is closed; or the insurance policy is canceled.*

Home

_____
Checking account number

_____
Account holder's name (Please print.)

_____
Joint account holder or other authorized representative's name (Please print.)

_____
Account holder's signature

_____
Joint account holder or other authorized representative's signature

_____
Date

_____
Date

# FLORIDA COMBINED LIFE INSURANCE COMPANY, INC. (FCL)

## AUTHORIZATION TO USE AND RELEASE PROTECTED HEALTH INFORMATION

This Authorization covers any and all information in the following categories ("protected health information" or "PHI") relating to the individual named below: (1) identifying information, (2) coverage information, (3) claims information, and (4) medical records, including information about, associated with, or with reference to certain conditions such as HIV test results, ARC, AIDS, alcohol or drug abuse, or mental illness.

**1. Use with or Release of PHI to FCL.**

I give to persons or entities that have any knowledge or records about me or my health permission to use with, and release to, FCL and its insurance affiliates, reinsurers, and authorized representatives and vendors the information described above to evaluate my application for insurance. Examples of the persons or entities to whom I give permission are the Medical Information Bureau (MIB) and any consumer reporting agency, employer, insurance carrier, HMO, physician, hospital, or other health plan or health care provider.

**2. FCL's Use and Release of PHI.**

I give FCL permission to use any information described above to evaluate my application for insurance and to administer and pay claims under any insurance coverage for which I apply and FCL issues and to release this information to other persons or entities involved with those activities of FCL. Examples of the persons or entities to whom FCL may release this information are: (1) FCL's (a) auditors, (b) insurance affiliates, (c) reinsurers, (d) authorized representatives and (e) vendors; and (2) with the exception of information about, associated with, or with reference to HIV test results, ARC and/or AIDS, the MIB and other insurance carriers.

**3. FCL's Release of PHI for Others' Purposes.**

I give FCL permission to release any information described above, with the exception of information about, associated with, or with reference to HIV test results, ARC and/or AIDS, to MIB and to other insurance carriers to which I may apply for life or other insurance coverage or to which I may submit a claim for life or other benefits. The information released will be used to evaluate my application for insurance or my claim for benefits.

FCL must obey federal health information privacy laws and may only use and release my protected health information as those laws provide**.** Other persons and entities to whom I give permission with this authorization to receive my protected health information may not have to obey those laws and may further release my protected health information.

I must sign this authorization before FCL can consider my application for insurance and pay claims under any insurance policy FCL may issue covering me, EXCEPT I do not have to sign this authorization to enroll in, be eligible for benefits under, or receive payment of claims, for any health insurance FCL issues.

This authorization will expire upon FCL's payment of all benefits due under any insurance policy FCL may issue covering me. Should FCL not issue any insurance policy covering me, this authorization will expire upon FCL's notice denying coverage.

I understand that I may withdraw this authorization at any time by giving written notice to FCL's customer service area. Withdrawal of this authorization will not affect any action FCL or any other person or entity has taken in reliance on this authorization prior to receiving my written notice of withdrawal. Action taken in reliance includes FCL's issuance and provision of any insurance coverage for which I apply.

Please keep a copy of your signed authorization. A photocopy is as valid as the original.

Proposed Insured's Signature: _____ Date: _____

Name (please print): _____ Birth date: _____

**If a legal representative signs this authorization form on the proposed insured's behalf, please complete the following:**

*Legal representative's name: _____

Relationship: _____

**Note:** * Please provide written documentation to support your status as a guardian or other legal representative.

**FLORIDA COMBINED LIFE INSURANCE COMPANY, INC.**
**5011 GATE PARKWAY, BLDG. 200**
**JACKSONVILLE, FL 32256**

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Check or Other Order of Payment Must Accompany Application.
All Checks Must be Made Payable to **Florida Combined Life Insurance Company, Inc.**

Received from _____ on _____ the Sum of $ _____

1. This receipt is issued on the condition that any check or other order of payment be good and collectible. The deposit of your check or other order of payment to the account of Florida Combined Life Insurance Company, Inc. (FCL), does not guarantee acceptance for insurance.

2. If your application is approved and accepted by FCL, you will be entitled to benefits in accordance with the provisions of your policy.

3. If your application is approved and accepted, the effective date of your policy will be assigned by FCL and will be the date your application is approved by FCL.

4. There is no coverage between the application date and the effective date of the policy.

5. If you are not satisfied with the policy, you may return the policy to FCL within 30 days of its delivery to you. The policy will be void from the effective date and your premium payment will be refunded.

