Under 65 Products Resource Guide
Updated February 2007

Contents:

BLUE CROSS AND BLUE SHIELD OF FLORIDA and HEALTH OPTIONS FIELD UNDERWRITING GUIDELINES FOR MEDICALLY UNDERWRITTEN INDIVIDUAL PRODUCTS

It has been provided to assist you in the overall underwriting process. This manual contains guidelines only. Final underwriting decisions are the responsibility of the Home Office, Individual Medical Underwriting Department.

"Blue Cross and Blue Shield of Florida and Health Options does not refuse to insure any individual solely because of race color, creed, marital status, sex, national origin or for any reason prohibited by law. The Company does not refuse to insure any individual solely because of their residence, age, lawful occupation or mental or physical handicap unless there is a reasonable relationship between the residence, age, lawful occupation, or mental or physical handicap of the individual and the risk to be undertaken by the Company by issuing the insurance."

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FIELD UNDERWRITING GUIDELINES

FOR THE UNDER AGE 65 INDIVIDUAL MEDICALLY UNDERWRITTEN PRODUCTS

Introduction

The selection of quality, high persistency business is vital in order for Blue Cross and Blue Shield of Florida and Health Options (hereto referred as "The Company") to continue to make outstanding products available on an individual basis. It is through the efforts of the writing agent that this high quality of business can be obtained. The Company relies on the agent to carefully select risks and to supply the facts needed so that we may classify applicants properly, fairly and quickly. The agent must report any personal observations or facts bearing on the insurability of the risk, even if it is expected that The Company will get the facts from another source such as a previous application, previous claim, medical records or a paramedical examination.

The Company should have a feeling of confidence when an agent recommends an applicant, and the agent can gain our confidence if he/she has a record of submitting good business. The success and continuation of the sale of our policies and the success of the individual agent, and the general agency, depends upon the agent's use of common sense underwriting.

These Field Underwriting Guidelines have been provided as a reference tool for the BCBSF sales agent. **The Company expects each agent to use this manual as a guide before submitting an application on a proposed insured.**

UNDER AGE 65 INDIVIDUAL MEDICALLY UNDERWRITTEN PRODUCTS AND DESCRIPTION

The current, actively marketed, medically underwritten insurance products available for Individuals Under 65 are: BlueOptions, BlueChoice, Dimension IV (DIV) and Essential. Our medically underwritten HMO product is BlueCare for Individuals Under 65.

- **BlueOptions** is the newest family of products that includes Coventional plans, Low Cost plans, Hospital and Surgical Plans, and HSA Compatible plans. Maximum benefits are provided when using providers that participate in *NetworkBlue*. Services may be obtained from providers that do not participate in *NetworkBlue,* however, higher out-of-pocket costs will result. Conventional plans provide comprehensive coverage with co-payments for in-network physician visits and other selected services including prescription drugs. Low Cost plans provide comprehensive coverage with higher out-of-pocket limits, generic only prescription drug coverage, co-payments for in-network physician visits, and cost sharing for other services. The Hospital and Surgical Plans are primarily designed to cover catastrophic illness. HSA compatible plans offer comprehensive coverage subject to high deductibles and stated co-insurance amounts. If desired, an HSA compatible plan may be coupled with a tax deductible health savings account through a financial institution.

- **BlueChoice** is a co-pay PPO product providing flexible comprehensive major medical health care benefits. Covered services rendered by a PPO family physician are subject to a pre-determined co-payment amount. Benefits for covered services rendered by a provider other than a PPO Family Physician are subject to deductibles and coinsurance.

- **DIV** product is a Traditional Insurance Plan which provides comprehensive major medical health care benefits subject to a deductible and out-of-pocket maximums allowing the consumer to have “freedom of choice” with the providers.

- **Essential** product is a hospital-surgical contract and is primarily designed to cover catastrophic illness.

- **BlueCare** offers a comprehensive set of health benefits, on a fixed-premium basis, to a voluntarily enrolled population. The choice of providers is usually limited to our HMO’s network of physicians and hospitals. BlueCare limits or eliminates out-of-pocket expenses to the member, as long as the member seeks care from our HMO-designated providers. A primary care physician is used as a gatekeeper or manager of referrals for specialty care and hospitalization.

FOR THE PURPOSES OF THIS MANUAL, “INSURANCE PRODUCTS” REFERS TO BLUEOPTIONS, BLUECHOICE, DIV AND ESSENTIAL PRODUCTS. “HMO” REFERS TO BLUECARE.
REMEMBER: ALL OF THE ABOVE PLANS HAVE SEPARATE DISTINCT NETWORKS.

OTHER PRODUCTS OF INSURANCE

BlueOptions Temporary Insurance Product (TIP) is a traditional comprehensive short-term health insurance plan that is not-underwritten. Coverage is available to adult applicants, under the age of 65, and their families who have not previously been medically declined.

TIP coverage is available in increments of 30, 60, 90, and 180 day policies. Applicants can select either a $500 or a $1000 deductible. The following also applies to all TIPs:

- Applicants cannot have previously been medically declined.
- Applicants must be at least 18 years of age; child only applications are not available.
- Applicants cannot exceed the age of 64 years and 11 months.
- Multiple policies up to 180 days of **consecutive** coverage may be issued (a grace period of 10 working days or less will be permitted between policies. See ASIB 06-086).
- Coverage cannot exceed 180 days within a 12 month period.
- A full single premium payment is submitted with the application.

- The BlueOptions TIP policy is creditable coverage and portability of Pre-existing credit of subsequent policies is appropriate.

- Application for TIP coverage may not be written in front of Guaranteed Issue (GI) policies.

Conversion and Guarantee Issue (GI) policies are also available. These policies have specific eligibility requirements which must be met. They are solely written by the Direct Sales Center agent. Applicants interested in these products of insurance should be advised to contact the Direct Sales Center at 1-800-876-2227.

MATERNITY / OBSTETRICAL CARE OPTION

BLUEOPTIONS PRODUCTS:
Maternity/Obstetrical Care Endorsement is available with Blue Options plans 10, 11, 12, 13, 50, and 51, and may be purchased at the time of initial application or any point thereafter. This benefit may not be sold as a stand-alone product. This optional benefit is available for an additional rate (cost will vary according to county). The endorsement must have been in effect continuously for a period of 30 days immediately preceding the date of conception. Two deductible options of $1,500 or $2,500 are available. Once the deductible is met, there will be a 50% coinsurance for all covered services during pregnancy and delivery with the exception of treatment for complications of pregnancy as defined in the Covered Services Section of the contract. The maternity deductible and out-of-pocket are separate from the health plan deductible. (See ASIB's 05-053 and 05-043)

BLUECHOICE AND DIMENSION PRODUCTS:
BlueChoice and Dimension Products Maternity benefits are available for an additional cost. The Maternity Endorsement provides coverage for health care expenses associated with maternity, delivery and postnatal care. The endorsement must have been in effect continuously for a period of 30 days immediately preceding the date of conception. Payment for services is not subject to the deductible or coinsurance specified in the contract Schedule of Benefits. This endorsement offers a total maximum payout of $1500 for all maternity related services. The maximum allowable payment to providers is as follows: Delivering Physician or Midwife - $750, Hospital - $750. (See ASIB 05-010)

BLUECARE PRODUCTS:
Maternity benefits are available for an additional cost, and may be provided by the Primary Care Physician (PCP) or a specialist on referral from the PCP. Eligibility for benefits require that the maternity endorsement must have been in effect continuously for a period of 30 days immediately preceding the date of conception. Care may be received at a Hospital (within the Health Options Service Area only), at a Birthing Center, a physician's office, or at home. Coverage includes physical assessments, and any medically necessary clinical tests. Co-payments: Physician Services, Maternity Initial Obstetrician visit only $35; Hospital Services, Outpatient Birthing Center, $0; Inpatient $150 per day for the first 5 days, $750 maximum per stay. No coverage is provided for maternity services outside the Health Options Service Area. (See ASIB 00-013).

ESSENTIAL PRODUCTS:
NOT COVERED (Exception – complications of pregnancy may be covered if they meet the requirements as outlined in the contract).

UNACCEPTABLE APPLICATIONS

Applications should **not** be written for individuals who:

1. Live in a non-operational service area for the product being sold. (See **Florida and County Residency Requirements** chapter of these Administrative Guidelines.)
2. Are about to be seen by a physician or about to enter a hospital, sanitarium, rest home, prison or other institution, or who are sick, infirm, or otherwise not healthy at the time of the application.
3. Have a medical appointment scheduled within the next 30 days, including appointments for routine physicals, until **after** the physician has been seen and all test results are known (generally two weeks after the exam).
4. Recently had or anticipate testing or surgery and have not been released from the physician's care.
5. Are pregnant women, spouses of pregnant women, pregnant dependents, or *prospective fathers* **until** after delivery and released from the physician's care (generally, after the six-week check-up). ***NOTE:*** Prospective fathers include married and single individuals. Child-only applications may be completed for other dependent children.
6. Are dependent children under two months of age **on a family application** and/or who have not had their first well child examination after release from the hospital. (See **Dependent Eligibility Requirements** chapter of these Administrative Guidelines.)
7. For BlueOptions and BlueChoice, is a child under the age of 1 year when the child will be the proposed insured on a **Child Only** application (See **A Minor Child as the Applicant** chapter of these Administrative Guidelines and ASIB 06-008). The minimum age for child only contracts for DIV, Essential, and BlueCare is 3 (ASIB 01-040).
8. Is a dependent child, over the age of 19, on a family application, unless the child is a full-time student attending an accredited college or university in the U.S., and whose permanent residence is with the primary applicant and who depends upon the primary applicant for support. (See **Dependent Eligibility Requirements** chapter of these Administrative Guidelines.)
9. Is a dependent child, over the age of 23, on a family application. (See **Dependent Eligibility Requirements** chapter of these Administrative Guidelines.)

UNACCEPTABLE APPLICATIONS - continued

10. Are currently receiving Social Security Disability and/or early Medicare benefits, or unable to work due to disability or receiving Workers' Compensation or disability income benefits.

11. Are currently an eligible employee currently enrolled for group coverage through Blue Cross and Blue Shield of Florida or Health Options. (See **Replacement of Blue Cross Blue Shield of Florida/Health Options Group Coverage** chapter of these Administrative Guidelines.)

12. Reside in Florida less than six full consecutive months of the year. (See **Florida and County Residency Requirements** chapter of these Administrative Guidelines.)

13. Are a non-U.S. citizen who has been in the United States for less than six full consecutive months, or are visiting the United States on a temporary basis, or do not have a valid VISA as of the effective date of the policy. (See **Non United States Citizens** chapter of these Administrative Guidelines and ASIB 00-066)

14. Have previously applied for a Blue Cross Blue Shield of Florida or Health Options Individual contract that was offered but refused by the applicant within the past 6 months.

15. Have been medically rejected for coverage by Individual Medical Underwriting in the past year, unless otherwise instructed by the Individual Medical Underwriting Department that a new application may be completed. (See **Appeals Process and Procedures** chapter of these Administrative Guidelines.)

16. Refuse to provide their social security number (See **Social Security Number Requirement** chapter of these Administrative Guidelines.) Social Security Numbers are for internal use only. Contracts are assigned a policy number.

17. Have been previously rejected by Individual Medical Underwriting due to outstanding information needed to determine insurability. A new application should **not** be completed until authorized by the Individual Medical Underwriting Department after review of the outstanding information. (See **Appeals Process and Procedures** chapter of these Administrative Guidelines.)

UNACCEPTABLE APPLICATIONS - continued

18. Are unable to sign his or her own application for whatever reason (other than a minor child under the age of 18 in which case the parent is required to sign). A power-of-attorney is not acceptable.

19. Will become age 65 as of the proposed effective date of coverage.

20. Are applying for the HMO product and have health history requiring a Medical Exclusionary Rider; this type of applicant is unacceptable for the HMO product. Please refer to the Medical Histories Guidelines section of this manual when assessing the medical eligibility of the applicant(s).

APPLICATION COMPLETION

Applications completed in person with the applicant is the preferred method. On the day the application is written and initial premium accepted, the agent is to visually examine the applicant and spouse (if applying) and any dependent children if it is a family coverage application. The persons proposed for coverage must be in good physical and mental health and must be able to pursue their normal activities and respond normally to the questions asked. The agent should look for any defects or symptoms which would cause a reasonable person to conclude that the individual seeking insurance is sick, infirm, or otherwise not healthy. If for any reason the dependent children are not present at the time of application, the agent should include a statement in the Agent Remarks section of the application indicating the child's name and reason not seen. (See **Dependent Eligibility Requirements** chapter of these Administrative Guidelines.) The writing agent should sign and date the Agent Certification on page 4 of the application certifying that the applicant was seen and all questions were asked. The applicant and spouse (if applying) should sign and date the application at the time of completion.

On rare occasions if the applicant is unable to meet personally with the agent for an interview, a "Telemarketed" application is acceptable. The agent should ask and record all questions prior to mailing the application to their client. The applicant should be instructed to currently date and sign the application and all forms in the appropriate places prior to mailing the application back to the agent. Once the application is received by the agent, the agent should thoroughly review for completeness. The agent should then sign and date the Telemarketing certification on page 4 of the application.

In the situation where one family member completed the application in person and the other family member(s) completed via a telephone interview, the agent should sign both certifications. The name(s) of the person interviewed via telephone should be indicated in the "Telemarketed" certification area.

The application is the **primary** basis upon which The Company relies before issuing an Individual Insurance Contract or an HMO Membership Agreement. Every question on the application is critically important. The writing agent should ask each question separately, in full, and then record with care the answers **exactly** as given by the applicant. Keep in mind that the application is a legal contract. Medical records furnished with the application and/or claims data that may be on file with BCBSF/HOI cannot be made part of the contract and should not be used as a substitute for obtaining and recording complete medical history on the application. Therefore, it is extremely

APPLICATION COMPLETION - continued

important that full disclosure of all medical history be provided on the application. Failure to properly disclose complete and accurate information could result in an inappropriate underwriting action, or rejection of the entire application if discovered during the underwriting process (refer to ASIB #00-018). Undisclosed health history discovered after issue could also result in serious problems at the time of a claim and could result in possible rescission *or cancellation* of the contract.

Handwritten applications must be completed in a legible manner. Complete names and addresses of all doctors and hospitals, and **dates first and last consulted** should be provided. If, during the visual examination of the applicant(s), the height and weight or other health history appears different than provided by the applicant, requestion him or her and provide the details. If you still feel the information is inaccurate please write a separate note to the Underwriting Department and staple it to the application. (See Agent's Remark Section for additional details)

All questions on the application must be answered and details to any "yes" answers provided. Any changes to the answers provided must be **initialed** and **dated** by the ***applicant***. ***The use of correction fluid is not acceptable.*** (See **Changes and Corrections** chapter of these Administrative Guidelines.) If additional space is needed, use an **Addendum to the Medical History** (see the **Forms** section of this manual**, sample number 1**) **and/or an Addendum to the Prescription Drugs** (see the **Forms** section of this manual**, sample number 2**). These forms should also be properly signed and ***dated,*** as both are a continuation of the application and will become a part of the contract.

For additional information to aid the writing agent in obtaining medical information, please refer to the **Medical Histories Guidelines** section of this manual.

INELIGIBLE OCCUPATIONS

Wild Animal Trainers	Hazardous Waste Handlers
Active Armed Forces Personnel	Off-Shore Oil Workers
Asbestos and Toxic Workers	High Risk Aviation such as: Crop Dusters, Helicopter Pilots and Aerial Photographers
Professional and Semi Professional Athletes involved in Contact Sports or high risk for injury	Police, Law Enforcement Personnel, or Armed Security Guards
Carnival, Circus or Rodeo Workers	Race Car Drivers
Explosives Dealers, Makers or Handlers	Sky Diving Instructors
Fishers and Fishing Workers, including Commercial Fishing Crew Members	Timber & Wood Cutters, and Loggers
Firefighters	Underwater or Caisson Workers

Revised October 2005. See ASIB 05-088.
Revised December 2006.

SOCIAL SECURITY NUMBER REQUIREMENT

Please keep in mind that Social Security numbers are required for all applicants, including dependents, applying for our products. Health ID numbers will be assigned as contract numbers, however, Social Security Numbers are still required.

1. If the proposed insured or dependent(s) does not have, or has not applied for, a Social Security number, a full explanation needs to be provided in the Agent Remarks section of the application.

2. If the client has applied for a Social Security number, which has not yet been received, details as to when the Social Security number was applied for and when it is expected should also be provided in the Agent Remarks section of the application.

3. If a Social Security number is not available when underwriting is completed, the application may be declined.

4. ***If a client has a Social Security number but refuses to provide it, an application may not be written***.

NON UNITED STATES CITIZENS

Applicants may be considered for coverage if they have been a legal resident of the United States for a minimum of six full consecutive months and have a valid Resident Alien Card (Green Card), or unexpired VISA. They must intend and/or expect to remain in this country for the next two years and they must be permanent residents of the State of Florida.

A copy of their valid VISA or Resident Alien Card must also be submitted with the application. Resident Alien cards are given for permanent residency status while VISAs are generally given for a specific time frame depending upon the reason the VISA is being issued. Some VISAs are considered more likely to help secure a Resident Alien Card while others are considered temporary. All VISAs are issued with an expiration date. If a client has received an extension on their VISA expiration date, a copy of their I-94 form, showing the new expiration date, should also accompany the VISA. The VISA must be valid as of the effective date of the policy.

An applicant with significant health history such as a heart disorder, heart murmur, neurological disorder, seizure history, cancer history, etc. may not be considered unless they have established a physician/patient relationship with a doctor in the U. S. Medical records (to be obtained by the Underwriting department) must be available and must include recent documentation regarding this significant health history.

Additionally, while it is preferred that the applicant has established a physician/patient relationship with a U.S. physician so that medical records may be obtained if desired by underwriting; it is not required provided the applicant does not have a significant health history. In this situation, the application may be written and a Paramedical Exam will be ordered by Underwriting. A Paramedical Exam Disclosure statement must be taken for these individuals (Please refer to the **Paramedical Examinations** chapter of these Administrative Guidelines.) Refer to ASIB 05-088.

FLORIDA *& COUNTY* RESIDENCY REQUIREMENTS

For an Insurance Product, the applicant's primary residence address must be in the State of Florida, and in an operational county for the product for which they are applying, for more than six full months of the year. This includes a minor child applying as the applicant. An applicant who is a full-time student and relies on his/her parents for support and maintenance may be written only if attending an accredited college or university, located in the state of Florida. The name and address of the school should be included in the Employer/School address field of the application.

A full-time student who is a resident of Florida and attending a college or university located outside of the State of Florida may only be considered for coverage as a dependent on a family contract. Benefits may be limited for services rendered outside the state of Florida and it is important to make the applicant aware of this.

For dependent children who do not reside with the Primary Applicant, see the **Dependent Eligibility Requirements** chapter of these Administrative Guidelines.

SPLIT POLICIES

We prefer that all family members be enrolled under one contract. However, to assist applicants in achieving the most appropriate coverage to meet their needs, applications for family members may be split in any manner desired, **except same product, same deductible.**

- Different products for each family member or different deductibles within the same product for each family member are acceptable.
- Separate applications with separate premium payments are required and separate underwriting for each will occur.
- The applications will **not** be linked together and will be processed as they are approved.
- Different effective and billing dates are likely.

Note: It is not recommended that split policies be written in a situation where the family is replacing other coverage, as we will not coordinate effective dates nor paid-to-dates between the family members. Refer to ASIB 05-088.

For in-force policies, family members may split off and roll to the same or a higher deductible within the same product without underwriting. Also, in some circumstances, the family member may roll to a different insurance product without underwriting. These change requests are handled through the Membership and Billing Department. If a family member desires a lower deductible or richer product, a plan change application and underwriting is required. (See **Changes To An Existing Contract** chapter of these Administrative Guidelines.)

DEPENDENT ELIGIBILITY REQUIREMENTS

Eligible dependents are a spouse, unmarried natural child(ren), adopted child(ren) or stepchild(ren).

Spouse
Applicants that are legally married can include their spouse as an eligible dependent. Please remember that common law marriages are *not* recognized in the State of Florida. Therefore, common law spouses are not eligible dependents. If the spouse's last name is different from the primary applicant, note the reason why they are different in the Agent Remarks section of the application.

Children
Unmarried children may be covered until the end of the calendar year in which they reach the limiting age of 19, or 23 if attending an accredited college or university on a **full-time basis.** The dependent, unmarried child must also be dependent upon the primary applicant for support.

Dependent children are medically assessed for the Under 65 Medically Underwritten products the same as adult applicants. It is impossible to determine a newborn child's insurability for coverage when they have not yet established a relationship with a Pediatrician/Physician. Therefore, dependent children, under two months of age **and** who have not had their first Well Child examination after release from the hospital, cannot be considered for coverage on a family application. If existing coverage is available, the parent(s) should be encouraged to add the newborn child to the current contract until the child is eligible for the Under 65 Medically Underwritten products. Keep in mind, the majority of contracts include a provision to add newborn children, without evidence of insurability, if enrolled within a specified time period (generally 30 to 60 days).

DEPENDENT ELIGIBILITY REQUIREMENTS - continued

A Child(ren) applying as a dependent, but who does not reside with the applicant on a primary basis, must still be a resident of the state of Florida, and live in an operational county for the product for which they are applying, for more than six full months of the year. The zip code of the child's residential address must be noted in the Part I: Enrollment Information questions, in the space provided for the dependent information, if the child's zip code is different from the primary applicant. These children should be identified in the Agent Remarks section of the application. It should also be noted whom they reside with, why they reside there and how familiar the primary applicant is with the child's health history. The parent with whom the minor child resides must be interviewed for answers to all questions. Indicate the name, relationship and date of interview in the Agent Remarks section of the application.

The following applies to the Insurance Products only:

Foster child(ren) or child(ren) in court-ordered custody or legal guardianship of the primary applicant may be covered to the end of the Calendar Year in which they reach the age of 19, or to the end of the calendar year of the child's 23'rd birthday if attending an accredited college or university on a **full-time basis.** The dependent, unmarried child must also be dependent upon the primary applicant for support.

A copy of the court ordered custody document must be submitted with the application.

The following applies to the HMO product only:

The HMO product does not consider foster children or children in a court ordered custody or legal guardianship arrangement as eligible dependents on a family contract.