6. If your application is denied, you will receive no coverage and your premium payment will be refunded to you.

Signature of Agent:_____ Date:_____

Signature of Applicant:_____ Date:_____

50362-497 SR White Copy - Applicant Yellow Copy - FCL Pink Copy - Agent

# FLORIDA COMBINED LIFE

5011 Gate Parkway, Bldg. 200
Jacksonville, Florida 32256
904-828-7809


## Notice to Applicant
## Regarding Replacement of Life Insurance and/or Annuities

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ Yes ☐ No

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

| | |
|---|---|
| _____ Applicant's Signature | _____ Date |
| _____ Agent's Signature | _____ Date |
| _____ Agent's Name (Printed or Typed) | _____ Date |
| _____ Agent's Address (Printed or Typed) | _____ Date |
| _____ Agent's Company (Printed or Typed) | _____ Date |

Information on Policies which may be replaced:

| Company Name | Policy Number | Name of Insured |
|---|---|---|
| | | |
| | | |
| | | |

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

# Prior/Concurrent Coverage / Pre-Existing Condition Affidavit

***(For applicants applying for Individual Under 65 insurance products only)***

Applicant's name _____ Social Security # _____

Individuals age 19 or older who currently have health care coverage or who have had previous health care coverage that was similar to or exceeded the coverage provided under the new contract and if the coverage was continuous to a date not more than 62 days prior to the effective date of coverage under this contract (if issued) may be entitled to a credit towards their pre-existing limitation period. **This does not apply to temporary insurance.**

Please provide the following information and, when possible, attach a photocopy of proof of previous coverage (i.e., identification card):

| List all family members that were covered | Name of plan/company and Customer Service telephone number | Policy number | Type coverage* A-F *[see below]* | Effective date | Cancel date and reason |
|---|---|---|---|---|---|
| *Most recent:* | | | | | |
| | | | | | |
| | | | | | |

*Type Coverage: A – PPO C – Hospital only E – Major Medical
B – HMO D – Surgical only F – Other (please specify): _____

*I acknowledge that credit toward my pre-existing limitation period is contingent upon the complete and accurate disclosure of the information requested above. I represent that information on this form is true and complete and understand that any misstatements may result in denial of benefits and/or termination of coverage. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.*

I understand that the information provided in this document is subject to verification by the Home Office.

Applicant's signature _____ Date _____

Agent's signature _____ Date _____

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

# REPLACEMENT OF INSURANCE

(Attach to Application)

Applicant Name _____ Social Security Number _____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE:

According to the information you gave us in your application, you intend to lapse or otherwise terminate your existing health insurance you have with the below named company and replace it with coverage issued by Blue Cross and Blue Shield of Florida.

Company Name _____ Group Policy # _____ and/or

Street Address _____ Individual Policy # _____

City, State, Zip _____ Is this COBRA? ☐ Yes ☐ No

**Please indicate the type of coverage being replaced:** ☐ Major Medical; ☐ Hospital & Surgical; ☐ Hospital Indemnity; ☐ Temporary Policy; ☐ Accident Policy; ☐ Cancer Policy; ☐ Dental

What was the effective date of coverage? _____

Is this coverage expiring/terminating due to contractual cessation, limiting age, etc.? ☐ Yes ☐ No

If "YES", why? _____ What date? _____

If reason for replacement is other than above, please provide details. _____

If not expiring/terminating, what is the date through which premiums have been paid? _____

Please list all family members covered under the insurance policy being replaced. _____

If any member covered under your current policy is not enrolling with BCBSF, please advise why they are not included. _____

Have you had coverage with BCBSF previously? ☐ Yes ☐ No Policy # _____

If "YES", please provide policy number and termination date. Termination Date _____

FOR YOUR INFORMATION AND PROTECTION, YOU SHOULD BE AWARE OF AND SERIOUSLY CONSIDER CERTAIN FACTORS WHICH MAY AFFECT THE INSURANCE PROTECTION AVAILABLE TO YOU UNDER YOUR NEW POLICY

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. This item does not apply to any applicant under the age of 19.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all questions on the application concerning your medical/health history are truthfully and completely answered. Failure to include all material medical information on an application may provide a basis for the Company to deny your future claims and to refund your premiums as though your policy had never been in force. After the application has been completed it should be carefully reviewed before being signed to be certain that all information has been properly recorded.
4. New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending on the benefits, may be higher than you are paying for your present policy.
5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.

My signature below indicates that I understand that a policy may not be issued by Blue Cross and Blue Shield of Florida and that I should not terminate my other coverage until a policy has, in fact, been received and coverage is accepted by me.

Home

The above "Notice to Applicant" was delivered to me on _____
Date

Witness _____ _____
Writing Agent Applicant's Signature

Form #8422-0810R SR

***TOP COPY- HOME OFFICE*** ***BOTTOM COPY-APPLICANT***

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

# PHYSICAL AND CHECK-UP QUESTIONNAIRE

This form is to be completed by the writing agent when the applicant or spouse/domestic partner applying for coverage indicates a routine physical exam or check-up within the past 3 years.

Applicant Name: _____ SS#: _____

Spouse/Domestic Partner's Name: _____

A. Date of Physical Exam:

Applicant: _____

Spouse/Domestic Partner: _____

Physician Name/Address:

_____

_____

_____

_____

B. What was the reason or symptoms prompting this exam?

Applicant: _____

Spouse/Domestic Partner: _____

C. What tests were done?

Applicant: _____

Spouse/Domestic Partner: _____

D. Were any subsequent tests, referrals to other physicians, or follow-up visits recommended?

Applicant: _____

Spouse/Domestic Partner: _____

E. What were the findings, diagnosis or results of this physical examination including results of any tests?

Applicant: _____

Spouse/Domestic Partner: _____

F. What medication(s) and/or treatment was prescribed?

Applicant: _____

Spouse/Domestic Partner: _____

Home Application

Signatures:

Applicant: _____ Spouse/Domestic Partner: _____

Agent: _____ Date: _____

**If a checkup is obtained to qualify for this insurance, please submit a copy of the examination and laboratory results with the application.**

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

# Supplemental Information Addendum

**Applicant:** _____

1. If not a United States citizen, do all persons listed in Part 1, Question #7 on your health insurance application, have a valid government issued VISA or photo ID? ☐ Yes ☐ No
2. If "YES", please indicate below the Applicant's Name, country of Citizenship, ID Type, ID Number and ID Expiration date for all persons listed in Part 1, Question #7 on your health insurance application who are not US citizens.
3. Please include copies of two forms of a valid, unexpired government-issued identification, one of which must be a passport or national identity card with a photograph; OR one valid, unexpired government-issued identification (either a passport or national identity card with a photograph) and one alternate form of confirmation in the form of a utility bill, tax identification information, etc.

   **Note:** These documentation requirements apply to all adult dependents and minor dependents (to the extent that the minor has a passport or national identity card) on the application.

*Home*

| Applicant Name | Country of Citizenship | Type of ID, such as National Identity Card, Passport, Cedula, etc. | ID Number | ID Expiration Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Signatures:**

_____ _____ _____ _____
Signature of Applicant Date Signature of Spouse/Domestic Partner (if proposed for coverage) Date

If coverage is requested for dependent children age 18 and above, signature of each child age 18 and above is required below.

_____ _____ _____ _____
Signature of Dependent Child Date Signature of Dependent Child Date

_____ _____
Signature of Agent Date

**RATE CALCULATION SHEET**

**INDIVIDUAL PRODUCTS**

Blue Cross Blue Shield of Florida
P.O. Box 44052
Jacksonville, Florida 32231-9961

SSN:

Agent's Name: _____ Agent #: _____

County Code: *Washington* *69* Seq #: _____

Deductible Option: _____ Product: *Select Product/Term*

OOP Option: _____

Child Only: ☐

Maternity Benefit: ☐ Yes ☐ No

*Home*
*TIP APP*

| Name | Age | Sex | Relation | Smoker | Basic Premium |
|---|---|---|---|---|---|
| | | ☐ M ☐ F | | ☐ Y ☐ N | |
| | | ☐ M ☐ F | | ☐ Y ☐ N | |
| | | ☐ M ☐ F | | ☐ Y ☐ N | |
| | | ☐ M ☐ F | | ☐ Y ☐ N | |
| | | ☐ M ☐ F | | ☐ Y ☐ N | |
| | | ☐ M ☐ F | | ☐ Y ☐ N | |
| | | ☐ M ☐ F | | ☐ Y ☐ N | |

| Total amount due: | *$0.00* |
|---|---|

This information is intended solely for
If you are not , this information does not apply to you. The rate shown, which is based on the information provided by , is subject to change and is not a guarantee of coverage. Also, coverage is not effective until after your application has been approved by BCBSF, a contract has been issued and the initial premium has been paid. No agent can make or change a contract term or waive any of the company's rights. The precise coverage afforded by any BCBSF insurance policy is subject to the terms and conditions of the policies as issued.