CHILD ONLY APPLICATION
(A MINOR CHILD APPLYING AS THE APPLICANT)

1. A minor child at 1 year of age or older for BlueChoice and BlueOptions or 3 years of age or older for DIV, Essential or BlueCare may be considered for coverage as the Applicant. It is unacceptable to submit a Child Only application for a child under 1 year of age for BlueChoice and BlueOptions or under 3 years of age for DIV, Essential or BlueCare.[1]
2. A ***Child-Only application*** should not be completed for a dependent child 18 years or older as this applicant is considered a legal adult and must sign his or her own application.
3. When an application is taken on more than one minor child from the same family, **separate applications** should be taken on each child applying for coverage.
4. The parent or legal guardian must be interviewed for answers to all questions on the application. When a child does not reside with the parent applying for the coverage, the parent with whom the minor child resides must be interviewed to verify answers to all Part II: Medical History questions. Indicate the name, relationship and date of the interview in the Agent Remarks section of the application.
5. The parent or legal guardian must sign and date the application. In addition, the signer **must also indicate their relationship to the child in Part V**: Authorizations/Acknowledgements of the underwritten application. If the child resides with a legal guardian, a copy of the **court order** naming the guardian must be submitted with the application. Also, include a statement explaining why the child does not reside with the natural parents in the Agent Remarks section of the application.
6. Supporting forms: If replacing other coverage, see **Replacement of Existing Insurance** chapter of these Administrative Guidelines for additional information and provide the appropriate forms.

Children should have an established pediatrician whereby they have received immunizations and well child exams. This, and all other health history, should be noted on the application for each child applying for coverage. Blank applications on children are **not** acceptable.

[1] Child Only minimum age reduced to age 3 for Insurance and HMO applications signed 6-15-01 and later. Child Only minimum age reduced to age 1 for BlueOptions and BlueChoice effective February 1, 2006. See ASIB 06-008.

SMALL GROUP REFORM IMPACT ON INDIVIDUAL HEALTH COVERAGE

Florida Senate Bill 1914 was enacted in 1993 and governs the participation of a small business owner (employees 1-50) in the contribution of premium payment and administrative support for the payment of premiums for an individual's non-group health coverage. This legislation stipulates that:

1. A small business owner (employees 1-50) cannot contribute to an individual employee's individual medical contract, and

2. A small business owner (employees 1-50) cannot provide administrative support for the billing of an employee's individual medical contract and if coverage is approved, all premium billing will be sent to the primary contract holder. The exception to this is a List Billing arrangement enacted by Florida legislation in 2005 (HB 811). Refer to ASIB 05-109 for details to the Workplace From Blue program.

To ensure that compliance with this Florida Senate Bill is met, the **Premium Validation Statement**, form 10066, must be completed and attached to every Under 65 product application.

The legistlation allows certain exemptions from the Small Group Reform and if applicable, **Part II** of the **Premium Validation Statement** should be completed.

REPLACEMENT OF EXISTING INSURANCE

STATUTORY OBLIGATIONS AFFECTING THE INSURANCE PRODUCTS ONLY:

The State of Florida defines Replacement of Accident or Sickness insurance as coverage that is permanent and the applicant is forfeiting their available benefits. It is not considered replacement of Accident or Sickness insurance*, under the statutory language*, when prior coverage benefits are no longer available to the insured (i.e. reaching limiting age, exhaustion of COBRA benefits, or coverage that is temporary or short-term that is not considered creditable coverage).

To further meet the State of Florida statutory requirements, form 8422**, Replacement of Existing Insurance** was developed. This form, in part, carries the state-required language "Notification to Applicant" and requires the signature and date of the applicant and writing agent. A copy of this form is *always* to be provided to the applicant at the time of application.

The Replacement of Existing Insurance form was also developed to meet the underwriting needs for *any* case in which prior coverage is proposed to be replaced (*even if not defined under the State of Florida definition of replacement*). **Therefore, in any possible replacement situation, the agent is to complete the Replacement of Existing Insurance form**.

Insurance and HMO products:

If other insurance is to be given up, it is extremely important that the applicant understand the full significance of this action. Replacement of existing coverage should be considered only when it is in the best interest of the applicant. The applicant should be advised to take advantage of any benefits they may be eligible for under COBRA, Conversion or the HIPAA/IPAA statutes.

Please inform the applicant it can take up to 60 days for an underwriting decision to be made. The applicant should be advised **not** to lapse existing coverage that can be continued before the Blue Cross and Blue Shield of Florida or Health Options contract is issued or an offer is made.

In any situation where the applicant wishes to replace their current coverage (group, other non-group coverage, COBRA coverage, etc.) with the underwritten insurance or HMO products, the agent is to indicate "yes" on the application in Part I, Question 9 and provide the paid to date of the current coverage.

REPLACEMENT OF EXISTING INSURANCE - continued

If an applicant is replacing Blue Cross and Blue Shield coverage from another state, it is important that the agent make clear to the applicant that Blue Cross and Blue Shield of Florida and Health Options are **different entities** from their current Blue Cross and Blue Shield Plan.

Please emphasize to the applicant:

- That they are applying for a medically underwritten product that is not a conversion or COBRA product.
- That they are not applying for coverage available due to the HIPAA/IPAA legislation.
- That they are not applying for guaranteed issued coverage.
- That the product for which they are applying is medically underwritten. This means there are no statutory limitations that preclude the Individual Medical Underwriting Department from imposing Exclusionary Riders and/or Rate Modifications, and/or excluding a member on a family application, or declining the entire application on our individual underwritten products.

IMPORTANT

It is the agent's responsibility to notify the Individual Medical Underwriting Department, via fax, if the applicant makes a premium payment on their current coverage while their application is in the underwriting process. The agent's notification should indicate the new paid to date of the current coverage so that the effective date for the proposed coverage will be advanced accordingly, upon issue, provided this date is not more than 90 days from the application date.

***Requests for effective date changes will not be approved once the contract has been issued*. See the Dating The Application chapter AND Changes to an Existing Contract: Effective Date Changes chapter of these Administrative Guidelines.**

For additional information see the **Portability** chapter of these Administrative Guidelines. If replacing Blue Cross Blue Shield of Florida or Health Options coverage, refer to **Replacement of Blue Cross Blue Shield of Florida/Health Options Group Coverage** chapter of these Administrative Guidelines.

REPLACEMENT OF BLUE CROSS BLUE SHIELD OF FLORIDA/HEALTH OPTIONS GROUP COVERAGE

An individual application may be written on a BCBSF group eligible employee that was either never enrolled or who has cancelled off of their BCBSF group contract (i.e. the individual is eligible for the BCBSF group coverage but chooses not to be covered). This still does not permit the writing of an individual application on an employee who is presently covered under the BCBSF group plan unless their employment has terminated with the employer and the group coverage will cancel within the next billing period. See ASIB 05-088

If BCBSF or HOI group coverage is active and the employee is applying for the individual product due to anticipated termination of employment within the next 60 days, a letter from their employer indicating the anticipated termination date must be submitted with the application. If terminating employment due to a job change, the applicant's new date of hire and place of employment, as well as, occupational duties must be furnished in the Agent Remarks section of the application. (See **Ineligible Occupations** chapter of these Administrative Guidelines.)

Please be aware that we cannot, due to system limitations, issue an individual product if the BCBSF/HOI group coverage or COBRA is active on our membership system, even when the client knows that their group coverage is no longer in force. This pertains to all individual policies including Temporary Insurance Protection (TIP), BlueOptions, BlueChoice, Dimension IV, Essential & BlueCare coverage.

Group coverage cancellation can only be accomplished by the applicant's previous employer who must notify their Group Personal Service Representative (PSR) in the BCBSF/HOI Group Membership & Billing Department.

If the applicant is covered under COBRA coverage, the cancellation is handled through both the COBRA administrator and previous employer. To expedite the processing of the cancellation, the applicant must notify their COBRA administrator.

Please keep in mind that unlike group coverage, these are medically underwritten products with no guarantee of issuance. If current coverage can be continued, the applicant should **not** be instructed to cancel any prior coverage. The Individual Medical Underwriter will advise when a final decision has been made so that the writing agent can instruct the applicant of the cancellation process for the BCBSF/HOI Group coverage.

PORTABILITY OF PRE-EXISTING CREDIT

This chapter applies to the Insurance Products only.

Senate Bill 910, Portability of Insurance, passed by the Florida Legislature, became effective October 1, 1996. *This Senate Bill only applies to the insurance products.* ***This statute does not apply to persons who are enrolling into an HMO product***. This statute requires that credit of or toward the contractual 24-month pre-existing period be given if the benefits of the prior coverage were similar to or exceeded the benefits of the new coverage. This coverage is considered to be creditable if no more than 62 days have passed from the termination date of the prior coverage to the effective date of the proposed insurance product.

In order to comply with this statute, all applicable Certificate(s) of Creditable Coverage must be attached to and submitted with the underwritten insurance product application. In some instances, the Certificate of Creditable Coverage may not be available. In these situations, the **Prior Concurrent Coverage Affidavit**, form 15562, must be completed and submitted with the underwritten insurance product application. Credit of or toward the 24 months pre-existing limitation clause will not be given if the appropriate proof of creditable coverage is not submitted with the underwritten insurance product application. Be sure that either a Certificate of Creditable Coverage is submitted or a Prior Concurrent Coverage Affidavit is submitted for all prior creditable coverage up to 24 months.

Please bear in mind that Senate Bill 910 only requires that insurers give credit for prior creditable coverage, upon issue. This statue does not:

- limit BCBSF's ability to impose Medical Exclusionary Riders or Rate Modifications on our individual insurance products.
- limit BCBSF's ability to exclude a member on a family application or to decline the entire application.
- limit BCBSF's ability to medically underwrite individual product applications.

MEDICAL HISTORIES, CHECK-UPS, AND PHYSICAL EXAMS

When an application is submitted for consideration of coverage, it is the applicant's responsibility to prove insurability. In order to determine someone's eligibility for Blue Cross and Blue Shield of Florida and Health Option's medically underwritten individual products, the Underwriter must have access to reliable medical information. We rely on the agent to obtain and properly record the applicant's health history, past and current, in accordance with the questions on the application.

When an applicant fails to provide the agent with details concerning his/her past or present health history, the applicant's insurability for the coverage cannot be properly assessed. Therefore, an agent should not hesitate to encourage their client to remember consultations with a physician. Any admission, no matter how insignificant it may seem to be, is of importance and should be recorded on the application. As indicated in ASIB 00-018, undisclosed health history may result in declination of the entire application.

Please be sure to obtain health history for all dependent children and provide it on the application. This should include the name of the pediatrician, date last seen and reason seen. (See also **Application Completion and Medical Histories, Check-ups, and Physical Exams** chapters of these Administrative Guidelines.)

The results of a physical examination, medical records submitted with the application or claims history on file with BCBS are not to be used as a substitute for acquiring the applicant's past and present health history. All questions to Part II: Medical History section of the application should be asked and answers properly recorded. If coverage is approved, the application becomes part of the issued contract. However, the physical examination or medical records submitted with the application cannot be made a part of the contract.

MEDICAL HISTORIES, CHECK-UPS, AND PHYSICAL EXAMS - continued

Whenever a medical history of a physical impairment or other condition is recorded in Part II: Medical History section of the application, the following details must be provided:

1. A clear description of each illness or condition. Complete details should include:
    - The symptoms prompting the examination, and
    - The doctor's assessment or diagnosis, and
    - The type treatment the doctor recommended or prescribed, and
    - If operated provide details.
2. Month, day and year the illness or injury began and date of last check-up.
3. How much time was lost from normal activities.
4. Month, day and year of full recovery.
5. The *complete* names and addresses of all attending physicians and hospitals.
6. The name of any testing and the results.
7. List any prescription drugs given, dosage and how often taken and duration of treatment.
8. For histories of check-ups, routine exams, etc. complete the **Physical and Check-up Questionnaire** providing complete details for all family members applying for coverage.

If sufficient information is included, the underwriter may be able to properly classify the risk without requiring additional information (such as an Attending Physician's Statement or a Paramedical Examination), thus, avoiding an unnecessary delay. Please refer to the **Medical Histories Guidelines** section of this manual for assistance in developing medical information.

MEDICAL HISTORIES, CHECK-UPS, AND PHYSICAL EXAMS - continued

During the process of completing the application, Part II: Medical History questions, the agent should refer to the **Medical Histories Guidelines** section of this manual. If the applicant has medical history that would result in a Medical Exclusionary Rider or a Rate Modification, the underwriting action should be discussed with the applicant during the interview process. If the condition indicates a **DEC**, in the **Medical Histories Guidelines** section of this manual, an application should not be taken.

Insurance Products Only:

- A complete physical examination by a family physician (*established patient/physician relationship with multiple visit*s) within the past two years is usually sufficient for underwriting purposes even though blood and urine testing may not have been done. Examples of this may include but are not limited to: annual gynecological check-ups; post-pregnancy exams; regular exams for blood pressure treatment; etc. Keep in mind, when determined to be necessary, the Individual Medical Underwriter may order a paramedical examination, at no expense to the applicant.

- Employment; FAA; Immigration; exams by a family member; DOT, and exams for other insurance companies are generally not sufficient and/or available for underwriting purposes and will not be requested by the Individual Medical Underwriting Department.

- Also, brief notes from the examining physician that the patient is in good health are not sufficient.

Insurance and HMO Products:

An applicant with significant health history, such as: a heart disorder, heart murmur, neurological disorder, seizure history, cancer history, anemia, colon disorder, etc. cannot be considered unless a **current medical evaluation/examination** by their physician has been performed within the previous 12 months. In these situations, a paramedical examination is not sufficient for an underwriting assessment. This current examination, performed by the applicant's physician, should generally include:

1. Documentation with evaluation of the significant health history and an overview of all past and current health history, and

2. A current medical evaluation and the results of all testing deemed appropriate by the physician within the previous 12 months.

PARAMEDICAL EXAMINATIONS

A Paramedical Examination, when determined to be necessary, will be ordered by the Individual Medical Underwriter at no expense to the applicant. The examination will include check of height, weight, blood pressure and pulse. In addition to routine urine and fasting blood testing, we also test for nicotine, cocaine, pregnancy, hepatitis, and HIV. Blood will not be drawn on children under age 12. The examination will also include completion of a medical history questionnaire.

For Insurance Products:

If an applicant is applying for an underwritten *insurance product* and has not had a complete physical examination within the past two years and does not have a patient/physician relationship with a medical doctor, a paramedical examination will be required.

For HMO Product:

A current paramedical examination is required for each applicant age 18 and older when applying for the HMO product. However, at the Underwriter's discretion, medical records may be ordered prior to scheduling a paramedical examination. Additionally, at the Underwriter's discretion, a paramedical examination may be ordered for children under the age of 18.

For Insurance and HMO Products:

Although a paramedical examination may be ordered, this should not be used as a substitute for acquiring and recording the applicant's past and present health history on the application. We continue to rely on the agent to carefully select risks and to supply the facts needed for us to assess applicants properly, fairly and quickly. If an applicant has a patient/physician relationship with a past or existing health history, the information should be included in Part II: Medical History section of the application. If significant health history is noted on a paramedical examination that was not disclosed in Part II: Medical History section of the application, rejection of the entire application could result (Refer to ASIB #00-018).

PARAMEDICAL EXAMINATIONS - continued

The **Paramedical Examination Disclosure Statement** was designed to aid the writing agent in informing applicants that a paramedical examination may be required by Individual Medical Underwriting. This form also provides the applicant with written details that explain why the paramedical examination is necessary and tells the applicant what type of testing will be done. The agent should explain the examination process to the applicant(s) prior to having them sign and date the **Paramedical Examination Disclosure Statement.**

When taking an underwritten application for an applicant that appears will require a Paramedical Examination, the writing agent is responsible for:

1. Explaining to the applicant(s) that a paramedical examination may be ordered and what the paramedical examination includes.

2. Explaining to the applicant that they will be contacted by the paramedical examination service, within the next week or so, to schedule the examination, provided that medical records are not ordered by the Individual Medical Underwriter first.

3. Explaining to the applicant that they will need to fast for a minimum of **4** hours **prior to** the scheduled paramedical examination.

4. Having the applicant, and spouse if appropriate, sign the **Paramedical Examination Disclosure Statement** and give a copy to the applicant. The original should be submitted with the application.

PARAMEDICAL EXAMINATIONS - continued

The following information will outline what happens after the Underwriter reviews the application and determines that a paramedical examination is necessary.

- The Individual Medical Underwriter will contact the paramedical examination service.

- The branch office located closest to the applicant's home will be assigned the request. An examiner will contact the applicant(s) to schedule an appointment for the examination(s), the urine specimen and the blood sample. Applicant(s) must have the examination performed in the State of Florida and preferably in the county where they reside. If examinations need to be done in another county, please provide where and why in the Agent Remarks section of the application. If, due to travel plans, the applicant will be unavailable for a paramedical examination, the agent should postpone taking the application until their return.

- The paramedical examination service will forward the examination results to the Individual Medical Underwriting Department. The blood and urine sample(s) will be forwarded to the laboratory service for analysis.

- The laboratory service will then forward the blood and urine results to the Individual Medical Underwriting Department for review.

- The examination and laboratory results are generally received in the Individual Medical Underwriting Department within 7 to 10 days from the examination date.

- The agent will be able to receive status information via the Partner Relationship Management Report (PRM). It will indicate when the examination and laboratory work were ordered and when the examination and laboratory results were received in the Individual Medical Underwriting Department.

It is advantageous for the paramedical examination(s) to be scheduled and completed as quickly as possible. However, should the paramedical service report difficulties in scheduling the required examination, the Individual Medical Underwriter will notify the writing agency and request the agent's assistance.

If the applicant refuses to complete the examination, or if the examination is not completed within the usual underwriting time period, the application will be declined.

DATING THE APPLICATION

The application must be dated the day that it is completed, and the initial premium collected.

- Changes or alterations to the date of the application are not acceptable and a new application must be taken.

- Backdating or advance dating of the application is not permitted. (See **Changes and Corrections** chapter of these Administrative Guidelines.)

CASH AND CONDITIONAL RECEIPTS

THE FOLLOWING APPLIES TO THE INSURANCE PRODUCTS ONLY:

The Company, acknowledging the initial premium payment, gives a receipt for premium to the applicant. Two types of premium receipts are offered to meet the variety of needs of our applicants. **ONLY ONE TYPE OF RECEIPT MAY BE COMPLETED AND SUBMITTED FOR EACH APPLICATION**. In other words, it is inappropriate to complete both receipts for one application.

The writing agent should consider the applicant's insurance needs and evaluate the advantages of each receipt with the applicant. The effective date is determined based upon the type of receipt selected at the time of application. Therefore, it is important that the correct receipt is chosen, as *effective date changes will not be approved once the contract has been issued*. The applicant should then select and properly sign either the Cash or Conditional receipt. The applicant's copy of the completed receipt is to be given to the applicant at the time the premium is collected. The receipt not selected should be marked "VOID". Refer to ASIB No. 92-041 for additional details. Please note while an effective date may be an off-cycle date, the billing date for the contract must be a valid BCBSF billing date (1st, 8th, 15th, and 23rd); therefore, it may be necessary to send a supplemental bill to pre-pay the contract and place it on the appropriate BCBSF billing date.

The Conditional Receipt (The Conditional Receipt is not available for the HMO Product):

The Conditional receipt entitles the applicant to have an effective date of coverage equal to the application date, if coverage is approved. The applicant is entitled to coverage and benefits in accordance with the provisions of the issued contract as of the assigned effective date, provided the applicant accepts the contract.

When using the CONDITIONAL receipt:

1. It is required that **two months'** initial premium be collected.
2. In a **non-replacement** situation, if the Individual Medical Underwriter approves the application, **the effective date of coverage will be the date the applicant signs the application**. Advanced effective dates are not allowed in a non-replacement situation.
3. In a **replacement of existing coverage** situation, if coverage is approved, the effective date will be coordinated with the prior coverage paid to date. An advanced effective date can be given up to 90 days from the signing date of the application to coincide with the prior coverage termination date.

CASH AND CONDITIONAL RECEIPTS - continued

In any situation where the applicant wishes to replace their current coverage (group, other non-group coverage, COBRA coverage, etc.) with the underwritten insurance product, indicate "yes" on the application in Part I, Question 9 and provide the paid to date of the current coverage.

If other insurance is to be given up, it is extremely important that the applicant understand the full significance of this action. Replacement of existing coverage should be considered only when it is in the best interest of the applicant. The applicant should be advised to take advantage of any benefits that they may be eligible for under COBRA, Conversion or the HIPAA/IPAA statutes.

THE FOLLOWING APPLIES TO THE INSURANCE PRODUCTS ONLY:

IMPORTANT

It is the agent's responsibility to notify the Individual Medical Underwriting Department, via fax, if the applicant makes a premium payment on their current coverage while their application is in the underwriting process. The agent's notification should indicate the new paid to date of the current coverage and that the effective date for the proposed coverage should be advanced accordingly, upon issue, provided this date is not more than 90 days from the application date.

***Requests for effective date changes will not be approved once the contract has been issued*. See the Dating The Application chapter AND Changes to an Existing Contract: Effective Date Changes chapter of these Administrative Guidelines.**

*Please inform the applicant it can take up to 60 days for an underwriting decision to be made. The applicant should be advised **not** to lapse existing coverage that can be continued before the Blue Cross and Blue Shield of Florida or Health Options contract is issued.*

NOTE: If the current coverage is being replaced, the writing agent must also complete the **Replacement of Existing Insurance** form. See the **Replacement of Existing Insurance** chapter of these Administrative Guidelines for additional information. The completed form must be attached to the application for the underwritten insurance coverage and a copy provided to the applicant.

CASH AND CONDITIONAL RECEIPTS - continued

THE FOLLOWING APPLIES TO THE INSURANCE PRODUCTS ONLY:

The Cash Receipt:

When the Cash receipt is selected, it is important that the agent inform the applicant that there is no coverage between the application date and the effective date of the insurance contract, if approved. Additionally, it is important that the writing agent inform the applicant that any change in the applicant's health history, after completion of the application, can be used in the underwriting assessment.

When using the CASH receipt:

1. When using the Cash receipt, it is required that **two month's** initial premium be collected.

2. However, if the applicant chooses to pay their subsequent premiums via the Automatic Payment Option (APO), form number 9499, only one month's premium is required at the time of application. The completed APO form and voided check is required at the time the application is submitted to Individual Medical Underwriting.