BlueCross BlueShield of Florida
An Independent Licensee of the Blue Cross and Blue Shield Association

4800 Deerwood Campus Parkway • Jacksonville, Florida 32246

# Temporary Insurance

| FOR HOME OFFICE USE ONLY | REF | EFFECTIVE DATE | COV. | RATING AREA | DIV. |
|---|---|---|---|---|---|
| | OC CODE | BIRTHDATE (MO./DAY/YR.) | REP CODE | | |
| | CONTRACT # ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ | | | | |

## SECTION A

(1) APPLICANT'S LAST NAME, FIRST NAME, MIDDLE INITIAL , , | (2) BIRTHDATE (MO/DAY/YR.) | (3) AGE

(4) SOCIAL SECURITY NUMBER | (5) STREET ADDRESS

(6) CITY | COUNTY *Washington* | STATE | ZIP CODE

(7) MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED | (8) DATE OF RESIDENCY IN FLORIDA

(9) SEX ☐ M ☐ F | (10) ☐ EMPLOYED ☐ SELF EMPLOYED ☐ UNEMPLOYED ☐ RETIRED | (11) TELEPHONE NUMBER

(12) SPOUSE/DOMESTIC PARTNER'S NAME — IF TO BE INSURED | (13) DOMESTIC PARTNER'S SEX ☐ M ☐ F

(14) SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NO. | (15) SPOUSE/DOMESTIC PARTNER'S BIRTHDATE (MO/DAY/YR) | (16) SPOUSE/DOMESTIC PARTNER'S AGE

| (17) CHILDREN'S FULL NAME – IF TO BE INSURED | SOCIAL SECURITY NO. | BIRTH DATE (MO./DAY/YR.) | AGE | RELATIONSHIP TO YOU | ZIP CODE (If Different) |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

## SECTION B

1. Have all persons shown on this application been residents of the United States for at least one year and do they plan to reside in Florida for the duration of this coverage?
   ☐ Yes ☐ No **If No, this policy cannot be issued.**
2. Is any person listed in Section A (or any immediate family member not listed in Section A) now pregnant?
   ☐ Yes ☐ No **If Yes, this policy cannot be issued.**
3. Will the coverage being applied for replace any hospital or medical expense insurance? ☐ Yes ☐ No
   Name of Company | Policy Number | Termination Date
4. Do you or any listed dependent(s) now have hospital or medical expense insurance (other than coverage terminating on the date shown above) with any other company?
   ☐ Yes ☐ No **If Yes, then this policy cannot be issued.**
5. Have you, or any person to be insured, been declined for insurance due to health reasons during the past 2 years?
   ☐ Yes ☐ No **If Yes, then this policy cannot be issued.**

*Home*

## SECTION C

(1) POLICY EFFECTIVE DATE | (2) POLICY EXPIRATION DATE | (3) POLICY TERM SELECTED ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days

(4) I AM APPLYING FOR ☐ SINGLE or ☐ FAMILY COVERAGE | (5) Total Premium Collected $ *$0.00* | (6) DEDUCTIBLE OPTION SELECTED: ☐ $500 or ☐ $1,000

## SECTION D

I hereby apply for the coverage selected on this application form. I understand that the coverage shall not become effective until this application is accepted, the initial premium paid, and an effective date is assigned to my coverage by BCBSF. I have read this application carefully and I represent that the information I have provided in this application is true and complete. I understand that this information is the basis for determining the issuance or denial of coverage and any misstatement or omission may result in the denial of benefits and/or the termination of coverage. I understand that this policy is not renewable. I understand that I may purchase this policy more than once; however, I may not have coverage under any BCBSF Temporary product for more than 180 days in a 12-month period. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I further understand that there will be no continuation of benefits (continuous coverage) if I purchase another BCBSF policy and any condition that may have occurred under the first policy will be treated as a pre-existing condition under the second policy.

I authorize any physician, medical practitioner, hospital, clinic or other medical or medically-related provider, insurance company, employer or other organization, institution or person that has medical records or any other knowledge of me, or my eligible dependents, to release such information to BCBSF. This release specifically includes, but is not limited to, authorization to release any and all medical records and information associated with (or with reference to) the following conditions: exposure to HIV infection, ARC, AIDS, alcohol or drug dependency, mental and nervous disorders. I understand that this policy, if issued, will not cover benefits for any condition, illness or injury for which I received medical advice or treatment during the 24 months prior the effective date of this contract. This is a pre-existing condition limitation.

Applicant's Signature _____ Date _____

Spouse/Domestic Partner's Signature _____ Date _____

Licensed Agent's Name (Printed) _____ Agent's ID No. _____

Licensed Agent's Signature _____ Agent Code No. _____ Date _____

## SECTION E

Receipt for Premium (Make Check Payable to Blue Cross and Blue Shield of Florida.)