3. In a **non-replacement** situation, if coverage is approved, **the effective date of coverage will be the first available billing date (1st, 8th, 15th, 23rd) following the date of the final underwriting approval.**

4. In a **replacement of existing coverage** situation, if coverage is approved, the effective date of the contract will be coordinated with the prior coverage paid-to-date provided the prior coverage paid-to-date is a future date. An advanced effective date can be given up to 90 days from the signing date of the application to coincide with the prior coverage termination date.

If other insurance is to be given up, it is extremely important that the applicant understand the full significance of this action. Replacement of existing coverage should be considered only when it is in the best interest of the applicant. The applicant should be advised to take advantage of any benefits that they may be eligible for under COBRA, Conversion or the HIPAA/IPAA statutes.

CASH AND CONDITIONAL RECEIPTS - continued

This chapter is continued from the previous page.

THE FOLLOWING APPLIES TO THE INSURANCE PRODUCTS ONLY:

In any situation where the applicant wishes to replace their current coverage (group, other non-group coverage, COBRA coverage, etc.) with the underwritten insurance product, indicate "yes" on the application in Part I, Question 9 and provide the paid to date of the current coverage.

IMPORTANT!

It is the agent's responsibility to notify the Individual Medical Underwriting Department, via fax, if the applicant makes a premium payment on their current coverage while their application is in the underwriting process. The agent's notification should indicate the new paid to date of the current coverage and that the effective date for the proposed coverage should be advanced accordingly, upon issue, provided this date is not more than 90 days from the application date.

***Requests for effective date changes will not be approved once the contract has been issued*. See the Dating The Application chapter AND Changes to an Existing Contract: Effective Date Changes chapter of these Administrative Guidelines.**

*Please inform the applicant it can take up to 60 days for an underwriting decision to be made. The applicant should be advised **not** to lapse existing coverage that can be continued before the Blue Cross and Blue Shield of Florida or Health Options contract is issued.*

CASH AND CONDITIONAL RECEIPTS - continued

THE FOLLOWING APPLIES TO THE HMO PRODUCT ONLY:

The only available receipt for the HMO product is the HMO CASH RECEIPT.

It is important that the agent inform the applicant that there is no coverage between the application date and the effective date of the HOI contract, if approved. And, any change in the applicant's health history, after completion of the application, can be used in the underwriting assessment.

When the application has been completed and the initial premium collected, the writing agent is to sign and date the HMO Cash receipt. The applicant's copy of the completed receipt is to be given to the applicant at the time the premium is collected.

The HMO CASH receipt:

1. It is required that **two months'** initial premium be collected.

2. However, if the applicant chooses to pay their subsequent premiums via the Automatic Payment Option (APO), form 9499, only one month's premium is required at the time of application. The completed APO form and voided check is required at the time the application is submitted to Individual Medical Underwriting.

3. In a **non-replacement** situation, if coverage is approved**, the effective date of coverage will be assigned by the Individual Medical Underwriter and will be the first available billing date (1st, 8th, 15th, 23rd) following the required confirmation period*, which occurs after the date of final Underwriting approval.**

4. In **replacement of existing coverage** situation, if coverage is approved, the effective date of the contract will be coordinated with the prior coverage paid-to-date providing the paid-to-date is at least 10 days in the future*.

5. There is no coverage between the application date and the effective date of the contract.

6. Effective date changes will not be granted once the contract is issued.

* **Florida Statute** requires that a seven-day confirmation period for all approved underwritten HMO policies be provided. This allows the consumer to confirm their desire to enroll in the HMO product. The HMO product does NOT carry a 10-day free look. The confirmation requirement will advance the effective date by 10 days.

CASH AND CONDITIONAL RECEIPTS - continued

IMPORTANT!

It is the agent's responsibility to notify the Individual Medical Underwriting Department, via fax, if the applicant makes a premium payment on their current coverage while their application is in the underwriting process. The agent's notification should indicate the new paid to date of the current coverage and that the effective date for the proposed coverage should be advanced accordingly, upon issue, provided this date is not more than 90 days from the application date.

***Requests for effective date changes will not be approved once the contract has been issued*. See the Dating The Application chapter AND Changes to an Existing Contract: Effective Date Changes chapter of these Administrative Guidelines.**

In any situation where the applicant wishes to replace their current coverage (group, other non-group coverage, COBRA coverage, etc.) with the underwritten HMO product, indicate "yes" on the application in Part I, Question 9 and provide the paid to date of the current coverage in the area to the right of the affirmative answer. The other carrier name must be provided and the reason for replacement should be included. **The Replacement of Existing Insurance form is not applicable to the HMO application**.

If other insurance is to be given up, it is extremely important that the applicant understand the full significance of this action. Replacement of existing coverage should be considered only when it is in the best interest of the applicant. The applicant should be advised to take advantage of any benefits that they may be eligible for under COBRA, Conversion or the HIPAA/IPAA statutes.

*Please inform the applicant it can take up to 60 days for an underwriting decision to be made. The applicant should be advised **not** to lapse existing coverage that can be continued before the Blue Cross and Blue Shield of Florida or Health Options contract is issued.*

REVIEW AND SUBMISSION OF APPLICATION

The writing agent is responsible for checking the application for completeness prior to submission to The Company.

- All appropriate signatures and dates must be provided on the application, receipt, and addendums and all forms. Applicants 18 and over on the application need to sign and date the "Notice of Medical Underwriting Processes and Authorization for Release of Medical Records".

- If the applicant (and spouse, if applying) has failed to **sign** and **date** the application in all appropriate areas, the application should not be submitted to the Individual Medical Underwriting Department until **all signatures and dates** have been obtained.

- With the exception of the application date, any changes or deletions on the application **must be initialed and dated by the applicant**.

- The application date cannot be altered. If the application date is altered, the application will be rejected.

- All questions must be answered and appropriate details provided.

- The applicant's copies of all signed and dated forms and the selected receipt should be detached and provided to the applicant.

- For additional information see chapters **Changes and Corrections** and **Dating of the Application** of these Administrative Guidelines.

- For applications taken in person, ***the Home Office must receive the application, initial premium, and all required forms within <u>seven</u> days of the date the application was completed. Telemarketed applications, forms and premium are required within <u>fourteen</u> days of the application date. Failure to receive the application within the specified time period will result in automatic rejection and refund of premiums. A new, currently dated application will be required.***

CHANGES AND CORRECTIONS

The application is a legal document between the applicant and The Company. If coverage is approved, the application becomes a part of the issued contract.

1. **If a mistake is made when dating the application, a new application must be taken**. See **Dating the Application** chapter of these Administrative Guidelines for additional information.

2. **Other than the date,** if an error is made while completing an application, line through the incorrect information and write the correct information above, below, or beside it.

   - **The applicant must then initial and date all corrections**.

   - **Do not** erase or use correction fluid to change the incorrect information.

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ANSWERS TO FREQUENTLY ASKED QUESTIONS BROCHURES

The **Answers to Frequently Asked Questions** brochures were designed to be reference material for the applicant after the application has been completed. Therefore, at the point the sale has been closed and the application completed, the applicant should be provided with the appropriate Q & A brochure, depending upon the product selected. The information provided in these brochures should be discussed with the applicant.

These brochures were **not** designed to replace the role of the agent in explaining or assisting with the medical underwriting and enrollment processes.

For Insurance Products:

Form 18388 has been provided for the underwritten insurance products.

For the HMO Product:

Form 18143 has been provided for the underwritten HMO product.

ADDITIONAL UNDERWRITING INFORMATION AFTER SUBMISSION OF THE APPLICATION

After submission of an application and prior to contract placement, if the writing agent learns of information that should have been recorded on a pending application but was not recorded, he/she should contact the Individual Medical Underwriting Consultant immediately.

The Individual Medical Underwriting Consultant should also be immediately contacted if the writing agent learns of a claim, treatment, or change of health history after the application was taken and prior to placement of the contract.

Further, if the agent becomes aware of either of the above situations during the placement process, the contract package should not be placed or left with the applicant/spouse prior to contacting the Individual Medical Underwriting Consultant for further instruction.

Complete details should be provided which should include, but are not limited to:

1. Date of first symptom

2. Diagnosis

3. Type of treatment received

4. Full name and address of provider first consulted

RATE MODIFICATIONS

The Individual Insurance and HMO products are marketed with the objective of providing broad health care coverage to as many applicants as possible. However, firm guidelines must be followed in order to make these superior health care plans available on an individual basis with reasonable premium levels. Therefore, every application for the Under 65 Individual Medically Underwritten Products (BlueOptions, BlueChoice, BlueCare, Dimension IV and Essential) are carefully reviewed by the Individual Medical Underwriter.

The majority of applicants and their dependents will qualify for coverage at standard rates. However, when an individual does not qualify for coverage at the standard rate, a counter offer of coverage may be made offering the coverage at a higher premium rate or an alternative product may be offered. The offer of coverage with a Rate Modification applies to all of the Individual Underwritten products (HMO and Insurance). In some instances it may be necessary to impose a rate modification and a medical exclusion rider for the same condition if maintenance prescription drugs are being taken.

At the present time, there are ***four*** substandard risk ratings (SRR) approved for the individual underwritten products:

- SRR I equates to 25% additional premium
- SRR II equates to 50% additional premium
- SRRIII equates to 75% additional premium
- SRRIV equates to 100% additional premium

The final determination of the amount of the rating imposed will be made by the Individual Medical Underwriter after a comprehensive review of the application and any requested medical records and/or Paramedical Examination.

RATE MODIFICATIONS – continued

ISSUE PROCESS - CONTRACTS ISSUED WITH A RATE MODIFICATION:

1. At the time of the Underwriting final decision, an advance notice will be sent to the writing agent advising of the Rate Modification and the reason for this action.

2. The issued contract will be endorsed with the Rate Modification, which also indicates the condition requiring the additional premium rating. Also, additional details are provided for the applicant in the document titled: "An Important Notice Regarding Your Health Insurance Policy", which is included in the issue package.

3. At the time of contract delivery, the agent should explain the reason for the Rate Modification(s) and that the additional premium charge(s) is required due to the condition indicated on the Rate Modification endorsement(s). It should also be explained that the rating is a permanent part of the contract. (See **Appeals Process and Procedures** chapter of these Administrative Guidelines). It should be emphasized that this action has no affect on the contract benefits.

There is no requirement to return the Rate Modification endorsement(s). Payment of premium as billed indicates the applicant's acceptance of the counter offer of coverage with the Rate Modification(s).

MEDICAL EXCLUSIONARY RIDER

THIS SECTION APPLIES TO THE UNDERWRITTEN INSURANCE PRODUCTS ONLY

In some situations, coverage may be offered to an individual with a counter offer of coverage resulting in a condition or body part being excluded from all benefits under the contract. Medical Exclusionary Riders will be used when the nature of the condition(s) indicates the potential for recurrence, treatment, or likelihood of surgery.

Imposing Medical Exclusionary Riders to a contract enables us to provide coverage for other than the ridered condition. Generally, coverage will not be offered with more than three Medical Exclusionary Riders imposed on one person. However, coverage offered to a family may include Medical Exclusionary Riders on one or more family members, depending upon each individual's health history (See **– Member Exclusionary Rider** chapter of these Administrative Guidelines). In some instances it may be necessary to impose a rate modification and a medical exclusionary rider for the same condition.

Medical exclusionary riders cannot be issued on an HMO agreement. (See **Member Exclusionary Rider** Administrative Guidelines.) If a medical condition requires a Medical Exclusionary Rider, the applicant will be declined for HMO. The writing agent should refer to the **Medical History** section of these guidelines when assessing the medical eligibility of the applicant. For additional information, see the **Unacceptable Applications** chapter of these Administrative Guidelines.

MEDICAL EXCLUSIONARY RIDER - continued

ISSUE PROCESS - CONTRACTS ISSUED WITH MEDICAL EXCLUSIONARY RIDER(s):

1. At the time of the Underwriting final decision, an advance notice will be sent to the writing agent advising of the Medical Exclusionary Rider(s) and the reason for this action.

2. The issued contract will be endorsed with a Medical Exclusionary Rider applicable for each condition and/or body part excluded from contractual benefits. Also, additional details are provided for the applicant in the document: "An Important Notice Regarding Your Health Insurance Policy", which is included in the issue package.

3. The wording used in the Medical Exclusionary Rider is pre-established according to the condition and the potential risks of related conditions. The wording of an exclusionary rider cannot be changed. Requests to change rider wording of the Medical Exclusionary Rider will not be considered. We must be consistent with the action taken on all applicants with similar health histories.

4. At the time of contract delivery, the agent should explain the reason for the Medical Exclusionary Rider(s). It should be emphasized that the underwriting action is necessary for the pre-existing condition as an alternative to declining the applicant. The agent should also explain how the Medical Exclusionary Rider(s) affects the contract benefits.

See the **Placement Procedures** chapter of these Administrative Guidelines for additional information.

MEMBER EXCLUSIONARY RIDER

THIS SECTION APPLIES TO THE UNDERWRITTEN INSURANCE AND HMO PRODUCTS:

There are situations when a person applying for coverage on a family application is so seriously impaired that it is not possible to issue health coverage to them. In these instances, a family member is declined but coverage is offered to the remaining family members. When this underwriting action is necessary, the contract is issued with a *Member Exclusionary Rider* (INSURANCE PRODUCTS) or *an Exclusionary Rider of Person* (HMO PRODUCT).

ISSUE PROCESS FOR *HMO* COVERAGE ISSUED WITH A RIDER EXCLUDING A FAMILY MEMBER:

1. If HMO coverage is approved with a proposed member excluded, the Underwriter will request that the agent contact the applicant and verify that coverage with a member excluded will be accepted. Whenever possible, the HMO Underwriter will also inform the writing agent if the excluded family member can be considered for coverage under one of the insurance products (i.e., BlueOptions, BlueChoice, DIV or Essential).

2. If the applicant is unwilling to accept the coverage with a family member excluded, the agent should immediately fax the HMO Underwriter and request a withdrawal of the application. Applications withdrawn cannot be re-written for a period of 6 months.

3. If the applicant will accept the coverage with a family member excluded, the agent should immediately notify the HMO Underwriter via fax.

4. If coverage will be accepted, the HMO Membership Agreement will be sent to the Agency for delivery by the writing agent. Included in the membership packet will be the Exclusionary Rider of Person(s) form, which indicates the name of the person who is excluded from all benefits of the issued coverage.

5. As required by Florida State Statute, a confirmation letter is sent to the applicant at time of approval.

See the **Placement Procedures** chapter of these Administrative Guidelines for additional information.

MEMBER EXCLUSIONARY RIDER - continued

ISSUE PROCESS FOR *INSURANCE* COVERAGE ISSUED WITH A RIDER EXCLUDING A FAMILY MEMBER:

1. In a replacement situation, if insurance coverage is approved with a proposed member excluded, the Underwriter will request that the agent contact the applicant and verify that coverage with a member excluded will be accepted. In a Non-Replacement situation the contract package will be issued with the member excluded. An advanced notice will be sent to the agent advising of the exclusion, and possible appeal information (if applicable).

2. If the applicant is unwilling to accept the coverage with a family member excluded, the agent should immediately fax the Underwriter and request a withdrawal of the application. Applications withdrawn cannot be re-written for a period of 6 months.

3. If the applicant will accept the coverage with a family member excluded, the agent should immediately notify the Underwriter via fax.

4. If coverage will be accepted, the Insurance Contract will be sent to the Agency for delivery by the writing agent. Included in the contract package will be the Member Exclusionary Rider Form, which indicates the name of the person who is excluded from all benefits of the issued coverage.

See the **Placement Procedures** chapter of these Administrative Guidelines for additional information.

EXCLUSIONARY RIDER(S) PLACEMENT PROCEDURES

This section applies to both the Underwritten Insurance and HMO products.

1. The writing agent should successfully deliver the issued contract to the insured within two (2) weeks of receipt in the Agency office for Insurance Products and prior to the effective date for HMO.

2. At the time of delivery, the agent should explain the reason for the sub-standard action and how it affects coverage. It should be emphasized that the underwriting action is necessary for the pre-existing condition(s) as an alternative to declining the applicant for coverage.

3. The Exclusionary Rider(s) is considered a **permanent** part of the issued contract. The writing agent should obtain the appropriate signature and date on all rider forms.

4. The agent is to secure the signature and date of the **primary contract holder (applicant)** on the Exclusionary Rider form(s), thereby "placing the contract". Signature of the spouse, child or person other than the primary contract holder is not acceptable and coverage is not considered placed.

5. When the primary applicant is excluded, the spouse will become the contract holder and coverage will be issued under a Health ID Number. The agent is to secure the signature and date of the **primary contract holder of the issued contract** on the Exclusionary Rider form. **THE PERSON BEING DECLINED FOR COVERAGE CANNOT SIGN THE EXCLUSIONARY RIDER FORM**. The following example is provided to assist the agent:

   John Smith is the primary applicant and his application also requests coverage for his spouse, Mary Smith. During the underwriting period, John is determined to be uninsurable and coverage is offered to Mary. The Member Exclusionary Rider form will indicate that John Smith is *excluded from all benefits*. *The signature on the Member Exclusionary Rider form must be that of Mary Smith, as she is now the contract holder*.

6. The agent is to return the properly signed and dated Exclusionary Rider form(s) to the Individual Medical Underwriting Department within 10 days from the delivery of the contract.

EXCLUSIONARY RIDER(S) PLACEMENT PROCEDURES - continued

7. It is important that the writing agent either FAX **or** utilize the pink and white courier envelope (form# 8766) for the purpose of returning the appropriately signed and dated Exclusionary Rider form(s). Use of this envelope will assure that the rider forms are delivered to the appropriate area in a timely manner.

8. **The Exclusionary Rider(s) may not be altered or changed in any manner.** Any comments or change to the rider form renders the rider form null and void. Rider forms that have been altered do not represent "placed" coverage and jeopardizes the offer of coverage.

9. The Exclusionary Rider(s) must be returned to Blue Cross Blue Shield of Florida, signed and dated. Receipt of a rider form that is not properly signed or dated is considered not placed, and will result in cancellation of the coverage.

10. The writing agent should not delay returning the signed rider(s) because he/she has begun working the appeal process. This will not be a reason for an extension for the placement of the policy and will place the coverage in jeopardy of cancellation. *Keep in mind that an appeal will not be considered until the correctly signed and dated rider(s) for the specified contract is received.* (See the **Appeals Process and Procedures** chapter of these Administrative Guidelines for further information.)

11. In the situation of issuance of a BlueCare agreement with a member excluded, the writing agent should never postpone placement of the BlueCare agreement awaiting an invitation or issue of a BlueChoice or Dimension IV contract for the excluded BlueCare member. The HMO product allows for access to coverage upon the contract effective date.

12. If the coverage cannot be placed or is not accepted, the writing agent should return the riders clearly marked "NOT TAKEN". Staple the ID card to the riders and return to the Individual Medical Underwriting Department in the pink and white envelope (form # 8766) to ensure timely refund of appropriate premiums.

    Any contract reported as not taken cannot be rewritten for six months. For additional information, please refer to ASIB 97-023.

CANCELLATION DUE TO NON-RECEIPT OF APPROPRIATELY SIGNED/DATED RIDER FORM(S)

If the appropriately signed and dated rider form(s) is not received in the Individual Medical Underwriting Department by the 28th day from the date the contract was sent from the Home Office, cancellation of the issued coverage will result. The collected premium will be refunded directly to the contract holder, less any payment for claims.

The Individual Medical Underwriting Department will not grant extensions for placement of the ridered contract without a detailed explanation from the Contracted General Agent. This explanation must be provided prior to the cancellation of the contract.

Contracts that have been cancelled due to non-receipt of properly signed and dated Exclusionary Rider(s) will not be reinstated (see ASIB 97-023). Contracts that have cancelled due to non-receipt of properly signed and dated Exclusionary Rider(s) are considered not taken and cannot be rewritten for a minimum of six months.

REJECTION OF ENTIRE APPLICATION

There are some health conditions that result in an applicant being so heavily impaired that the issuance of coverage is not possible. If an applicant's health history and/or condition is indicated as a **DEC** in the **Medical Histories Guidelines** section of this manual, an application for coverage should not be taken.

Due to the complexities of **multiple impairments** that do not lend themselves to a reliable standardized classification, each applicant's situation must be separately and individually considered. While the applicant's condition individually may be ratable or riderable, the combination of the conditions could render the applicant uninsurable for the product for which they applied. Under certain circumstances, an alternative offer may be made. (See ASIB 04-025)

When an application contains **inadequate, understated or incomplete health history**, the Underwriter is unable to assess the risk and it becomes questionable whether there is additional undisclosed health history. Applicants and family members with significant health history that was not disclosed on the application may result in the entire application being rejected. A rejection of this nature prevents the applicant and/or family members from applying for any underwritten product for a minimum of one year, even if subsequent details or medical records are submitted for review. See ASIB 00-018 for further details.

If coverage cannot be issued, a letter is sent to the applicant, with a copy to the agent, explaining the reason for the rejection. A full refund of the initial premium is sent directly to the applicant.

An applicant who has been medically rejected for coverage may not reapply for coverage for a minimum of one year, unless otherwise stated by the Individual Medical Underwriter on the agent's advance rejection notice.

APPEALS PROCESS AND PROCEDURES

We realize there are situations that pose challenges for the agent when placing a policy that has been issued on a non-standard basis. A*n underwriting decision should not be appealed unless* ***additional medical information*** *is submitted from the applicant's physician.* ***However, this does not apply to rejections due to significant undisclosed health history*****,** ***in which reconsideration cannot be given for 12 months***. Please remember that the passage of Senate Bill 910, Portability of Insurance, does not affect the ability of the Medical Underwriting Department to impose medical exclusionary riders and/or ratings on coverage or reject individuals applying for individual medically underwritten products of insurance. (Refer to the **Inappropriate Appeals** chapter of these Administrative Guidelines.)

This section is provided to guide the agent through the ***appropriate*** appeal process.

An appropriate appeal must be submitted in writing and must include:

1. All related additional medical records, and

2. All office notes including physician's assessment, and

3. All laboratory and test results along with supporting medical documentation for the testing.

4. If an applicant is declined due to multiple conditions, all conditions must be addressed in the appeal information. Appeals from multiple physicians should be submitted at the same time.

5. If an applicant is declined due to symptoms for which a firm cause/diagnosis has not been established, a physician's assessment to include a final cause/diagnosis and treatment plan is required.

6. The Properly signed and dated Medical or Member Exclusionary rider(s) must be received prior to processing any change request (i.e. Effective Date, Rate Removal, Product/Deductible changes etc.).

Medical Rejections Based Upon Paramedical Examination Laboratory Results

In the advance rejection notice, the Individual Medical Underwriter will indicate the laboratory values that are outside the normal clinical range. *If the Underwriter indicates these values require a* ***permanent*** *rejection, an appeal of the decision should not be submitted.*

APPEALS PROCESS AND PROCEDURES - continued

When further consideration can be given (not a permanent rejection), the following requirements are needed:

1. Repeat **normal** laboratory results for **all** laboratory values indicated as outside the normal clinical range.

2. Complete office notes from the physician seen for the repeat laboratory testing.

3. The notes must include the physician's assessment for the cause of the unacceptable test results.

4. If unacceptable results are determined to be the result of illness, the records should indicate a diagnosis and indication that treatment has been completed, and that the applicant has been released from care.

INAPPROPRIATE APPEALS

A policy should never be placed under the premise that the underwriting action can be changed through the appeal process. Similarly, an applicant that has been declined for coverage should not be given false hope that the rejection action can be overturned.

While the underwriting area is happy to reconsider an action based on a justified appeal; inappropriate appeals are time consuming and result in an unhappy customer. We rely on our agents to effectively control inappropriate appeals.

Examples of inappropriate appeals are:

1. Brief notes from any provider.

2. Corrections to the medical records or appeals based solely on a statement by the applicant or agent without supporting medical documentation.

3. Applicants and family members rejected for significant health history that was not disclosed on the application. A rejection of this nature prevents the applicant and/or family member from applying for any underwritten product for a minimum of one year, even if subsequent medical records are submitted for review (See ASIB 00-018).

4. Request to rewrite a medical rejection less than one year from the decision unless otherwise noted on the Advance Rejection Notice.

5. Appeals of an Underwriting decision for which action is clearly noted in the **Medical Histories Guidelines** section of this manual. If these guidelines indicate a rider, rating or rejection for a specific condition, requests that we not take the action indicated will not be considered. We must be consistent with the action taken on all applicants with similar health histories.

6. Repeat laboratory test results alone, without a physician's assessment, are not sufficient for appeal review.

7. If the Advanced Rejection Notice indicates a **permanent rejection** due to medical records reviewed and/or paramedical laboratory results, an appeal of this decision should not be submitted.

INAPPROPRIATE APPEALS - continued

8. An appeal requesting a change in the wording used in the Medical Exclusionary Rider. This wording is pre-established according to the condition and the potential risks of related conditions and we must be consistent with the action taken on all applicants with similar health histories. The wording of a Medical Exclusionary rider cannot be changed. Requests to change rider wording of the Medical Exclusionary Rider will not be considered.

RATE MODIFICATION AND/OR EXCLUSIONARY RIDER REQUEST FOR REMOVAL TO AN EXISTING, PLACED, CONTRACT

Rate Modifications and Medical Exclusionary Riders are PERMANENT as long as the coverage is kept in-force. However, we may consider removal of a Rate Modification and/or Medical Exclusionary Rider on an individual basis under the following situations:

1. The coverage has been in-force for a minimum of two years, and

2. The Rated and/or Ridered condition is not permanent and no longer exists, and

3. There have been no symptoms or treatment for the condition Rated or Ridered within the previous 24-months (see Note below), and

4. The condition Rated or Ridered does not require periodic medical treatment or evaluation.

5. Ratings for Maintenance Prescription Drugs: As with all Rate Modifications, the rating for maintenance prescription drugs is considered a permanent rating. However, consideration for possible removal of the rating can be given after discontinuation of the medication for a minimum of one year, as recommended by a physician.

NOTE: Certain conditions such as, *but not limited to*, polyps, ulcer, etc., require a Medical Exclusionary Rider for a minimum of five years. Some Medical Exclusionary Riders and Rate Modifications may be necessary for even longer periods of time or may be permanent. The agent should always refer to the **Medical Histories Guidelines** section of this manual for time frames on specific conditions.

RATE MODIFICATION AND/OR EXCLUSIONARY RIDER REQUEST FOR REMOVAL TO AN EXISTING, PLACED, CONTRACT - continued

In order for consideration of removal of a Rate Modification and/or Exclusionary Rider, **after meeting the requirements in numbers 1-5 on the previous page,** the following must occur:

A. The contractholder specifically requests removal of the Rate Modification and/or Exclusionary Rider, in writing, and

B. The written request is accompanied with current medical documentation from the physician familiar with the member's health status. This medical documentation must include the physician's office notes and results of any laboratory or other testing performed within the previous 24 months. A brief note from the provider will not be sufficient.

C. The medical records must be furnished at the expense of the Contract Holder.

D. In the case of the Rate Modification due to maintenance prescription drugs, in addition to A, B, and C above, discontinuation of the medication for a minimum of one year, as recommended by a physician.

Only an Individual Medical Underwriter can approve the removal of any Exclusionary Rider or Rate Modification.

Written notification of the final underwriting decision will be sent to the appropriate person. If an Exclusionary Rider or Rate Modification is removed, the change is generally effective on the current paid to date of the contract.

CHANGES TO AN EXISTING CONTRACT

PLAN or PRODUCT CHANGE

A Change to increase benefits within the same product (decrease of deductible), or a change to a richer product (i.e. hospital & surgical policy to a major medical policy), requires current underwriting evaluation. A new application, with all appropriate forms and initial premium, is required.

Changes to a higher deductible option or a lesser benefit product may be done with the completion of a Benefit Authorization Form. BAF's are available on the PRM site and they are processed by the Under 65 Membership & Billing department.

ADDING OR REMOVING THE OPTIONAL MATERNITY BENEFIT

The optional maternity benefit endorsement can be added or deleted without evidence of insurability. Benefits under the maternity benefit are subject to a 10-month waiting period and with an additional premium rate. To add or delete the optional maternity benefit to an existing contract, a written request from the member should be sent to the Under 65 Membership and Billing Department. (See **Maternity/Obstetrical Care Option** chapter of these Administrative Guidelines).

NOTE: The Essential Product does not offer the optional Maternity Endorsement.

CHANGES TO AN EXISTING CONTRACT - continued

For Insurance Products Only

EFFECTIVE DATE CHANGES IN NON-REPLACEMENT SITUATIONS:

Effective dates are assigned under the terms of the type of receipt selected at the time of application. **Requests for effective date changes in a non-replacement situation will not be considered.** For additional information, refer to the **Prepayment Receipts** chapter of these Administrative Guidelines.

For Insurance Products Only

EFFECTIVE DATE CHANGES IN REPLACEMENT SITUATIONS:

It is the agent's responsibility to inform the Individual Medical Underwriter when the client has paid another premium on their existing contract while the application for BCBSF coverage is in the Underwriting process. It is also the agent's responsibility to **verify** the paid to date of the existing contract with the applicant if requested to do so by the Individual Medical Underwriter, prior to policy issue.

The effective date is determined based upon the type of receipt selected at the time of application and the paid to date of the coverage being replaced. Please remember that the only advanced effective date will be the date that coincides with the termination date of the replaced coverage. **In any replacement situation, the effective date cannot exceed 90 days from the application date.**

In that it is the agent's responsibility to inform the Individual Medical Underwriter of any change in paid to dates, as well as to verify the paid to date of existing coverage if requested to do so prior to policy issue, a change in a policy effective date should not be necessary. Therefore, requests for effective date changes after issue are not routinely allowed.

CHANGES TO AN EXISTING CONTRACT - continued

For Insurance Products Only

EFFECTIVE DATE CHANGES IN REPLACEMENT SITUATIONS:

While requests for effective date changes after issue are not routinely allowed, we realize there may be situations in which termination of the prior coverage may be out of the member's control. In these situations, an exception for an effective date change may be considered to coincide with the termination date of the prior coverage. In order to consider an effective date change, as an exception, the agent must provide:

1. A signed and dated statement from the Contract Holder explaining the reason for the requested effective date change, **and**

2. A Certificate of Creditable Coverage providing the termination date of the prior coverage. If this is not available, a statement from the prior carrier providing the termination date of the replaced coverage will be sufficient.

*A request for an effective date change **will not be considered** if only the following documentation is submitted:*

1. cancelled checks or copies of cancelled checks

2. prior coverage billing statements

For the HMO Product:

During the Underwriting process, at the time of the Underwriter's final decision and prior to issue, the agent is requested to verify with the applicant the termination date of the previous coverage. It is the agent's responsibility to verify this information and respond to the Underwriter within the allotted response period.

Requests for effective date changes after the HMO product has been issued will not be honored. The HMO product allows for access to coverage upon the contract effective date. Remember that capitation has been paid to the Primary Care Physician as of the coverage effective date.

CHANGES TO AN EXISTING CONTRACT - continued

This section applies to the Underwritten INSURANCE PRODUCTS only

CHANGE IN SMOKING STATUS

A member who was rated as a smoker (tobacco user) at the time of contract issue may request the non-smoker rate after they have discontinued **all** tobacco products for a minimum of 12 consecutive months. In order to be considered for the non-smoker rate, the member must not have used **any** tobacco products or medication for smoking cessation for a period of 12 consecutive months, and they cannot currently be under treatment, or have been treated, for any tobacco related diseases.

A request for the non-smoker rate must be submitted to the Individual Medical Underwriting Department in the following manner:

1. The request must be made in writing by the Insured, and

2. The written request must be accompanied with the results of a negative urine cotinine test (test for nicotine) obtained at the expense of the Insured, and

3. The written request must be accompanied with documentation from the Insured's physician that the Insured has not smoked or used tobacco products for *at least* one year.

Upon receipt of the above requirements, and in reviewing this request, claims histories will be utilized, as treatment for any tobacco related diseases (i.e. cancer of the mouth, throat, lungs; emphysema, etc.) will be taken into consideration. Written notification regarding the Underwriter's decision will be provided to the Insured, as well as the writing agent.

If the non-smoker rate is approved, it will become effective on the contract paid to date after receipt of the request and necessary medical information.

PLEASE REMEMBER: THE NONSMOKER RATE IS NOT APPLICABLE TO THE HMO PRODUCT.

CHANGES TO AN EXISTING CONTRACT - continued

CREDIT OF OR TOWARD THE 24-MONTH PRE-EXISTING PERIOD

This section applies to the Underwritten INSURANCE PRODUCTS only

The credit of or toward the 24-month pre-existing period of the underwritten insurance products is in accordance with Senate Bill 910, Portability of Insurance. Request for consideration for credit of or toward the 24-month pre-existing period must include supporting documentation, for all insured family members, of the prior coverage and the effective date and termination date of this coverage. A Certificate of Creditable coverage is the best form of this documentation.

We recognize that there will be situations where Certificates of Creditable Coverage are not available. In these situations, the required documentation must be submitted on the **Prior/Concurrent Coverage Affidavit** for all insured family members with full details as indicated on the form. The **Prior/Concurrent Coverage Affidavit** must be signed and dated by the Contract Holder as well as the writing agent.

Coverage is considered creditable if the prior benefits are similar to, or exceeds the benefits of the BCBSF contract, and there has been no more than a 62-day lapse in coverage. Most TEMPORARY OR SHORT TERM POLICIES ARE NOT CONSIDERED CREDITABLE. A copy of the contract indicating it is creditable must be submitted.

If the coverage replaced does not meet the requirements set forth in Senate Bill 910, credit of or toward the BCBSF 24-month pre-existing period will not be given.

Please keep in mind: Senate Bill 910 is not applicable to the HMO Product. It is inappropriate to request credit of or toward the HMO 24-month pre-existing period and these types of requests should not be submitted.

CHANGES TO AN EXISTING CONTRACT - continued

Adding a Dependent to an existing contract

Dependents to be added to an existing contract are subject to evidence of insurability unless the dependent to be added is a newborn child, less than 60 days old, or an adopted child who is within the 60 day period immediately following the date of adoption.

To add a newborn child who is less than 60 days old or to add an adopted child during the 60-day period immediately following the date of adoption to an existing contract, a Membership Change Request must be completed by the contract holder and submitted to the Under 65 Membership and Billing Department.

Dependents, other than those outlined above, are subject to complete medical underwriting and evidence of insurability. ***A new application for an add-on dependent should be completed in the following manner***:

1. The proper underwritten application must be used. In other words, if the existing contract is the HMO product, the writing agent must use the currently approved application form for this product. If the existing contract is one of the underwritten insurance products, the writing agent must use the currently approved application form for these products.

2. The front of the application should clearly be indicated as **"Add-on".**

3. The current adult subscriber/contract holder information should be recorded in Part I: Enrollment Information Questions 1 though 6 of the application.

4. The information for the dependent(s) proposed to be added should be recorded in Part I: Enrollment Information Questions 7 through 11 and Questions 13 through 14 of the application.

5. The Part II: Medical History questions of the application should be completed **only** for the dependent(s) proposed to be added.

6. The answers to Part III: Supplemental Information of the application should be recorded for the dependent(s) proposed to be added.

CHANGES TO AN EXISTING CONTRACT - continued

Adding a Dependent to an existing contract continued

7. Part IV: Additional Information questions should be answered, signed and dated by the existing adult contract holder.

8. There are two required signature fields in Part V: Authorizations/Acknowledgements section of the application. The existing adult contract holder must sign and date the Cancellation Provision. The date and signature of the existing adult contract holder and spouse, if proposed to be added, are required under the "PLEASE READ AND SIGN THE APPLICATION" language.

9. The For Agent Use Only section should be completed in the usual manner.

10. All appropriate forms (i.e. Premium Validation Statement, Replacement of Existing Insurance form, etc.) must be submitted and must be signed by the add-on dependent proposed to be added. However, if the add-on dependent proposed to be added is a dependent child, all signatures must be that of the current adult subscriber/contract holder.

11. Authorization for release of medical records must be signed by all applicants over the age of 18 including dependent children.

12. Collection of premium at the time of application is currently not required for add-on applications.

13. The Home Office will assign the effective date for the add-on applicant, if approved for coverage, and the contract holder's premium statements will be reflected accordingly.

Examples of Inappropriate Add-On Applications are:

A. An add-on application submitted for a contract that is not in-force.

B. An add-on application submitted prior to approval of coverage for the primary Contract Holder. Once the application on the primary Contract Holder is approved and placed, an add-on application may be submitted.

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MEDICAL HISTORIES GUIDELINES

For Insurance and HMO products:

This Medical Histories section is to be used in the evaluation of medical histories presented by applicants for medically underwritten individual policies. This guide is intended to help the agent determine the usual underwriting action of the Individual Medical Underwriting Department for listed health impairments. It is intended for use as a guide. ***Only the Individual Medical Underwriting Department has the authority to accept applications, issue coverage, or change any of the underwriting guidelines in this manual.***

This guide includes only generally recognizable conditions and is not totally inclusive of all medical conditions since it would otherwise be too lengthy and too technical to be of use. It does not necessarily reflect the ultimate decision of the Individual Medical Underwriter. Each applicant will be considered individually on the basis of all medical and underwriting information. In some situations, the probable final action indicated in this guideline may be subject to review of medical records, such as an Attending Physician Statement or Paramedical Examination obtained by, and at the discretion of the Individual Medical Underwriting Department.

Based on the overall evaluation of a condition; specifically, the severity, duration, any complications, type of treatment, and any related conditions, it may be necessary to impose ***both*** *a Medical Exclusionary Rider* ***and*** *a Substandard Risk Rating in order to offer coverage*. Due to all the variables involved, these situations cannot be indicated in these guidelines. Therefore, ***this guide should not be interpreted as a guarantee of underwriting action on any specific case.***

For the Insurance products only:

The medically underwritten insurance products can be offered in a variety of ways, all of which are dependent upon the applicant's health history. One way that the medically underwritten insurance product can be offered is on a *Standard* basis. This offer means that the underwriting decision allows for the applicant to be enrolled into the product with no exclusions, other than those referenced in the contract language. Contracts issued on a Standard basis are subject to the Pre-Existing clause of the contract unless portability of coverage applies. For further information, see **Portability** in the **Administrative Guidelines** section of this manual.

This subject continues on the following page.

This subject is continued from the previous page.

The second offer of coverage allows for the issuance of the insurance product with a Medical Exclusionary Rider(s). The Medical Exclusionary Rider excludes coverage for health care services for a specified body part or condition. This action allows us to provide coverage for most of the applicant's health care needs rather than decline the applicant entirely. This is in addition to any applicable pre-existing period of the contract. Contracts issued with a Medical Exclusionary Rider(s) are subject to the Pre-Existing clause of the contract unless portability of coverage applies. For further information, see **Portability** in the **Administrative Guidelines** section of this manual.

The third offer of coverage allows for the issuance of the insurance product with a Rate Modification(s). The Rate Modification does not exclude otherwise covered benefits, as outlined in the contract language. The Rate Modification is used for certain conditions in which a Medical Exclusionary Rider is not appropriate (i.e. elevated or abnormal lipids, elevated blood pressure, build, and etc.). The Rate Modification does not waive any applicable pre-existing period of the contract. Contracts issued with a Rate Modification(s) are subject to the Pre-Existing clause of the contract unless portability of coverage applies. For further information, see **Portability** in the **Administrative Guidelines** section of this manual.

The fourth offer of coverage allows for the issuance of the insurance product with both a Medical Exclusionary Rider(s) and a Rate Modification(s). In some situations, the condition or body part excluded by a rider may also require a rating due to the individual's use of related prescription drugs. While the rider excludes coverage for the health care services provided to treat or care for a specified body part or condition, it does not exclude benefits for the prescription drug(s) taken for the excluded condition or body part. The Rate Modification is used to cover the cost of any applicable maintenance drugs. Please refer to ASIB 00-036 for additional information. Contracts issued with a Medical Exclusionary Rider and a Rate Modification(s) are subject to the Pre-Existing clause of the contract unless portability of coverage applies. For further information, see **Portability** in the **Administrative Guidelines** section of this manual.

For the HMO product:

The HMO product cannot be issued to an applicant who demonstrated a health history requiring a Medical Exclusionary Rider. This is necessary due to the overall product design that allows access to contract benefits, without restriction, when rendered by a Primary Care Physician (PCP). *An HMO application is not to be taken for any individual who has a health history requiring a Medical Exclusionary Rid*er. This type of applicant is unacceptable for the HMO product. Please refer to the list of medical conditions and probable underwriting action provided in this section when assessing the medical eligibility of the applicant(s).

The HMO product can be issued with a Rate Modification due to health history that may require higher utilization of medical services. The Rate Modification may also be imposed due to the applicant's use of maintenance prescription drugs. See ASIB 00-036 for additional information. The Rate Modification does not affect the contractual pre-existing period when benefits are rendered by a Specialist.

For the Insurance and HMO products:

Due to all the variables involved, all situations cannot be indicated in these guidelines. Therefore, ***this guide should not be interpreted as a guarantee of underwriting action on any specific case.*** It is not the intent of Blue Cross and Blue Shield of Florida and Health Options to provide coverage to applicants who are progressively ill. The term **"complete recovery,"** as used in the following guide, presupposes a complete and uneventful restoration of health, uncomplicated by residuals.

The following key to the guide should be used to interpret the abbreviations:

STD	Standard – acceptable without limitations.
R	Rider – no benefits will be provided for the impairment described in the rider.*
SRR I	a Substandard Risk Rating of 25% additional premium.**
SRR II	a Substandard Risk Rating of 50% additional premium.**
SRR III	a Substandard Risk Rating of 75% additional premium.**
SRR IV	a Substandard Risk Rating of 100% additional premium.**
DEC	Decline – no coverage can be offered.
IC	Individual Consideration will be given for the listed impairment. This consideration involves obtaining additional underwriting information before a final decision can be made by the underwriter.
UFC	Underwrite for Cause.

During the process of completing Part II: Medical History questions of the application, the agent should refer to this Medical Histories section. If the applicant has a medical history that would result in a Medical Exclusionary Rider or Rate Modification, the underwriting action should be discussed with the applicant during the interview process. If the condition indicates a **DEC**, an application should not be taken.

FOR THE PURPOSES OF THIS SECTION OF THE MANUAL, "HMO" REFERS TO BLUECARE. "MAJOR MED" REFERS TO BLUEOPTIONS, STANDARD & LOW COST PLANS, BLUECHOICE AND DIV. "HOSP & SURG" REFERS TO BLUEOPTIONS HOSPITAL & SURGICAL AND ESSENTIAL PRODUCTS. "BO RC" REFERS TO BLUEOPTIONS ROUTINE CARE PRODUCTS.

.. Note: No more than two (2) Medical Exclusionary Riders can be imposed per person. If the medical history requires three or more Medical Exclusionary Riders, final action will result in declination of coverage. Medical Exclusionary Riders apply to the Insurance products only.*

*..** Note: Substandard Risk Ratings apply to the Insurance and the HMO products.*

UNDERWRITING INFORMATION

UNDERWRITING QUESTIONS

The most important step in the underwriting process is ***accurate*** and ***detailed*** answers to all questions on the application, especially the Part II: Medical History questions. The following will help you to provide the necessary information. Always include this information where there is a "yes" answer to a medical history question.

FOR ALL HISTORIES – Always include complete name (first and last), address, zip code, and telephone number of the attending physician (and specialty, if known).

- ⇒ When was a doctor last seen? Provide dates (month and year) and reason for the office visit.
- ⇒ What tests were done? Provide date and test results.
- ⇒ What did the doctor call the ailment or disorder?
- ⇒ Was medication prescribed? If yes, the name of the medication and dosage. (This can usually be obtained from the prescription bottle.)
- ⇒ Is medication still being taken? If not – when stopped?
- ⇒ Are there still symptoms or episodes? How often? Include dates.
- ⇒ Is there any residual impairment?
- ⇒ Were any other doctors seen? If yes, repeat the questions.

ADDITIONAL MEDICAL QUESTIONS

Use these questions **in addition** to the usual questions to provide further underwriting information.

BRAIN OR NERVOUS SYSTEM

Epilepsy, Seizures or Fainting Spells

1. Describe type of seizure, name of epilepsy, or fainting spells.
2. What were the dates of first episode and last episode?
3. How often do symptoms occur? Give dates.
4. What studies have been done? Give dates and results.
5. How treated? Give name and dosage of medication. Give date physician last seen.
6. Give name(s) of all physician(s) seen, specialty and date last seen.