Received from _____ (Applicant's name) an application to Blue Cross and Blue Shield of Florida, and $ *$0.00* _____ in consideration for the insurance for which application is made. Such consideration is accepted subject to the answers to the questions on the application being true and correct. This receipt is subject to all terms, conditions and representations contained in the application and the coverage applied for.

Licensed Agent's Signature _____ Agent Code No. _____ Date _____

# BlueDental Care Prepaid Individual Application

# Florida Combined Life

Mail To:
Florida Combined Life
Dental Services Administrator
PO Box 769569
Roswell, GA 30076-8223

| Social Security Number | Last Name | First Name | MI | Sex ☐M ☐F | Date of Birth: MM/DD/YYYY |
|---|---|---|---|---|---|
| | | | | | / / |

| Home Address | Suite/Apt Number | City | State | Zip Code |
|---|---|---|---|---|
| | | | | |

*Minimum applicant age is 18.*

| Home Phone Number | Business Phone Number | Dental Facility # (Select from provider directory) |
|---|---|---|
| ( ) | ( ) | |

## List All Eligible Dependents To Be Covered.

Eligible Dependents include your spouse and/or unmarried child(ren) to age 19 or 25 if such child is dependent on you for support and is living in your household or is a full-time or part-time student.

| | Social Security Number | Last Name | First Name | MI | Sex | Date of Birth | Dental Facility # (Select from provider directory) |
|---|---|---|---|---|---|---|---|
| Spouse | | | | | ☐M ☐F | | |
| Child | | | | | ☐M ☐F | | |
| Child | | | | | ☐M ☐F | | |
| Child | | | | | ☐M ☐F | | |

**I wish to enroll in the FCL prepaid individual plan. I understand that this is a MINIMUM ONE (1) YEAR CONTRACT and that all necessary dental services will be provided as described in the plan. Completed applications with correct payment received by the 15th of the month will take effect on the 1st of the following month. Applications received after the 15th of the month will take effect on the 1st of the month following the subsequent month. Make checks payable to Florida Combined Life.**

| Applicant Signature | Date |
|---|---|
| | |

| Agent Name | Agent Code Number |
|---|---|
| | |

## Credit Card Section

| CHECK ONE | Credit Card Number | Exp. Date: MM/YY |
|---|---|---|
| ☐ MasterCard ☐ Visa ☐ Discover | | / |

Amount Charged **(Annual Premium + one time $35 non-refundable enrollment fee = Annual Amount You Pay)**

$ _____ + $35 = $ _____

| **I hereby authorize charging by Credit Card:** Cardholder's Signature | Date |
|---|---|
| | |

## PI210 Plan Rates

| **Policy Type (select one)** | Monthly Premium (Bank Draft Only) | Annual Premium (Check, Money Order or Credit Card) |
|---|---|---|
| Individual | $10.65 | $127.80 |
| Individual + one dependent | $18.19 | $218.28 |
| Individual + two dependents | $24.65 | $295.80 |
| Individual + three dependents | $31.00 | $372.00 |
| Individual + four or more dependents | $36.88 | $442.56 |

| **Calculate Your Total Below** | **Monthly** | **Annual** |
|---|---|---|
| Premium Amount | $ | $ |
| One time non-refundable enrollment fee | + $35.00 | + $35.00 |
| Administrative Fee (Bank Draft Only) | + $1.00 | |
| Total Amount Due | $ | $ |

**FRAUD NOTICE:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Home

## Monthly Bank Draft Authorization for Deduction Section

| Accountholder's Name | Social Security Number |
|---|---|
| | |

I authorize: _____ to make a monthly bank draft of
(Financial Institution/Bank Name)

$ _____ **+ $1.00 = $** _____ from Account # _____
(Monthly premium + $1.00 administrative fee) (Monthly Only)

and to remit the amounts deducted to FCL, upon instructions from FCL. The amount of deduction indicated above is approximate and may be corrected as instructed by FCL. This authorization will remain in effect until: (a) I/we cancel it in writing; (b) the above account is closed; (c) the deduction and remittance arrangements between the above financial institution and FCL are discontinued; or (d) the insurance policy is cancelled. I understand that this authorization does not waive or change any of the payment provisions of the policy issued to me by FCL, and if this authorization terminates for any reason, any further payments required under the policy will be made as provided in the policy. I agree that the above financial institution is acting gratuitously and for my sole accommodation and not as an agent for FCL.

**YOU MUST INCLUDE A VOIDED CHECK WITH THIS APPLICATION**

Accountholder's Signature: _____ Date: _____
(Signature Required)

BlueCross BlueShield of Florida

**FOR MORE INFORMATION CALL**
**1-888-753-4363**