Mental and Emotional Histories Including Anxiety, Depression and Any Form of Counseling

1. Give full name of diagnosis, if known.
2. How was condition treated and by whom? Any hospitalization? When, where and how long?
3. Was counseling received? Provide date of first and last visit and frequency of visits.
4. Have they been released from care?
5. What medications were taken? Give name(s) and dosage. Is any medication taken currently? Give name(s) and dosage. When was medication discontinued?
6. Was there any disability or restrictions of activities? Provide details.
7. Give name(s) of all physician(s) seen, specialty and date last seen.

CARDIOVASCULAR SYSTEM

Blood Pressure

*Note: If blood pressure is controlled with medication, applicant **mu**st have consulted attending physician within the past 12 months. A prescription will usually not be re-filled without ongoing monitoring.*

1. What is date of last evaluation?
2. Is medication taken? Give name and dosage. When was medication first prescribed (month and year)?
3. How often is blood pressure checked and by whom?

Chest Pain

1. Give dates of episodes.
2. What was the cause and/or final diagnosis? (If cause or final diagnosis not determined, an application should not be submitted.)
3. Dates of any ECG (EKG), Stress Test and Echocardiogram and the results. Include all follow-up testing.
4. What other studies were done and what were the results of each?
5. Has applicant been hospitalized? (Place, date, Name of Physician in charge.)
6. What is the current treatment, including medications? Provide name and dosage.
7. Are activities restricted?
8. Give name(s) of all physician(s) seen, specialty and date last seen.

Heart Murmur

1. When was murmur diagnosed?
2. Name type of murmur, location, and grade if known.
3. How was it diagnosed? What tests were done and dates?
4. Name of Physician that did the test and name of Physician that checked it most recently. Give date(s).
5. Are there any restrictions of activities?

DIGESTIVE SYSTEM

Stomach, Intestine, Colon

1. Give diagnosis.
2. Was a biopsy or culture done? If so, provide results.
3. Was it treated? Type of treatment? Date of last symptoms?
4. When was medication last taken? Give name and dosage.
5. Was there any bleeding? Was transfusion required?
6. Was any hospitalization required? When and for how many days?
7. Was any surgery performed? Give type, reason and dates.
8. Was any follow-up testing performed? If so, give type of test, dates and results.
9. Give name(s) of all physician(s) seen, specialty and date last seen.

ENDOCRINE SYSTEM

Hypoglycemia

Note: Diabetes, Glucose Intolerance, Hyperglycemia, or a Sugar Disorder are uninsurable conditions.

1. When was Hypoglycemia first diagnosed?
2. Is it controlled by diet?
3. What was the date and result of the latest blood sugar test? Was it done after fasting?
4. Give name(s) of all physician(s) seen, specialty and date last seen.

Thyroid

1. Is applicant hyperthyroid (overactive) or hypothyroid (underactive)?
2. Are nodules present?
3. Is a goiter present or has one been diagnosed?
4. How was condition treated? medication or surgery? Give dates.
5. What medication is taken? Give name and dosage.
6. What symptoms did applicant have?
7. Give name(s) of all physician(s) seen, specialty and date last seen.

GENITOURINARY SYSTEM

Kidney, Bladder or Urinary Tract Disorders

1. What was the diagnosis?
2. How many episodes have occurred? Give dates.
3. What tests were done and what were the results?
4. How was disorder treated? Give name of any medication(s) and dosage.
5. Is applicant still taking medication? Give name and dosage.
6. If a kidney stone (urinary stone) was diagnosed is it present, was it passed or removed? How was it removed? Also, give number of occurrences.
7. Give name(s) of all physician(s) seen, specialty and date last seen.

MUSCULOSKELETAL SYSTEM

Arthritis

1. Give type of arthritis (rheumatoid, osteo, gouty, etc.)
2. Indicate location or joint involved.
3. What was the date of most recent arthritic episode?
4. What activities are restricted and how often? How disabling is it?
5. Type treatment received? (physical therapy, chiropractic manipulations, or massage)
6. If medication taken, provide name(s) and dosage.

Back and Neck

1. What was the diagnosis?
2. What areas of the back and neck are/were affected?
3. Any disability including missed work? Provide date of first and last symptoms.
4. Were any X-ray, MRI, CAT scan, or other testing done? If so, provide name, date and results.
5. How was the condition treated, including therapies? For how long? Still receiving treatment and/or medication? Give details, including name and dosage of all medications.
6. Give name(s) of all physician(s) seen, specialty and date last seen

RESPIRATORY SYSTEM

Allergies, Asthma, Emphysema, Bronchitis and other Respiratory Disorders

1. What was the diagnosis?
2. How many attacks occur per year? What was the date of the last attack?
3. How disabling are the attacks? How many days lost from work or school?
4. What medication(s) are used for control? Give name and dosage.
5. Was a nebulizer prescribed? If yes, provide complete details.
6. Are any drug injections required? How often? Give name, dosage and frequency.
7. What tests were done and what were the results?
8. Has any emergency room visit or hospitalization been required? When, how many times and for how long? Give details.
9. Give name(s) of all physician(s) seen, specialty and date last seen.

TUMOR

Tumor, Polyp, Cyst

1. What was the diagnosis? (Give technical name or pathology diagnosis, if known.)
2. Where was growth located? Where and what organ?
3. When was it removed and how? (Surgery, burned off, radiation, chemotherapy?)
4. Was any treatment or follow-up needed after it was removed? Provide test name, date and results.
5. Give name(s) of all physician(s) seen, specialty and date last seen.

	HMO	Major Med.	Hosp/ Surg	BO RC
ABNORMAL GLUCOSE	**IC**	**IC**	**IC**	**IC**
Not diagnosed as Diabetic - need subsequent normal 3-hour glucose tolerance test (GTT) and physician's assessment.				
ABNORMAL LABORATORY RESULTS				
No diagnosis made	**DEC**	**DEC**	**DEC**	**DEC**
For reconsideration, need physical assessment with diagnosis and Subsequent normal lab results	**UFC**	**UFC**	**UFC**	**UFC**
Cholesterol or Triglycerides (see LIPIDS)				
ABNORMAL PAP				
All treatment and testing completed, with subsequent normal PAP (depending on the severity of results, other testing and a second normal pap may be required; and an exclusion rider may be imposed)	**IC**	**IC**	**IC**	**IC**
ABSCESS				
Skin or subcutaneous tissue, complete recovery	**STD**	**STD**	**STD**	**STD**
Others	**IC**	**IC**	**STD**	**STD**
ACNE				
Mild to Moderate	**STD**	**STD**	**STD**	**STD**
Severe	**DEC**	**R**	**STD**	**STD**
Currently on, or within 3 months of discontinuance of Rx Accutane	**DEC**	**DEC**	**DEC**	**DEC**
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) OR A.R.C.				
All Cases	**DEC**	**DEC**	**DEC**	**DEC**
Exposure - close contact, living in the same house with a person who is HIV positive requires two current negative HIV test results; six months apart, for consideration	**IC**	**IC**	**IC**	**IC**
ADENOMAS (provide location)	**IC**	**IC**	**IC**	**IC**
ADHESIONS				
Present	**DEC**	**R**	**R**	**STD**
Operated within 5 years	**DEC**	**R**	**STD**	**STD**
Operated after 5 years	**STD**	**STD**	**STD**	**STD**
ADRENAL GLAND DISORDERS				
Hypofunction				
Acute	**IC**	**IC**	**IC**	**STD**
Chronic (Present or History)	**DEC**	**DEC**	**DEC**	**DEC**
Hyperfunction				
Present or within 1 year of surgery	**DEC**	**DEC**	**DEC**	**DEC**
After 1 year of surgery and Full Recovery	**IC**	**IC**	**IC**	**STD**

	HMO	Major Med.	Hosp/ Surg	BO RC
ALCOHOLISM/ALCOHOL ABUSE				
(More favorable cases with active involvement in AA)				
Within 5 years of reform	**DEC**	**DEC**	**DEC**	**DEC**
6 to 10 years	**SRRI**	**SRRI**	**SRRI**	**STD**
After 10 years	**STD**	**STD**	**STD**	**STD**
DUI (driving under the influence) (see **DUI**)				
ALLERGIES				
(State type of reaction and treatment/any history of asthma?)				
All cases	**IC**	**IC**	**STD**	**STD**
Currently receiving allergy injections	**STD**	**STD**	**STD**	**STD**
Currently under allergy study	**DEC**	**DEC**	**STD**	**STD**
ALZHEIMER'S DISEASE (Organic Brain Syndrome)				
All cases	**DEC**	**DEC**	**DEC**	**DEC**
AMPUTATION				
Thumb, fingers, or toes, recovered	**STD**	**STD**	**STD**	**STD**
Other extremities after 12 months and complete recovery				
Due to trauma – Extremities	**DEC**	**R**	**R**	**STD**
Due to trauma – Thumb, Fingers, Toes, Fully recovered	**STD**	**STD**	**STD**	**STD**
Due to disease	**DEC**	**IC**	**IC**	**IC**
ANAL FISSURE OR FISTULA				
Operated, complete recovery	**STD**	**STD**	**STD**	**STD**
Unoperated – within 2 years	**DEC**	**R**	**R**	**R**
Unoperated – after 2 years	**STD**	**STD**	**STD**	**STD**
ANEMIA (specify type of anemia and a CBC must be available within the past 12 months)				
Aplastic or Hypoplastic	**DEC**	**DEC**	**DEC**	**DEC**
Sickle Cell	**DEC**	**DEC**	**DEC**	**DEC**
Sickle Cell Trait	**STD**	**STD**	**STD**	**STD**
Thalassemia (Cooley's or Mediterranean) Major	**DEC**	**DEC**	**DEC**	**DEC**
Others	**IC**	**IC**	**IC**	**IC**
ANEURYSM (STATE LOCATION OR ORGAN INVOLVED)				
Abdominal Aorta				
Present or history	**DEC**	**DEC**	**DEC**	**DEC**
Brain/Intracranial (see **CEREBRAL HEMORRHAGE)**				
Heart Aortic	**DEC**	**DEC**	**DEC**	**DEC**
Others				
Due to injury				
Present or within 2 years	**DEC**	**DEC**	**DEC**	**DEC**
After 2 years, fully recovered, no circulatory problems	**IC**	**IC**	**IC**	**STD**
Due to disease or with circulatory problems	**DEC**	**DEC**	**DEC**	**DEC**

	HMO	Major Med.	Hosp/ Surg	BO RC
ANXIETY (see PSYCHONEUROSES)				
ANOREXIA NERVOSA				
Complete recovery within 5 years	**DEC**	**DEC**	**DEC**	**DEC**
After 5 years	**IC**	**IC**	**IC**	**STD**
APPENDICITIS				
Operated, complete recovery	**STD**	**STD**	**STD**	**STD**
Unoperated – within 2 years	**DEC**	**R**	**R**	**R**
Unoperated – after 2 years	**STD**	**STD**	**STD**	**STD**
ARTERIOSCLEROSIS (Hardening of the Arteries)				
Present or History	**DEC**	**DEC**	**DEC**	**DEC**
ARTERIOVENOUS MALFORMATION (AVM)				
Present	**DEC**	**DEC**	**DEC**	**DEC**
Operated (state location of AVM)	**IC**	**IC**	**IC**	**IC**
ARTHRITIS				
Juvenile Rheumatoid Arthritis/Still's Disease				
History or Present	**DEC**	**DEC**	**DEC**	**DEC**
Osteoarthritis				
Spine or hip or knee involvement				
Asymptomatic or Incidental findings	**STD**	**STD**	**STD**	**STD**
Symptomatic	**DEC**	**R**	**R**	**R**
No spine, hip, or knee involvement				
Mild – no treatment or medication	**STD**	**STD**	**STD**	**STD**
Moderate – requiring treatment or medication	**DEC**	**R**	**STD**	**STD**
Rheumatoid Arthritis or Psoriatic Arthritis				
Present or History	**DEC**	**DEC**	**DEC**	**DEC**
ASCITIES				
Present or History	**DEC**	**DEC**	**DEC**	**DEC**
ASPERGER'S SYNDROME				
Present or History, generally	**DEC**	**DEC**	**DEC**	**DEC**
ASTHMA				
Mild				
less than 2 physician visits per year, no hospitalization, no emergency room visits, no steroid treatment, no nebulizer, non-smoker	**STD**	**STD**	**STD**	**STD**
Severe				
any hospitalization within 2 years or recurrent emergency room visits or currently smoking	**DEC**	**DEC**	**DEC**	**DEC**
Others				
Within 4 years of last attack	**DEC**	**R**	**IC**	**STD**
After 4 years of last attack	**IC**	**IC**	**IC**	**STD**

	HMO	Major Med.	Hosp/ Surg	BO RC
ATTENTION DEFICIT DISORDER/HYPERACTIVITY (ADD OR ADHD)				
Normal school, no counseling, with or without medication	**STD**	**STD**	**STD**	**STD**
Under Psychiatric or Psychological treatment, mild	**DEC**	**R**	**STD**	**STD**
More severe or hospitalization	**DEC**	**DEC**	**DEC**	**DEC**
AUTISM	**DEC**	**DEC**	**DEC**	**DEC**
AUTOIMMUNE DISEASE	**DEC**	**DEC**	**DEC**	**DEC**
BACK AND SPINAL COLUMN DISORDERS				
(Consideration will be given as to how the injury/ disorder occurred, the area of the spine involved, duration of the disorder, treatment received, and degree of recovery.)				
Sprain or strain of the back				
Single episode, complete recovery within 6 weeks, non-disabling	**STD**	**STD**	**STD**	**STD**
Single episode others				
Within 2 years of recovery	**DEC**	**R**	**STD**	**STD**
After 2 years	**STD**	**STD**	**STD**	**STD**
Recurrent episodes				
Within 3 years of recovery from last attack	**DEC**	**R**	**R**	**STD**
After 3 years	**STD**	**STD**	**STD**	**STD**
Intervertebral disc disorders				
Unoperated	**DEC**	**R**	**R**	**R**
Operated (state type of surgery)				
Within 3 years of complete recovery	**DEC**	**R**	**R**	**R**
After 3 years with no residuals	**STD**	**STD**	**STD**	**STD**
Scoliosis (Spinal curvature)				
Slight, with no symptoms	**STD**	**STD**	**STD**	**STD**
Moderate, not progressive, asymptomatic	**DEC**	**R**	**STD**	**STD**
Others	**IC**	**IC**	**IC**	**IC**
Sciatica				
Present or within 2 years of last symptoms	**DEC**	**R**	**R**	**R**
BELLS PALSY				
Complete recovery, no more than slight residuals	**STD**	**STD**	**STD**	**STD**
Others within 3 years	**DEC**	**IC**	**IC**	**STD**
BERGER'S DISEASE/IgA NEPHROPATHY	**DEC**	**DEC**	**DEC**	**DEC**
BLADDER INFECTION (see CYSTITIS)				
BLINDNESS (see EYE DISORDERS)				
BLOOD PRESSURE (ELEVATED - see HYPERTENSION)				
BRAIN TUMORS OR CYSTS (BENIGN)				
Present or within 8 years	**DEC**	**DEC**	**DEC**	**DEC**
Others	**IC**	**IC**	**IC**	**IC**

	HMO	Major Med.	Hosp/ Surg	BO RC
BREAST				
Abnormal mammogram with recommended follow-up not completed	**DEC**	**DEC**	**DEC**	**DEC**
Adenoma, Cystadenoma, and Fibroadenoma				
Present (further work-up needed to evaluate)	**DEC**	**DEC**	**DEC**	**DEC**
Present (no surgery or work-up contemplated)	**DEC**	**R**	**R**	**STD**
Breast Augmentation (Implants) present or removed	**STD**	**STD**	**STD**	**STD**
Ruptured *Silicone* or *Soya*	**DEC**	**DEC**	**DEC**	**DEC**
Breast/Fibrocystic **(see FIBROCYSTIC BREAST DISEASE)**				
Breast Reduction, after recovery	**STD**	**STD**	**STD**	**STD**
BRONCHITIS				
Acute attacks (not more than two), complete recovery	**STD**	**STD**	**STD**	**STD**
Chronic or recurrent, no hospitalization & non-smoker				
Within 2 years of last attack	**DEC**	**R**	**R**	**R**
After 2 years	**STD**	**STD**	**STD**	**STD**
Chronic or recurrent or smoking history or hospitalization				
Within 1 year of last attack	**DEC**	**DEC**	**DEC**	**DEC**
2nd -5th years since last attack	**DEC**	**R**	**STD**	**STD**
After 5 years	**STD**	**STD**	**STD**	**STD**
BUILD TABLES (see HEIGHT AND WEIGHT TABLES at the end of these guidelines)				
BULIMIA				
Within 5 years	**DEC**	**DEC**	**DEC**	**DEC**
Complete recovery after 5 years	**IC**	**IC**	**IC**	**STD**
CANCER (see TUMORS)				
CARDIAC ARRHYTHMIA (see HEARTBEAT IRREGULARITY)				
(A variation from the normal rhythm of the heartbeat. Includes tachycardia, bradycardia, fibrillation, and premature beats.)				
All cases	**IC**	**IC**	**IC**	**IC**
CARDIOMYOPATHY (See HEART CONDITIONS)				
CAROTID BRUIT				
Present Generally	**DEC**	**DEC**	**DEC**	**DEC**
With favorable carotid Doppler or ultrasound	**IC**	**IC**	**IC**	**IC**
CARPAL TUNNEL SYNDROME				
Present, unilateral or bilateral (indicate which wrist)	**DEC**	**R**	**STD**	**STD**
Surgery, complete recovery	**STD**	**STD**	**STD**	**STD**
CATARACTS (see EYE DISORDERS)				

	HMO	Major Med.	Hosp/ Surg	BO RC
CEREBRAL CONCUSSION (No skull fracture, No operation)				
No unconsciousness	**STD**	**STD**	**STD**	**STD**
With unconsciousness, within 6 months	**DEC**	**DEC**	**DEC**	**DEC**
CEREBRAL PALSY				
Over age 20				
Mild to moderate, normal mentality, self supporting	**DEC**	**R**	**STD**	**STD**
Others	**DEC**	**DEC**	**DEC**	**DEC**
CEREBRAL HEMORRHAGE (STROKE), EMBOLISM, THROMBOSIS, TRANSIENT ISCHEMIC ATTACK (TIA)				
Present or history	**DEC**	**DEC**	**DEC**	**DEC**
CERVICITIS				
Single, acute episode, complete recovery	**STD**	**STD**	**STD**	**STD**
Multiple recurrent episodes, complete recovery				
Within 2 years of last attack	**DEC**	**R**	**STD**	**STD**
After 2 years	**STD**	**STD**	**STD**	**STD**
CESAREAN SECTION				
Within 5 years	**DEC**	**R**	**R**	**R**
After 5 years	**STD**	**STD**	**STD**	**STD**
CHLAMYDIA (see SEXUALLY TRANSMITTED DISEASES)				
CHOLESTEROL (see LIPIDS)				
CHRONIC FATIGUE				
Within 2 years of full recovery	**DEC**	**DEC**	**SRRII**	**SRRII**
After 2 years through 5th year of full recovery	**SRRII**	**SRRII**	**IC**	**STD**
After 5 years of full recovery	**STD**	**STD**	**STD**	**STD**
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) (see EMPHYSEMIA)				
CIRRHOSIS OF LIVER				
All cases	**DEC**	**DEC**	**DEC**	**DEC**
CLEFT PALATE OR CLEFT LIP (Harelip)				
Present or Operated within one year				
Under Age 18	**DEC**	**DEC**	**DEC**	**DEC**
Age 18 and over and no surgery recommended	**STD**	**STD**	**STD**	**STD**

	HMO	Major Med.	Hosp/ Surg	BO RC
CLUB FOOT				
Present	**DEC**	**R**	**R**	**R**
History, deformity corrected, no indication of surgery	**STD**	**STD**	**STD**	**STD**
COLITIS				
Spastic Colitis, Irritable Bowel Syndrome, Irritable Colon, Spastic Colon				
Single attack, complete recovery	**STD**	**STD**	**STD**	**STD**
Recurrent or chronic, complete recovery				
Within 5 years	**DEC**	**R**	**R**	**STD**
After 5 years	**STD**	**STD**	**STD**	**STD**
Ulcerative Colitis (a current CBC is required)				
Unoperated				
Within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
Within 2 to 8 years of recovery	**DEC**	**R**	**R**	**R**
After 8th year	**STD**	**STD**	**STD**	**STD**
Operated				
All cases	**IC**	**IC**	**IC**	**IC**
CROHN'S (see CROHN'S DISEASE)				
COLLAGEN DISEASE				
Dermatomyositis	**DEC**	**DEC**	**DEC**	**DEC**
Lupus Erythematosis	**DEC**	**DEC**	**DEC**	**DEC**
Disseminated or Systemic	**DEC**	**DEC**	**DEC**	**DEC**
Discoid, well controlled, no complications				
Within 2 years	**DEC**	**R**	**STD**	**STD**
After 2 years	**STD**	**STD**	**STD**	**STD**
Polyarteritis,	**DEC**	**DEC**	**DEC**	**DEC**
Scleroderma or Crest Syndrome				
Diffuse or widespread	**DEC**	**DEC**	**DEC**	**DEC**
Circumscribed				
Present or within 2 years	**DEC**	**DEC**	**DEC**	**SRRII**
Other	**IC**	**IC**	**IC**	**IC**
Sjogren's Syndrome	**DEC**	**DEC**	**DEC**	**DEC**
CONGENITAL HEART DEFECTS				
Patent Ductus Arterious, Pulmonary Stenosis, Aortic Stenosis, Atrial Septal Defect and Patent Foramen Ovale				
Operated, fully recovered, no residual murmur				
Within 3 years	**DEC**	**DEC**	**DEC**	**DEC**
After 3 years	**IC**	**IC**	**IC**	**STD**
Ventricular Septal Defect				
Operated, fully recovered, no residual murmur				
Within 10 years	**DEC**	**DEC**	**DEC**	**DEC**
After 10 years	**IC**	**IC**	**IC**	**STD**
Any of the above Congenital Heart Defects				
Unoperated	**DEC**	**DEC**	**DEC**	**DEC**
Spontaneous Closure, fully recovered, with negative ECHO	**IC**	**IC**	**IC**	**IC**
Coarctation of the Aorta, Tetrology of Fallot or Transposition of the Great Vessels				
Present or History	**DEC**	**DEC**	**DEC**	**DEC**
Artificial Valve Inserted	**DEC**	**DEC**	**DEC**	**DEC**

	HMO	Major Med.	Hosp/ Surg	BO RC
CONJUNCTIVITIS (see EYE DISORDERS)				
COPD (see EMPHYSEMA)				
CROHN'S DISEASE				
Within 7 years	**DEC**	**DEC**	**DEC**	**DEC**
8th – 10th year	**DEC**	**R**	**R**	**R**
After 10 years	**STD**	**STD**	**STD**	**STD**
CYSTIC FIBROSIS	**DEC**	**DEC**	**DEC**	**DEC**
CYSTITIS (BLADDER INFECTION)				
Acute attacks (no more than 2) complete recovery	**STD**	**STD**	**STD**	**STD**
Chronic or more than 2 attacks				
Within 2 years of recovery from last attack	**DEC**	**R**	**STD**	**STD**
After 2 years	**STD**	**STD**	**STD**	**STD**
CYSTOCELE, RECTOCELE, URETHROCELE, UTERINE PROLAPSE				
Present	**DEC**	**R**	**R**	**R**
Operated, after recovery	**STD**	**STD**	**STD**	**STD**
D AND C				
All cases, provide reason performed	**UFC**	**UFC**	**UFC**	**UFC**
DEAFNESS (TOTAL)	**STD**	**STD**	**STD**	**STD**
DEEP VEIN THROMBOSIS				
Present	**DEC**	**DEC**	**DEC**	**DEC**
Single occurrence, after complete recovery, not on blood thinners	**STD**	**STD**	**STD**	**STD**
Others	**IC**	**IC**	**IC**	**IC**
DEFORMITIES (Describe and state cause)	**DEC**	**IC**	**IC**	**IC**
DEPRESSION (see PSYCHONEUROSES)				
DERMATOMYOSITIS (see COLLAGEN DISEASE)				
DETACHED RETINA (see EYE DISORDERS)				
DEVIATED NASAL SEPTUM				
Present	**DEC**	**R**	**R**	**R**
Operated, complete recovery	**STD**	**STD**	**STD**	**STD**
DIABETES MELLITUS (Includes Glucose Intolerance, Hyperglycemia, Sugar Disorders, and Metabolic Syndrome)				
All cases	**DEC**	**DEC**	**DEC**	**DEC**
DISC DISEASE (see BACK DISORDERS)				

	HMO	Major Med.	Hosp/ Surg	BO RC
DISLOCATION OR MUSCLE OR LIGAMENT OR SOFT TISSUE INJURIES OF A JOINT				
Specify type of treatment, any fixation devices, and body part involved.				
Non-weight bearing joint (shoulder, elbow, wrist, etc.)				
Single Occurrence, fully recovered				
Within 1 year	**DEC**	**R**	**STD**	**STD**
After 1 year	**STD**	**STD**	**STD**	**STD**
Recurrent or Chronic				
Within 3 years	**DEC**	**R**	**R**	**STD**
After 3 years	**STD**	**STD**	**STD**	**STD**
Operated after 1 year	**STD**	**STD**	**STD**	**STD**
Weight bearing joint (hip, knee, leg or ankle)				
Single occurrence or operated, fully recovered				
Within 1 year	**DEC**	**R**	**STD**	**STD**
After 1 year	**STD**	**STD**	**STD**	**STD**
Recurrent or chronic				
Within 3 years, last occurrence	**DEC**	**R**	**R**	**R**
After 3 years	**STD**	**STD**	**STD**	**STD**
Spine (see BACK & SPINAL COLUMN DISORDERS)				
DISSEMINATED LUPUS ERYTHEMATOSIS (see COLLAGEN DISEASE)				
DIVERTICULOSIS AND DIVERTICULITIS				
Diverticulosis				
Asymptomatic	**STD**	**STD**	**STD**	**STD**
Symptomatic	**See Guidelines for Diverticulitis**			
Diverticulitis				
Single attack, Unoperated, complete recovery				
Within 2 years	**DEC**	**R**	**STD**	**STD**
After 2 years	**STD**	**STD**	**STD**	**STD**
Multiple attacks, Unoperated, complete recovery				
Within 5 years	**DEC**	**R**	**R**	**R**
After 5 years	**STD**	**STD**	**STD**	**STD**
Operated	**IC**	**IC**	**IC**	**IC**
DIZZINESS (see SYNCOPE)				
DOWN'S SYNDROME				
Age 14 and under	**DEC**	**DEC**	**DEC**	**DEC**
Age 15 and over	**IC**	**IC**	**DEC**	**IC**
DRUG ABUSE OR ADDICTION				
Within 5 years of discontinuance	**DEC**	**DEC**	**DEC**	**DEC**
6th through 10th year after discontinuance	**SRRII**	**SRRII**	**SRRII**	**STD**
After 10 years	**STD**	**STD**	**STD**	**STD**

	HMO	Major Med.	Hosp/ Surg	BO RC
DUI				
Court charges pending, hospitalization/alcohol treatment/counseling required and not completed, or multiple violations within 5 years	**DEC**	**DEC**	**DEC**	**DEC**
Isolated, one-time incident with negative liver values	**IC**	**IC**	**IC**	**STD**
DYSLEXIA (see ATTENTION DEFICIT DISORDER)				
DYSPEPSIA (see GASTRITIS)				
EAR INFECTION (see OTITIS MEDIA)				
EMPHYSEMA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)				
Mild, non-disabling, non smoker	**DEC**	**R**	**STD**	**STD**
Moderate or Severe or currently smoking	**DEC**	**DEC**	**DEC**	**DEC**
ENCEPHALITIS				
Primary Infectious, w/o residuals, within 2 years	**DEC**	**DEC**	**DEC**	**DEC**
Secondary to mumps, measles, trauma, fully recovered	**STD**	**STD**	**STD**	**STD**
ENDOCARDITIS				
Within 2 years	**DEC**	**DEC**	**DEC**	**DEC**
After 2 years complete recovery	**IC**	**IC**	**IC**	**IC**
ENDOMETRIOSIS				
Currently receiving Lupron injections	**DEC**	**DEC**	**DEC**	**DEC**
Unoperated or Operated within 5 years	**DEC**	**R**	**R**	**R**
Operated after 5 years without symptoms	**STD**	**STD**	**STD**	**STD**
EPILEPSY				
Grand Mal, Jacksonion Epilepsy, Narcolepsy, or Nocturnal				
Within 5 years since last seizure	**DEC**	**DEC**	**DEC**	**DEC**
After 5 years	**IC**	**IC**	**IC**	**STD**
Petit Mal Epilepsy				
Within 3 years since last seizure	**DEC**	**DEC**	**DEC**	**DEC**
After 3 years	**IC**	**IC**	**IC**	**STD**
Others- including febrile seizures	**IC**	**IC**	**IC**	**STD**
EPSTEIN-BARR DISEASE OR SYNDROME (see MONONUCLEOSIS)				
ESOPHAGEAL REFLUX (GERD)				
Recent onset, and/or multiple medications	**DEC**	**R**	**STD**	**STD**
Others	**IC**	**IC**	**IC**	**IC**

	HMO	Major Med.	Hosp/ Surg	BO RC
EYE DISORDERS				
Blindness				
Due to disease	**UFC**	**UFC**	**UFC**	**UFC**
Congenital or due to trauma	**STD**	**STD**	**STD**	**STD**
Cataracts				
Present, unilateral or bilateral (indicate which eye)	**DEC**	**R**	**R**	**R**
Operated, one or both eyes				
Within 1 year of recovery	**DEC**	**R**	**STD**	**STD**
After 1 year	**STD**	**STD**	**STD**	**STD**
Conjunctivitis	**STD**	**STD**	**STD**	**STD**
Detached Retina				
Due to injury – within 2 years	**DEC**	**R**	**STD**	**STD**
Due to disease	**IC**	**IC**	**IC**	**IC**
Glaucoma Occular Hypertension, or Pre-Glaucoma				
Within 2 years of surgery or diagnosis	**DEC**	**R**	**STD**	**STD**
After 2 years, no surgery indicated	**STD**	**STD**	**STD**	**STD**
Strabismus				
Present				
History of head injury as cause				
Within 2 years	**DEC**	**DEC**	**DEC**	**R**
After 2 years	**IC**	**IC**	**IC**	**STD**
No History of head injury				
Not congenital, within 5 years of onset	**DEC**	**DEC**	**DEC**	**DEC**
Congenital, or Present 5 years or more	**IC**	**IC**	**IC**	**R**
Operated	**STD**	**STD**	**STD**	**STD**
FACTORS V OR VIII DEFICIENCIES (See HEMOPHILIA)				
FEBRILE SEIZURE				
Under age 5, single attack	**STD**	**STD**	**STD**	**STD**
Otherwise	**IC**	**IC**	**IC**	**IC**
FIBROCYSTIC BREAST DISEASE	**STD**	**STD**	**STD**	**STD**
FIBROMYALGIA, POLYARTHRALGIA, POLYMYOSITIS, FIBROMYOSITIS				
Present, or on medication or within 2 years of full recovery	**DEC**	**DEC**	**STD**	**STD**
Chronic or Recurrent within 5 years of full recovery	**DEC**	**STD**	**DEC**	**STD**
Others	**IC**	**IC**	**STD**	**STD**
FIBROID TUMOR OF THE UTERUS				
Unoperated	**DEC**	**R**	**R**	**R**
Operated- hysterectomy	**STD**	**STD**	**STD**	**STD**
Operated-fibroidectomy or other surgery – within 5 years	**DEC**	**R**	**STD**	**STD**
FIXATION DEVICE				
Present (indicate area involved)	**DEC**	**R**	**STD**	**STD**
Removed, fully recovered	**STD**	**STD**	**STD**	**STD**

	HMO	Major Med.	Hosp/ Surg	BO RC
FRACTURE				
Present	**DEC**	**DEC**	**DEC**	**DEC**
Fracture involving one of the extremities				
Complete recovery no internal fixation device present	**STD**	**STD**	**STD**	**STD**
Complete recovery with internal fixation device present	**DEC**	**R**	**R**	**STD**
Others, including hip, skull, and spine	**IC**	**IC**	**IC**	**IC**
GALLBLADDER (Cholecystitis, Gallstones)				
Present or history without surgery	**DEC**	**R**	**R**	**R**
Operated, (Cholecystectomy) fully recovered	**STD**	**STD**	**STD**	**STD**
Others	**IC**	**IC**	**IC**	**IC**
GANGLION CYST				
Present or recurring	**DEC**	**R**	**R**	**R**
Surgical or medical cure, complete recovery	**STD**	**STD**	**STD**	**STD**
GASTRIC BYPASS, STOMACH STAPLING OR GASTRIC WRAPPING				
Complete recovery with no complications				
Within 5 years	**DEC**	**DEC**	**DEC**	**DEC**
After 5 years	**IC**	**IC**	**IC**	**IC**
GASTRITIS, DYSPEPSIA, INDIGESTION, NERVOUS STOMACH				
(These terms are often used loosely to cover a wide range of stomach and intestinal complaints. It is important to consider the underlying cause of the symptoms experienced by the individual.)				
Acute, single attack generally	**STD**	**STD**	**STD**	**STD**
Others	**IC**	**IC**	**IC**	**STD**
GASTROINTESTINAL HEMORRAGE				
Cause known	**UFC**	**UFC**	**UFC**	**UFC**
Cause unknown, within 4 years	**DEC**	**DEC**	**DEC**	**DEC**
Cause unknown, after 4 years	**IC**	**IC**	**IC**	**IC**
GERD (see ESOPHAGEAL REFLUX)				
GILBERT'S DISEASE				
With definite diagnosis by physician, all other liver values normal except elevated bilirubin	**STD**	**STD**	**STD**	**STD**
GLAUCOMA (see EYE DISORDERS)				
GOUT				
No cardiovascular or renal involvement, and blood pressure must be under good control				
Single attack within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
Single attack after 1 year	**IC**	**IC**	**IC**	**STD**
Multiple attacks within 2 years	**DEC**	**DEC**	**DEC**	**DEC**
Multiple attacks after 2 years	**IC**	**IC**	**IC**	**STD**
GROWTH HORMONES				
Presently on growth hormones or within 1 year of discontinuance	**DEC**	**DEC**	**DEC**	**DEC**

	HMO	Major Med.	Hosp/ Surg	BO RC
H-PYLORI				
Present or within 6 months of recovery, no ulcer present	**DEC**	**R**	**STD**	**STD**
After 6 months	**IC**	**IC**	**STD**	**STD**
HAY FEVER				
Mild, seasonal, treated with over the counter drugs	**STD**	**STD**	**STD**	**STD**
Others	**DEC**	**R**	**STD**	**STD**
HEADACHE (see MIGRAINE)				
HEARTBEAT IRREGULARITY				
Need firm diagnosis and date of last episode	**IC**	**IC**	**IC**	**IC**
HEART CONDITIONS AND DISORDERS				
Includes Angina Pectoris, Angioplasty, Coronary Occlusion, Coronary Insufficiency, Myocardial Infarction (heart attack), Coronary by-pass, Coronary Thrombosis, Ischemia, Cardiomyopathy, Hypertrophy				
Present or History	**DEC**	**DEC**	**DEC**	**DEC**
HEART VALVE REPLACEMENTS OR PACEMAKERS				
All cases	**DEC**	**DEC**	**DEC**	**DEC**
HEMATURIA				
Cause known	**UFC**	**UFC**	**UFC**	**UFC**
Cause unknown	**DEC**	**DEC**	**IC**	**IC**
HEMOCHROMATOSIS	**DEC**	**DEC**	**DEC**	**DEC**
HEMOPHILIA OR VON WILLEBRAND'S DISEASE, FACTOR V, OR FACTOR VIII DEFICIENCIES				
All cases	**DEC**	**DEC**	**DEC**	**DEC**
HEMORRHOIDS				
Operated, complete recovery	**STD**	**STD**	**STD**	**STD**
Present with symptoms or requiring treatment within one year	**DEC**	**R**	**STD**	**STD**
HEPATITIS (NORMAL LIVER FUNCTION REQUIRED)				
Hepatitis A; Single attack, complete recovery				
Within 6 months	**DEC**	**DEC**	**DEC**	**DEC**
After 6 months	**STD**	**STD**	**STD**	**STD**
Hepatitis B, Serum Hepatitis, or more than one attack (Hepatitis A or B)				
Within 2 years since last attack	**DEC**	**DEC**	**DEC**	**DEC**
During 3rd -5th years	**SRRII**	**SRRII**	**STD**	**STD**
During 6th & 7th years	**SRRI**	**SRRI**	**STD**	**STD**
After 7 years	**STD**	**STD**	**STD**	**STD**
Hepatitis C, Hepatitis D, Chronic Hepatitis, Autoimmune Hepatitis or Hepatitis carriers	**DEC**	**DEC**	**DEC**	**DEC**

Close contact with Hepatitis B or C requires a subsequent negative hepatitis panel.

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	HMO	Major Med.	Hosp/ Surg	BO RC
HERNIA				
Unoperated (indicate type or location)	**DEC**	**R**	**R**	**R**
Operated	**STD**	**STD**	**STD**	**STD**
HERPES				
Simplex I (non-genital)	**STD**	**STD**	**STD**	**STD**
Simplex II (genital herpes)				
Diagnosed within 1 year and no current negative HIV	**DEC**	**DEC**	**DEC**	**DEC**
Within 1 year of diagnosis with negative HIV testing	**STD**	**STD**	**STD**	**STD**
Zoster (see **SHINGLES**)				
HIP DISORDERS (see DISLOCATION OR MUSCLE OR LIGAMENT OR SOFT TISSUE INJURY)				
HIV POSITIVE	**DEC**	**DEC**	**DEC**	**DEC**
Exposure - close contact, living in the same house with a person who is HIV positive requires two current negative HIV test results; six months apart, for consideration	**IC**	**IC**	**IC**	**IC**
HODGKINS DISEASE	**DEC**	**DEC**	**DEC**	**DEC**
HYDROCELE				
Present	**DEC**	**R**	**R**	**R**
History, complete recovery	**STD**	**STD**	**STD**	**STD**
HYDROCEPHALUS				
Present or history	**DEC**	**DEC**	**DEC**	**DEC**
HYPERPARATHYROIDISM				
Present	**DEC**	**DEC**	**DEC**	**DEC**
Operated				
Within 4 years	**DEC**	**DEC**	**DEC**	**DEC**
After 4 years	**IC**	**IC**	**IC**	**IC**

HYPERTENSION (Elevated Blood Pressure)

The following factors are important when considering individuals with hypertension: proper medical supervision, treatment, actual blood pressure readings within the past 12 months, medication prescribed, and the applicant's overall health history. Also taken into consideration are cardiovascular risk factors such as current smoking status, build and lipids.

Diagnosed within 6 months	**DEC**	**DEC**	**DEC**	**DEC**
Diagnosed after 6 months				
Well controlled (action is subject to an APS and must have seen the Doctor within the past 12 months for Blood Pressure check)	**IC**	**IC**	**IC**	**STD**
Not well controlled or hypertension with combinations of other health problems such as overweight, circulatory disorder, or a combination of multiple cardiovascular risk factors or recent discontinuance of BP lowering medications without subsequent BP readings or on 3 or more BP medications for control	**DEC**	**DEC**	**DEC**	**DEC**

HYPERTHYROIDISM (see THYROID GLAND DISORDERS)

	HMO	Major Med.	Hosp/ Surg	BO RC
HYPERTROPHY (see HEART CONDITIONS)				
HYPERURICEMIA - NO SYMPTOMS OF GOUT				
Within 2 years	**SRRI**	**SRRI**	**SRRI**	**STD**
After 2 years	**STD**	**STD**	**STD**	**STD**
HYPOGLYCEMIA				
Cause known	**UFC**	**UFC**	**UFC**	**UFC**
Cause unknown				
Within 2 years of recovery	**SRRII**	**SRRII**	**STD**	**STD**
3 rd year	**SRRI**	**SRRI**	**STD**	**STD**
After 3 years	**STD**	**STD**	**STD**	**STD**
HYPOTHYROIDISM (see THYROID GLAND DISORDERS)				
HYSTERECTOMY				
All cases, advise reason for surgery	**UFC**	**UFC**	**UFC**	**UFC**
If due to cancer, see Cancer Table (Tumors)				
ILEITIS, REGIONAL ILEITIS, REGIONAL ENTERITIS, CROHN'S DISEASE (see COLITIS - Ulcerative)				
INDIGESTION (see GASTRITIS)				
INFERTILITY				
Currently undergoing testing, pursuing In-Vitro fertilization or using fertility drugs.	**DEC**	**DEC**	**DEC**	**DEC**
Discontinuance of testing or fertility drugs within one year	**DEC**	**R**	**R**	**STD**
Discontinuance of testing or fertility drugs after one year	**IC**	**IC**	**STD**	**STD**
JAUNDICE				
Newborn Jaundice after full recovery	**STD**	**STD**	**STD**	**STD**
Present	**DEC**	**DEC**	**DEC**	**DEC**
History	**UFC**	**UFC**	**UFC**	**UFC**
KAWASAKI SYNDROME				
Within 2 years of diagnosis or symptoms	**DEC**	**DEC**	**DEC**	**DEC**
KIDNEY INFECTION (see NEPHRITIS)				
KIDNEY STONE (see RENAL OR URINARY CALCULUS OR STONE)				
KNEE DISORDERS (see DISLOCATION OR MUSCLE OR LIGAMENT AND SOFT TISSUE INJURIES OF A JOINT)				

	HMO	Major Med.	Hosp/ Surg	BO RC
LAB TESTS (see ABNORMAL LABORATORY RESULTS)				
LABYRINTHITIS	**IC**	**IC**	**IC**	**IC**
LEUKEMIA	**DEC**	**DEC**	**DEC**	**DEC**
LIPIDS (CHOLESTEROL AND TRIGLYCERIDES), HYPERLIPIDEMIA				
The following factors are important when considering individuals with lipids requiring treatment: proper medical supervision, actual lipid readings, medication prescribed, and the applicant's overall health history. Also, taken into consideration are cardiovascular risk factors such as current smoking status, build and hypertension.				
Well Controlled (must have seen the doctor within the past 12 months for a lipid evaluation including labs)	**IC**	**IC**	**IC**	**STD**
Not Well Controlled or lipids with combination of other health problems such as: overweight, circulatory disorders, a combination of multiple cardiovascular risk factors or recent discontinuance of lipid lowering medication without subsequent lipid readings/physician assessment	**DEC**	**DEC**	**DEC**	**DEC**
LIVER DISORDERS				
Abnormal lab values requires a subsequent normal repeat lab and a physician's assessment as to cause for prior abnormal labs	**IC**	**IC**	**IC**	**IC**
Cirrhosis	**DEC**	**DEC**	**DEC**	**DEC**
Enlarged Liver	**DEC**	**DEC**	**DEC**	**DEC**
LOU GEHRIGH'S DISEASE	**DEC**	**DEC**	**DEC**	**DEC**
LUPUS ERYTHEMATOSUS (see COLLAGEN DISEASE)				
LYMES DISEASE				
Present or with remaining residuals	**DEC**	**DEC**	**DEC**	**DEC**
After full recovery and no residuals	**STD**	**STD**	**STD**	**STD**
MACULAR DEGENERATION OR BEST'S DISEASE				
Involvement of the eyes only and secondary to aging	**DEC**	**R**	**STD**	**STD**
Others or cause unknown	**DEC**	**DEC**	**DEC**	**DEC**
MALIGNANT TUMORS (see TUMORS, MALIGNANT)				
MARFAN'S SYNDROME	**DEC**	**DEC**	**DEC**	**DEC**
MENINGITIS OR CEREBROSPINAL MENINGITIS				
No residuals, complete recovery after 1 year	**STD**	**STD**	**STD**	**STD**
Residuals or with complications, or within 1 year	**DEC**	**DEC**	**DEC**	**DEC**

	HMO	Major Med.	Hosp/ Surg	BO RC
MENIERES DISEASE OR SYNDROME				
Controlled, not associated with hearing loss				
Single attack – within 2 years of attack	**DEC**	**R**	**STD**	**STD**
Single attack – after 2 years of attack ….	**STD**	**STD**	**STD**	**STD**
More than one attack – within 4 years of last attack	**DEC**	**R**	**STD**	**STD**
More than one attack – after 4 full years of last attack	**STD**	**STD**	**STD**	**STD**
MENSTRUAL ABNORMALITIES				
(Includes Amenorrhea, Dysmenorrhea, Menorrhagia, Metrorrhagia, and Post-Menopausal Uterine Bleeding.)				
Present	**DEC**	**UFC**	**IC**	**IC**
Others	**IC**	**IC**	**IC**	**IC**
MENTAL RETARDATION	**IC**	**IC**	**IC**	**IC**
MIGRAINE HEADACHE				
This is generally a symptom rather than a disorder. It is important to investigate the cause, frequency, severity and treatment.				
Mild to moderate, occasional, few hours duration, not incapacitating	**SRRI**	**SRRI**	**STD**	**STD**
More severe, within 2 years of last attack	**SRRII**	**SRRII**	**STD**	**STD**
Headache secondary to other impairment	**UFC**	**UFC**	**UFC**	**UFC**
Receiving Botox Injections	**DEC**	**R**	**STD**	**STD**
MITRAL VALVE PROLAPSE (Barlow Syndrome)				
No symptoms, no medication	**STD**	**STD**	**STD**	**STD**
Mild symptoms and/or cardiac medication	**DEC**	**R**	**STD**	**STD**
Myxomatosis/Myxomatous mitral valve found on Echo	**DEC**	**DEC**	**DEC**	**DEC**
History of mitral valve repair or replacement	**DEC**	**DEC**	**DEC**	**DEC**
MONONUCLEOSIS				
Present	**DEC**	**DEC**	**DEC**	**DEC**
History – duration less than 4 months, full recovery, with subsequent normal blood work	**STD**	**STD**	**STD**	**STD**
Others	**IC**	**IC**	**IC**	**IC**
MULTIPLE SCLEROSIS	**DEC**	**DEC**	**DEC**	**DEC**
MURMURS (Heart)				
All cases	**IC**	**IC**	**IC**	**IC**
MUSCULAR DYSTROPHY	**DEC**	**DEC**	**DEC**	**DEC**
MYASTHENIA GRAVIS				
History or Present	**DEC**	**DEC**	**DEC**	**DEC**
NEPHRECTOMY				
Transplant donor, complete recovery	**STD**	**STD**	**STD**	**STD**
Others (advise cause)	**UFC**	**UFC**	**UFC**	**UFC**

	HMO	Major Med.	Hosp/ Surg	BO RC
NEPHRITIS (Kidney Infection)				
One attack (duration 2 months or less), no complications, no residuals				
Within 2 years	**DEC**	**R**	**R**	**R**
After 2 years	**STD**	**STD**	**STD**	**STD**
2 or 3 attacks, no complications or residuals				
Within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
2nd – 5th year	**DEC**	**R**	**R**	**STD**
Chronic or more than 3 attacks	**DEC**	**DEC**	**DEC**	**DEC**
NERVOUS STOMACH (see GASTRITIS)				
NON-HODGKIN'S LYMPHOMA (see LYMPHOMA UNDER TUMORS, MALIGNANT)				
ORGAN TRANSPLANT	**DEC**	**DEC**	**DEC**	**DEC**
OSTEOPOROSIS				
If taking medications, provide date of most recent bone scan and T-score				
Present, marked deformity, or severe or progressive on bone scan, or with symptoms	**DEC**	**DEC**	**DEC**	**DEC**
Others, mild to moderate; no symptoms	**STD**	**STD**	**STD**	**STD**
OTITIS MEDIA				
Acute, one or two attacks, complete recovery	**STD**	**STD**	**STD**	**STD**
Chronic or recurrent, including tympanic tube or button present				
Within 2 years of last attack or surgery	**DEC**	**R**	**STD**	**STD**
After 2 years and no tubes present	**STD**	**STD**	**STD**	**STD**
OVARIAN CYSTS (BENIGN)				
Present	**DEC**	**R**	**R**	**R**
Operated, complete recovery	**STD**	**STD**	**STD**	**STD**
Polycystic Ovarian Disease (POD) treated with diabetic prescription	**DEC**	**DEC**	**DEC**	**DEC**
POD, present	**DEC**	**R**	**R**	**R**
operated within 2 years	**DEC**	**R**	**R**	**STD**
PACEMAKER OF THE HEART				
Present	**DEC**	**DEC**	**DEC**	**DEC**
PANCREATIC DISORDERS				
Alcohol related, chronic, or recurrent	**DEC**	**DEC**	**DEC**	**DEC**
Non-alcohol related, Pancreatitis, acute attack, within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
All others	**IC**	**IC**	**IC**	**IC**
PARKINSON'S DISEASE				
All cases	**DEC**	**DEC**	**DEC**	**DEC**
PARALYSIS				
All cases	**IC**	**IC**	**IC**	**IC**

	HMO	Major Med.	Hosp/ Surg	BO RC
PERICARDITIS				
Within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
After 1 year with negative EKG/Cardiology evaluation	**IC**	**IC**	**IC**	**STD**
PERIPHERAL VASCULAR DISEASE, ARTERIOSCLEROSIS OBLITERANS, THROMBOANGIITIS OBLITERANS, BUERGER'S DISEASE	**DEC**	**DEC**	**DEC**	**DEC**
PHLEBITIS AND THROMBOPHLEBITIS				
No remaining edema				
Single attack, complete recovery				
Within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
After 1 year	**STD**	**STD**	**STD**	**STD**
Recurrent attacks				
Within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
During 2nd and 4th years	**DEC**	**R**	**STD**	**STD**
After 4 years	**STD**	**STD**	**STD**	**STD**
With persisting edema or on blood thinner	**DEC**	**DEC**	**DEC**	**DEC**
PILONIDAL CYST OR SINUS				
Present or treated by incision or drainage within 2 years	**DEC**	**R**	**R**	**R**
After 2 years or surgically excised, complete recovery	**STD**	**STD**	**STD**	**STD**
PLEURISY (DRY)				
One attack, after recovery	**STD**	**STD**	**STD**	**STD**
More than 1 attack, after recovery - within 2 years	**DEC**	**R**	**STD**	**STD**
PNEUMONIA				
Single attack, within 6 months of complete recovery	**DEC**	**DEC**	**DEC**	**DEC**
After 6 months of complete recovery – generally	**STD**	**STD**	**STD**	**STD**
Multiple attacks	**IC**	**IC**	**IC**	**IC**
Pneumocystis Carinii	**DEC**	**DEC**	**DEC**	**DEC**
Walking Pneumonia, complete recovery	**STD**	**STD**	**STD**	**STD**
PNEUMOTHORAX				
Traumatic, complete recovery	**STD**	**STD**	**STD**	**STD**
Spontaneous				
One attack, complete recovery	**STD**	**STD**	**STD**	**STD**
Two or more attacks, after recovery – within 3 years	**DEC**	**R**	**STD**	**STD**

POLYARTERITIS (see COLLAGEN DISEASE)

POLYARTHRALGIA/POLYMYOSITIS (see FIBROMYALGIA)

POLYARTHRITIS (See OSTEOARTHRITIS)

	HMO	Major Med.	Hosp/ Surg	BO RC
POLYCYSTIC KIDNEY DISEASE	**DEC**	**DEC**	**DEC**	**DEC**
POLYCYTHEMIA	**DEC**	**DEC**	**DEC**	**DEC**
POLYMYOSTITIS (see FIBROMYALGIA)				
POLYPS AND PAPILLOMA				
Non-cancerous, state location and number				
Removed	**IC**	**IC**	**IC**	**IC**
Present				
Gallbladder, colon/intestine, urinary bladder or urethral	**DEC**	**DEC**	**DEC**	**DEC**
Other locations	**IC**	**IC**	**IC**	**IC**
PREGNANCY **(An application may not be submitted on a pregnant applicant, pregnant spouse, expectant father married or single, or a pregnant dependent.)**				
History				
Normal pregnancy	**STD**	**STD**	**STD**	**STD**
Complicated pregnancy within 5 years: (state complication, i.e. C-Section, tubal pregnancy, toxemia, miscarriage, etc.)	**DEC**	**R**	**R**	**R**
After 5 years	**STD**	**STD**	**STD**	**STD**
PREMATURE INFANTS				
Under 6 months of age or less than 8 pounds, or requiring oxygen or Monitoring within the past 6 months	**DEC**	**DEC**	**DEC**	**DEC**
Others	**IC**	**IC**	**IC**	**IC**
PROCTITIS				
Acute, single episode, fully recovered	**STD**	**STD**	**STD**	**STD**
Recurrent				
Within 5 years	**DEC**	**R**	**STD**	**STD**
After 5 years	**STD**	**STD**	**STD**	**STD**
Ulcerative Proctitis within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
After 1 year with current negative rectal/colon exam	**IC**	**IC**	**IC**	**IC**
PSORIATIC ARTHRITIS (See RHEUMATOID ARTHRITIS)				
PROSTATE DISORDERS				
Prostatitis, recovered, urinalysis normal				
Acute or simple congestion	**STD**	**STD**	**STD**	**STD**
Chronic prostatitis, within 3 years of complete recovery	**DEC**	**R**	**IC**	**IC**
After 3 years	**STD**	**STD**	**STD**	**STD**
Benign Prostatic Hypertrophy (enlargement)				
Mild to moderate (no urinary retention)	**DEC**	**R**	**STD**	**STD**
All others	**DEC**	**DEC**	**IC**	**IC**
Prostatectomy (TURP), complete recovery, benign pathology				
Within 2 years	**DEC**	**R**	**STD**	**STD**
After 2 years	**STD**	**STD**	**STD**	**STD**
PROSTHESIS				
Present (indicate extremity involved)	**DEC**	**R**	**R**	**R**

	HMO	Major Med.	Hosp/ Surg	BO RC
PSYCHONEUROSES				
(Most common classifications of Psychoneuroses include anxiety reaction, depressive reaction, nervous breakdown, nervous exhaustion, hysteria, hyperventilation, and panic attacks.)				
Within 1 year	**DEC**	**IC**	**IC**	**IC**
All others	**IC**	**IC**	**IC**	**IC**
PSYCHOTIC DISORDERS				
Bi-polar or Uni-polar disorder, manic depression, schizophrenics, etc.	**DEC**	**DEC**	**DEC**	**DEC**
PTOSIS				
Present	**DEC**	**R**	**R**	**R**
PULMONARY EMBOLISM OR INFARCTION				
Cause unknown				
Within 6 months of recovery	**DEC**	**DEC**	**DEC**	**DEC**
After 6 months – not under treatment	**IC**	**IC**	**IC**	**STD**
After 6 months, continuing treatment with anti-coagulants or Inferior Vena Cava Filter Present	**DEC**	**DEC**	**DEC**	**DEC**
Cause known	**UFC**	**UFC**	**UFC**	**UFC**
PYELITIS				
Present	**DEC**	**DEC**	**DEC**	**DEC**
Single acute attack				
Within 1 year of recovery	**DEC**	**R**	**STD**	**STD**
After 1 year	**STD**	**STD**	**STD**	**STD**
2 to 4 attacks				
Within 3 years of recovery from last attack	**DEC**	**R**	**STD**	**STD**
After 3 years	**STD**	**STD**	**STD**	**STD**
More than 4, or chronic	**DEC**	**DEC**	**DEC**	**DEC**
RAYNAUD'S DISEASE OR SYNDROME				
Within 1 year of diagnosis or last symptom	**DEC**	**DEC**	**DEC**	**DEC**
Others	**IC**	**IC**	**IC**	**IC**
RECTAL ABSCESS				
Single episode, operated, full recovery	**STD**	**STD**	**STD**	**STD**
Unoperated or recurrent, within 2 years	**DEC**	**R**	**R**	**R**
RECTAL POLYPS (see POLYPS)				
RECTAL STRICTURE/PROLAPSE				
Unoperated	**DEC**	**R**	**STD**	**STD**
Operated	**STD**	**STD**	**STD**	**STD**
RECTOCELE (see CYSTOCELE)				

	HMO	Major Med.	Hosp/ Surg	BO RC
RENAL OR URINARY CALCULUS OR STONE				
Stone present				
Unilateral	**DEC**	**R**	**R**	**R**
Bilateral	**DEC**	**DEC**	**DEC**	**DEC**
Non-surgical removal, includes lithotripsy, spontaneous passage or cystoscopic manipulation				
1 or 2 attacks				
Within 2 years of last attack	**DEC**	**R**	**STD**	**STD**
After 2 years	**STD**	**STD**	**STD**	**STD**
More than 2 attacks				
Within 5 years of last attack	**DEC**	**R**	**R**	**R**
After 5 years	**STD**	**STD**	**STD**	**STD**
Operated within 5 years (BP readings and urinalysis within 12 months required)	**DEC**	**R**	**STD**	**STD**
Operated after 5 years	**IC**	**IC**	**STD**	**STD**
RESTLESS LEG SYNDROME (RLS)				
Present or within 2 years with negative medical & neurological evaluation	**DEC**	**R**	**STD**	**STD**
Without negative medical & neurological evaluation	**DEC**	**DEC**	**DEC**	**DEC**
SCLERODERMA (see COLLAGEN DISEASE)				
SCOLIOSIS (see BACK DISORDERS)				
SEIZURES (see EPILEPSY)				
SEXUALLY TRANSMITTED DISEASES				
Chlamydia, Condylomata, Condyloma, Koilocytosis, Genital Warts, Gonorrhea, Syphilis, Urethritis, etc.				
Currently under treatment	**DEC**	**DEC**	**DEC**	**DEC**
Human Papilloma Virus (HPV)				
Currently under treatment	**DEC**	**DEC**	**DEC**	**R**
History – may require HIV testing and females must have a subsequent normal PAP smear	**IC**	**IC**	**IC**	**IC**
Multiple conditions				
Present or within 3 years	**DEC**	**DEC**	**DEC**	**DEC**
Herpes Simplex II - see **HERPES**				
SHINGLES				
Present	**DEC**	**DEC**	**DEC**	**R**
Single Attack, after recovery	**STD**	**STD**	**STD**	**STD**
Complicated or repeat attacks				
Within 3 years of recovery	**DEC**	**R**	**STD**	**STD**
After 3 years of recovery	**STD**	**STD**	**STD**	**STD**
SILICOSIS, ASBESTOSIS	**DEC**	**DEC**	**DEC**	**DEC**
SINUSITIS				
Infrequent acute attacks, complete recovery	**STD**	**STD**	**STD**	**STD**
Chronic	**DEC**	**R**	**STD**	**STD**
SJOGREN'S SYNDROME (see COLLAGEN DISEASE)				

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	HMO	Major Med.	Hosp/ Surg	BO RC
SLEEP APNEA				
Mild, obstructive type – adult				
No C-PAP required, controlled BP, & Build requiring less than 50% rating.....	**DEC**	**R**	**STD**	**STD**
With C-PAP, controlled BP and Build etc.				
Within 2 years	**DEC**	**DEC**	**DEC**	**DEC**
After 2 years, good compliance	**DEC**	**R**	**STD**	**STD**
Uncontrolled BP, Build requiring rating of 50% or greater,				
C-PAP non-compliance, surgery recommended, or discontinuance of C-PAP				
Within 6 months	**DEC**	**DEC**	**DEC**	**DEC**
Surgery recommended, or within 6 months of discontinuance of C-PAP.....	**DEC**	**DEC**	**DEC**	**DEC**
After surgery , no residuals	**STD**	**STD**	**STD**	**STD**
Mild, obstructive type – child under age 2	**DEC**	**DEC**	**DEC**	**DEC**
Mild, obstructive type – child over age 2	**IC**	**IC**	**IC**	**IC**
SPINA BIFIDA				
Present	**DEC**	**DEC**	**DEC**	**DEC**
Operated within 5 years.....	**DEC**	**R**	**STD**	**STD**
SPINA BIFIDA OCCULTA.....	**IC**	**IC**	**IC**	**IC**
SPLENECTOMY				
Due to trauma, complete recovery	**STD**	**STD**	**STD**	**STD**
Due to disease or cause unknown.....	**DEC**	**DEC**	**DEC**	**DEC**
STRABISMUS (see EYE DISORDER)				
STROKE (see CEREBRAL HEMORRAGE)				
SYNCOPE, VERTIGO, DIZZINESS				
Cause unknown				
Within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
Others.....	**IC**	**IC**	**IC**	**STD**
Cause known	**UFC**	**UFC**	**UFC**	**UFC**
SYSTEMIC LUPUS ERYTHEMATOSUS (SLE) (see COLLAGEN DISEASE)				
TABES DORSALIS (LOCOMOTOR ATAXIA).....	**DEC**	**DEC**	**DEC**	**DEC**
TREMORS	**UFC**	**UFC**	**UFC**	**UFC**
TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)				
Chronic symptoms, future testing, work-up or surgery anticipated	**DEC**	**DEC**	**DEC**	**DEC**
Others	**IC**	**IC**	**IC**	**STD**
THROMBOCYTOPENIA OR THROMBOCYTOSIS				
Cause unknown or Platelets not consistently normal for a minimum of 4 years..	**DEC**	**DEC**	**DEC**	**DEC**
Others	**IC**	**IC**	**IC**	**IC**

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	HMO	Major Med.	Hosp/ Surg	BO RC
THYROID GLAND DISORDERS				
Hyperthyroid, Goiter, Graves Disease				
Unoperated				
Within 6 months	**DEC**	**DEC**	**DEC**	**DEC**
After 6 months, well controlled	**DEC**	**R**	**IC**	**IC**
Operated, complete recovery	**STD**	**STD**	**STD**	**STD**
Others	**DEC**	**IC**	**IC**	**IC**
Hypothyroidism (without Goiter)	**IC**	**IC**	**STD**	**STD**
Thyroiditis (Hashimoto) Autoimmune Thyroiditis				
Within 2 years of complete recovery	**DEC**	**R**	**IC**	**STD**
After 2 years	**STD**	**STD**	**STD**	**STD**
TONSILLITIS and/or ADENOIDITIS				
Operated, complete recovery	**STD**	**STD**	**STD**	**STD**
Tonsillectomy recommended	**DEC**	**DEC**	**DEC**	**DEC**
Tonsils enlarged or chronically infected, or 3 or more attacks within the past yr	**DEC**	**R**	**R**	**R**
Others	**IC**	**IC**	**STD**	**STD**
TOURETTE'S SYNDROME				
Mild	**DEC**	**R**	**STD**	**STD**
Otherwise	**DEC**	**DEC**	**DEC**	**R**
TRANSIENT ISCHEMIC ATTACK (TIA) (see CEREBRAL HEMORRAGE)				
TRANSPLANTS (see ORGAN TRANSPLANTS)				
TRIGLYCERIDES (see LIPIDS)				
TUBERCULOSIS (TB) – PULMONARY				
Present or currently receiving INH therapy	**DEC**	**DEC**	**DEC**	**DEC**
History				
Within 5 years of recovery (resumption of activities on a full-time basis)	**DEC**	**IC**	**STD**	**STD**
Exposure				
Close contact – living in the same house with a person with active TB				
Currently or within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
After 1 year and with negative tuberculin skin test after cessation of contact	**STD**	**STD**	**STD**	**STD**
TUMORS				
BENIGN TUMORS (state location)	**IC**	**IC**	**IC**	**IC**

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	HMO	Major Med.	Hosp/ Surg	BO RC

MALIGNANT TUMORS

Each Cancer history must be carefully and individually evaluated on the basis of type, location, stage, and success of treatment. **Consideration can only be given for Stages I and II. Any lymph node involvement (Stage III) or metastasis (Stage IV) will result in a permanent declination of coverage.** The acceptance of any history of cancer presumes that the recovery appears complete and the above dates are from the time of return to work (or resumption of normal duties), and cessation of any treatment. An Attending Physician's Statement and pathology report will be obtained by the Home Office. If all factors are favorable and no metastasis, use the following list. This list only includes the more commonly encountered malignant tumors. The classification guide for these tumors will be as follows:

Cancer Schedule

Within 8 years of recovery	**DEC**	**DEC**	**DEC**	**DEC**
During 9th and 10th years	**DEC**	**R**	**R**	**STD**
After 10 years (generally)	**STD**	**STD**	**STD**	**STD**

The following are malignancies not necessarily confined to one organ or structure. They may affect one or more organs or locations at the same time and some may be generalized.

Type of Malignancy * See Cancer Schedule

Carcinoid				
Appendix or other location	*	*	*	*
Syndrome	**DEC**	**DEC**	**DEC**	**DEC**
Choriocarcinoma				
Malignant hydatidiform mole	*	*	*	*
Fibrosarcoma	*	*	*	*
Giant Cell Sarcoma (except bone)	**DEC**	**DEC**	**DEC**	**DEC**
Hodgkin's Disease	**DEC**	**DEC**	**DEC**	**DEC**
Leiomyosarcoma	*	*	*	*
Leukemia	**DEC**	**DEC**	**DEC**	**DEC**
Lymphoma	**DEC**	**DEC**	**DEC**	**DEC**
Malignant Melanoma	*	*	*	*
Multiple Myeloma	**DEC**	**DEC**	**DEC**	**DEC**

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	HMO	Major Med.	Hosp/ Surg	BO RC
MALIGNANT TUMORS - continued				
Location of Malignancy	* See Cancer Schedule			
Adrenal	*	*	*	*
Bladder	*	*	*	*
Bone	*	*	*	*
Brain	**DEC**	**DEC**	**DEC**	**DEC**
Breast				
Present or within 2 years of last treatment	**DEC**	**DEC**	**DEC**	**DEC**
After 2 years and full recovery, with evaluation within 2 years of application	**IC**	**IC**	**IC**	**IC**
Cervix	*	*	*	*
Cervix-Carcinoma-in-situ of cervix				
Hysterectomy performed after recovery				
Within 3 years	**DEC**	**R**	**R**	**R**
Conization performed, or cured by radiation				
Within 2 years	**DEC**	**DEC**	**DEC**	**DEC**
During 3rd -5th years	**DEC**	**R**	**R**	**STD**
After 5 years	**STD**	**STD**	**STD**	**STD**
Esophagus	*	*	*	*
Eye	*	*	*	*
Gallbladder	*	*	*	*
Intestine	*	*	*	*
Kidney	*	*	*	*
Larynx	*	*	*	*
Liver	*	*	*	*
Lung, bronchi	*	*	*	*
Lung removed is a permanent rejection for Insurance and HMO products				
Ovary	*	*	*	*
Pancreas	*	*	*	*
Parotid	*	*	*	*
Pharynx	*	*	*	*
Prostate	*	*	*	*
Skin				
Epithelioma, Basal Cell				
One or two occurrences				
Within 2 years	**DEC**	**R**	**R**	**R**
After 2 years	**STD**	**STD**	**STD**	**STD**
Three or more occurrences or recurrence at same site				
Within 10 years	**DEC**	**R**	**R**	**R**
Other types, including Squamous Cell Carcinoma	*	*	*	*
Stomach	*	*	*	*
Testicle	*	*	*	*
Thymus	*	*	*	*
Thyroid	*	*	*	*
Tongue	*	*	*	*
Uterus	*	*	*	*

	HMO	Major Med.	Hosp/ Surg	BO RC
TURNER'S SYNDROME				
Under age 18	**DEC**	**DEC**	**DEC**	**DEC**
Over age 18				
Mild, without renal, cardiac, gyn (young females on hormones) or GI tract abnormalities, with a negative ECHO of the heart	**IC**	**IC**	**IC**	**IC**
ULCERATIVE COLITIS (see COLITIS)				
ULCER: PEPTIC OR DUODENAL				
Treated with medication only				
Within 3 years of recovery	**DEC**	**R**	**STD**	**STD**
After 3 years	**STD**	**STD**	**STD**	**STD**
Operated				
Within 2 years of surgery or last symptoms	**DEC**	**DEC**	**R**	**R**
During 3rd through 5th years	**DEC**	**R**	**R**	**STD**
After 5 years	**STD**	**STD**	**STD**	**STD**
URETERAL OR URETHRAL STRICTURE				
Present, chronic/recurrent, or stent present	**DEC**	**R**	**R**	**R**
History, complete recovery				
Within 2 years	**DEC**	**R**	**R**	**R**
After 2 years	**STD**	**STD**	**STD**	**STD**
URETHROCELE (see CYSTOCELE)				
URETHERITIS OR URETHRITIS (Not Sexually Transmitted or Secondary to a Prostate Disorder)				
Acute, single attack, no complications	**STD**	**STD**	**STD**	**STD**
Chronic or repeated attacks, no complications				
Within 2 years of last attack	**DEC**	**R**	**STD**	**STD**
After 2 years, complete recovery	**IC**	**IC**	**STD**	**STD**
URINARY TRACT INFECTIONS				
Bladder (see CYSTITIS)				
Kidney (see NEPHRITIS)				
Kidney Pelvis (see PYELITIS)				
UTERINE PROLAPSE (see CYSTOCELE)				
VAGINITIS				
Present or history, acute attacks	**STD**	**STD**	**STD**	**STD**
Chronic or recurrent attacks	**DEC**	**R**	**STD**	**STD**

	HMO	Major Med.	Hosp/ Surg	BO RC
VARICOCELE				
Present, no treatment	**DEC**	**R**	**R**	**R**
Cured by injection, ligation, or excision				
Upon recovery	**STD**	**STD**	**STD**	**STD**
VARICOSE VEINS				
Present, minor	**STD**	**STD**	**STD**	**STD**
Operated or Cured within 1 year of recovery or more than minor	**DEC**	**R**	**R**	**R**

VERTIGO (see SYNCOPE)

WARTS – Venereal or Rectal (see SEXUALLY TRANSMITTED DISEASES)

WEIGHT (See HEIGHT AND WEIGHT TABLE at the end of this section.)

WOLFF PARKINSON WHITE PHENOMENON (ELECTROCARDIOGRAM CHANGE)				
Present	**DEC**	**DEC**	**DEC**	**DEC**
Cured by radiofrequency ablation				
Within 1 year	**DEC**	**DEC**	**DEC**	**DEC**
After 1 year, with negative EKG completed one year after ablation, No remaining symptoms	**STD**	**STD**	**STD**	**STD**

LIST OF UNACCEPTABLE MEDICATIONS

The conditions for which the following list of drugs are normally prescribed presents an uninsurable risk. This is not an all inclusive list due to consistently changing pharmacotherapy.

An application should not be completed on any person currently taking any of the following medications or its generic equivalent.

- ACCUTANE
- ARICEPT
- COREG
- COUMADIN / WARFARIN
- DIABETA / GLYBURIDE
- ENBREL
- GLUCOTROL
- GLUCOPHAGE / METFORMIN
- GLYBURIDE / DIABETA / MICRONASE
- HUMIRA
- INTERFERON
- LITHIUM
- METFORMIN / GLUCOPHAGE
- METHOTREXATE
- MICRONASE / GLYBURIDE
- NITROSTAT / NITROGLYCERIN
- PACERONE
- PLAVIX
- RIBRAVIRIN
- RISPERDAL
- SEROQUEL
- SORATANE
- WARFARIN / COUMADIN
- ZYPREXA

HEIGHT AND WEIGHT

One of the most basic items in evaluating an individual's insurability is to determine if the weight bears a satisfactory relationship to the height. Disproportion between height and weight can result in a possible extra insurance hazard.

1. While one's build alone would generally not be a basis for payment of health benefits, being overweight can be a significant underwriting consideration.

    - It increases the likelihood of developing degenerative cardiovascular-renal diseases, and
    - increases difficulty in surgery, and
    - delays recovery of injuries to weight bearing bones, and thus complicates or prolongs a sickness or injury.
    - It may also be an indication of other health problems.

2. Pronounced underweight may also be of significance. Abnormally thin people may be unable to gain weight due to:

    - nervous problems
    - chronic illnesses
    - lack of proper nutrition; possibly due to excessive alcohol or drug use

Thin people frequently have poor resistance to respiratory infections and other acute illnesses.

This section is continued on the following page

HEIGHT AND WEIGHT – continued

This section is continued from the previous page.

Changes in weight of more than ten pounds can be of underwriting significance. Complete details regarding weight changes within the 12-month period prior to application date is needed and should be provided on the application. Be sure to include:

A. The reason(s) for the changes in weight, and

B. the period of time these changes occurred, and

C. whether the weight is now stabilized or still changing (e.g. dieting, childbirth).

D. If stabilized, indicate how long the present weight has been maintained.

E. Also, include the name and address of any physician who may have been consulted in connection with such change in weight.

*Any history of surgery for weight loss within the past 5 years will result in rejection of the applican*t. For history of over 5 years ago individual consideration will be given.

In using the Height and Weight Tables, use of accurate height and weight figures of the applicant and family members are essential.

1. **An applicant is not eligible for coverage if their height and weight exceeds the maximum limit on the Height and Weight Table.**

2. An applicant may be rated 25%, 50%, 75%, or 100% for their build.

3. If the height and weight appear reasonable as given by the applicant, record the figures as given.

This section is continued on the following page.

HEIGHT AND WEIGHT – continued

This section is continued from the previous page.

5. If the figures given do not appear to be reasonable as stated by the applicant, the agent should send a separate note along with the application indicating their impression as to any mis-statement.

6. An application should not be taken on persons whose weight is less than that referenced on the Height and Weight table.

7. ***Any significant misstatement of an applicant's build requiring a different underwriting action than quoted may result in rejection of the entire application.***

8. Fractions of less than one-half inch in height should be dropped when using the Height and Weight Tables. Fractions of one-half or larger should be raised to the next higher inch.

A combination of overweight, with other health conditions such as high blood pressure and other cardiovascular risks are of increased underwriting significance and could result in a higher rating or rejection.

This section is continued on the following page

HEIGHT AND WEIGHT – continued

This section is continued from the previous page

HEIGHT AND WEIGHT TABLE:

Ages 15 and over

MALE			FEMALE		
Height Ft. In.	**Standard Weight Min - Max**	**Decline**	**Height Ft. In.**	**Standard Weight Min - Max**	**Decline**
4'10"	86-157	177+	4'10"	86-150	172+
11"	89-162	183+	11"	88-155	178+
5'0"	92-167	189+	5'0"	90-160	182+
1"	95-173	195+	1"	93-165	189+
2"	97-179	202+	2"	97-171	195+
3"	100-185	208+	3"	100-177	200+
4"	102-191	215+	4"	102-182	209+
5"	106-197	222+	5"	106-188	214+
6"	110-203	229+	6"	110-194	220+
7"	113-210	236+	7"	113-200	229+
8"	116-215	243+	8"	116-204	233+
9"	119-222	250+	9"	119-210	238+
10"	123-228	257+	10"	123-215	243+
11"	127-235	265+	11"	127-224	256+
6'0"	130-241	272+	6'0"	130-231	264+
1"	134-249	280+	1"	134-238	270+
2"	138-255	287+	2"	139-244	278+
3"	141-263	295+	3"	143-251	285+
4"	145-270	304+	4"	147-258	294+
5"	150-276	311+			
6"	154-283	319+			
7"	159-291	327+			
8"	162-298	335+			
9"	167-306	344+			
10"	171-313	352+			
11"	175-321	361+			

Weights between the maximum standard weight and decline weight are subject to a Substandard Risk Rating which is to be determined by the Individual Medical Underwriting Department.

Revised May 2006

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ORDER OF FORMS

NOTE: The forms provided in this manual are specimens and are provided for reference only. The actual forms are available for order from the BCBSF Material Management Department.

BlueCross BlueShield of Florida
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ADDENDUM TO THE MEDICAL HISTORY

Applicant: _____ SS# _____

Name and Question Number	Illness	Date and Duration	Full Name of Doctor/Hospital and Address

Signatures:

X _____
Signature of Applicant

X _____
Signature of Spouse (if proposed for coverage)

X _____
Signature of Agent

X _____
Date

BlueCross BlueShield of Florida

An Independent Licensee of the Blue Cross and Blue Shield Association

ADDENDUM TO PRESCRIPTION DRUGS

Applicant: _____ SS# _____

Name and Question Number	Name of Drug and Strength	Daily Dosage	Reason Drug Prescribed	Name and Address of Prescribing Doctor

Signatures:

X _____

Signature of Applicant

X _____

Signature of Spouse (if proposed for coverage)

X _____

Signature of Agent

X _____

Date

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

CHILD-ONLY QUESTIONNAIRE

I. Child's Name: _____ SS#: _____
(Applicant)

II. Interview Questions (to be asked of parent/legal guardian with whom the child resides):

A. Does the child reside in Florida?_____

B. Advise why the child's parents are not enrolling for this health care coverage.

Father: _____

Mother: _____

C. If parent is covered under another health plan, provide details below:

Father: _____Employer:_____Work#:_____

Carrier Name: _____Contract#:_____

Mother: _____Employer:_____Work#:_____

Carrier Name: _____Contract#:_____

Why is child not enrolling in parent's health plan?_____

D. List all dependent children (of this family) not applying for separate health care coverage. Indicate whether they are covered under Group or Individual policies:

Name of Child Insured Yes/No Group or Individual Carrier & Contract/Policy#

_____

_____

E. List the names of all other dependent children (of this family) applying for separate health care coverage on separate applications.

_____

III. **Signatures:**

_____ _____

Parent/Legal Guardian of Applicant Agent

_____

Date

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

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 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's (if applicable) employer. Further, 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.

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

Applicant's Social Security Number _____

Spouse'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 employer on my or my spouse'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.

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

Applicant's Social Security Number _____

Spouse's Signature (*if applicable*) _____ Date _____

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

Agency Number _____

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.

_____ Group Policy #_____ and/or

Company Name

_____ Individual Policy # _____

Street Address

_____ Is this COBRA? ☐Yes ☐No

City, State, Zip

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

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.
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.

The above "Notice to Applicant" was delivered to me on **X**_____

Date

Witness _____ **X** _____

Writing Agent Applicant's Signature

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 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. 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

PHYSICAL AND CHECK-UP QUESTIONNAIRE

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

Applicant Name: _____ SS#: _____
Spouse's Name: _____

A. Date of Physical Exam:
Applicant: _____

Spouse: _____

Physician Name/Address:
_____
_____

_____
_____

B. What was the reason or symptoms prompting this exam?
Applicant: _____
Spouse: _____

C. What tests were done?
Applicant: _____
Spouse: _____

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

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

F. What medication(s) and / or treatment was prescribed?
Applicant: _____
Spouse: _____

Signatures:

Applicant: _____ Spouse: _____

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
Health Options®

Independent Licensees of the
Blue Cross and Blue Shield Association

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.

_____ _____

(applicant's signature) *(date)*

_____ _____

(spouse's signature if also seeking coverage) *(date)*

_____ _____

(sales agent's signature) *(date)*

BlueCare

For Individuals Under 65
Answers to Frequently Asked Questions

BlueCross BlueShield of Florida
Health Options®

Now that I've completed the application, how does Health Options determine whether my family and I qualify for membership?

Part of what enables us to offer BlueCare for Individuals Under 65 is a comprehensive medical underwriting process of all applicants. Based on your information, you may be required to undergo a paramedical examination and laboratory screening. The results of this exam, along with information contained in your application or in requested Attending Physician Statements, help us determine if you and your family become members.

If a paramedical examination is required, when will I be notified of my appointment?

After we review your application, a determination will be made regarding the necessity of a paramedical exam. If an exam is required, we'll notify your agent and our contracted paramedical services vendor. A representative from our paramedical services vendor will contact you to schedule an appointment for the exam at your earliest convenience.

How soon will I know if I qualify for coverage?

Under most circumstances, you'll be notified of our decision within three weeks after we receive the results of the paramedical exam (if required) and any Attending Physician Statements that may be requested.

What will be the effective date of my membership?

Membership in BlueCare for Individuals Under 65 begins either on the 1st or the 15th of the month. If accepted for BlueCare membership, your effective date will be the first date (1st or 15th) following a state-required seven-day confirmation period.

A confirmation letter stating the effective date of your membership will be mailed to you on the day your application is approved. The confirmation letter will also provide key information on the role of your Primary Care Physician, pre-existing condition requirements and service area requirements.

An example of when coverage begins:

- Your membership is approved on April 2.
- Adding the seven-day confirmation period to April 2 brings us to April 9.
- The next available effective date of coverage is the 15th, so your effective date of membership will be April 15.

What is an exclusion rider?

If you or a family member has a condition that disqualifies you or a family member from coverage under BlueCare, we issue an exclusion rider to exclude the non-eligible member from coverage. You decide whether to accept membership with the exclusion rider or to decline membership. If the primary subscriber does not appropriately sign and date the exclusionary rider form and return it to us within 10 days from receipt, the BlueCare coverage will be considered null and void and all premiums collected will be refunded. If an excluded family member qualifies for one of our other Individual plans, we'll notify your agent. Any premiums owed will be returned to you after your decision.

What is a Rate Modification Endorsement?

There are health conditions which require us to offer coverage with an increase in premium in addition to the base rate quoted. This allows us to offer health coverage to individuals who would otherwise be disqualified. If we offer coverage to you or your family member with an increase in the base rate, your membership agreement will be issued with the Rate Modification Endorsement and the increase in premiums will be reflected in your billing notices. You will also receive a letter explaining our decision.

What happens if Health Options determines that membership cannot be issued?

If we determine that you do not qualify for coverage, whether you applied individually or as a family, you will receive a letter explaining our decision. All premiums submitted with your application will be refunded.

What if I have questions about your decision?

Our decisions are based on guidelines consistent with those used by other health insurers and HMOs. Any paramedical exam results or information provided in an Attending Physician's Statement are used for the exclusive purpose of our underwriting review. A clinical evaluation and an insurance evaluation often differ. The paramedical exam is not a clinical evaluation.

Decisions about BlueCare membership are made objectively and consistently to be fair to all applicants. If you have questions about our decision, you may contact your agent to discuss the matter. We recommend that rejected applicants obtain a physical examination from their private physician at their own expense to identify and gain medical advice on any underlying medical condition(s).

What if I change my mind about the Primary Care Physician I selected after my application is submitted?

You may request a change of your Primary Care Physician at any time. If you want to make a change while your application is being processed, please contact your agent.

I currently have other health care coverage that I plan to replace with BlueCare. When should I terminate my current coverage?

Your current coverage should be continued until you have been advised of and have accepted the decision on your BlueCare application.

Once I have been accepted for membership in BlueCare, how long before I receive my Agreement and identification cards?

If you applied for coverage through a Telemarketing Sales Representative, your Individual Health Services Agreement and identification cards will be mailed to the address indicated on your application form approximately seven days after your membership is approved. If you applied for coverage through one of our contracted general agencies, your Individual Health Services Agreement and identification cards will be sent to your agent, who will deliver them to you.

BlueCare

Questions and Answers

We're pleased you've selected BlueCare for Individuals Under 65.

After looking through the BlueCare information, you may have some questions about our application acceptance process. If so, we encourage you to read these frequently asked questions and answers.

We want to make sure you understand all aspects of the BlueCare application and medical underwriting process. If you have other questions, please don't hesitate to contact your agent.

Again, thank you for your interest in BlueCare. We look forward to being part of your health care coverage solution.

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.

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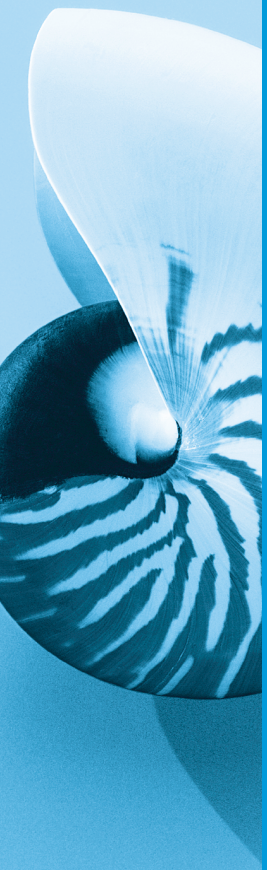

Answers to Frequently Asked Questions

For Individuals Under 65

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

Now that I've completed the application, how does Blue Cross and Blue Shield of Florida determine whether my family and I qualify for membership?

Part of what enables us to offer our Individual Under 65 products is a comprehensive medical underwriting process of all applicants. Based on your information, you may be required to undergo a Paramedical Examination and laboratory screening. The results of this exam, along with information contained in your application and in requested Attending Physician Statements, helps us determine if coverage can be offered to you and your family.

If a Paramedical Examination is required, when will I be notified of my appointment?

After we review your application, a determination will be made regarding the necessity of a Paramedical Exam. If an exam is required, we'll notify your agent and our contracted paramedical services vendor. A representative from our paramedical services vendor will contact you to schedule an appointment for the exam at your earliest convenience.

How soon will I know if I qualify for coverage?

Under most circumstances, you'll be notified of our underwriting decision within three weeks after we receive the results of the Paramedical Exam (if required) and any Attending Physician Statements that may be requested.

Do I have to pay to have copies of my medical records sent to Blue Cross and Blue Shield of Florida?

In most cases, no. We will pay any reasonable fees for your records. However, some physicians may charge a high fee for providing medical records. Should this occur, we will work with you, through your agent, to discuss alternative solutions.

What is a Rate Modification Endorsement?

There are health conditions which require us to offer coverage with an increase in premium in addition to the quoted base rate. This allows us to offer health coverage to individuals who would otherwise be disqualified. If we offer coverage to you or your family members with an increase in the base rate, your contract will be issued with the Rate Modification Endorsement and the increase in premiums will be reflected in your billing notices. You will also receive a letter explaining our decision.

What is a Medical Exclusionary Rider?

Our insurance products are marketed with the objective of providing broad health care coverage to as many applicants as possible. However, in some instances, an applicant's health history requires that we exclude coverage for health care services provided to treat or care for a particular body part or condition. This allows us to provide coverage for most of your health care needs rather than declining you for coverage. When this action is necessary, the contract is endorsed with the Medical Exclusionary Rider form which specifies the body part or condition that is excluded from benefits. The Medical Exclusionary Rider form is also used at times when a person on an application for family coverage is not insurable under our medical underwriting guidelines. In these instances, the individual is declined but coverage is offered to the remaining family members who applied. The contract is endorsed with the Medical Exclusionary Rider form which indicates the name of the person who is excluded from benefits.

In both instances, the Medical Exclusionary Rider form requires the signature of the primary contract holder which indicates acceptance of our offer of coverage. Failure to sign and return the rider form will result in our offer of coverage becoming null and void and any premiums submitted will be refunded accordingly.

Are ratings and riders permanent?

Yes, the medical ratings and riders imposed on a contract are considered permanent for as long as you keep the contract in force. We may (but are not required to) consider removal of the rating or rider on an individual basis after two years from the coverage effective date provided the condition rated or ridered is not permanent and it no longer exists and there have been no symptoms or treatment for the condition within the previous 24 months, nor does the condition require periodic medical treatment or evaluation. In order for this action to be evaluated, a written request must be submitted along with current medical documentation from the physician familiar with the member's health status, including the condition that is rated or ridered. This documentation must include the physician's office notes and results of any laboratory or other testing performed within the previous 24 months. This documentation must be furnished at the expense of the contract holder.

What happens if Blue Cross and Blue Shield of Florida determines that coverage cannot be issued?

If we determine that you do not qualify for coverage, whether you applied individually or as a family, you will receive a letter explaining our underwriting decision. All premiums submitted with your application will be refunded accordingly.

What if I have questions about your decision?

Our underwriting decisions are based on guidelines consistent with those used by other health insurers. Any Paramedical Examination or information provided in an Attending Physician's Statement is used for exclusive purposes of our underwriting review. A clinical evaluation and an insurance evaluation often differ. The Paramedical Examination is not a clinical evaluation.

continued on back

Our decisions about coverage are made objectively and consistently to be fair to all applicants. If you have questions about our decision, you may contact your agent to discuss the matter. We recommend that applicants declined for coverage obtain a physical examination from their private physician, at their own expense, to identify and gain medical advice on any underlying medical condition(s).

I currently have other health care coverage that I plan to replace with the Blue Cross and Blue Shield of Florida policy. When should I terminate this coverage?

Your current policy should be continued until you have been advised of and accepted our decision on your application. We will make every reasonable effort to coordinate the effective date of the Blue Cross and Blue Shield policy with the termination date of your current coverage. For this reason, it is important that you keep your agent informed if an additional premium is paid on your other policy while your application for our coverage is in the underwriting process.

Once I have been accepted for coverage with Blue Cross and Blue Shield of Florida, how long before I receive my Individual Under 65 contract and identification cards?

If you applied for coverage with a Telemarketing Sales Representative, your contract and identification cards will be mailed to the address provided on your application form approximately seven days after your application for coverage is approved. If you applied for coverage with one of our contracted general agencies, your contract and identification cards will be sent to your agent, who will deliver them to you. We recommend that you review your contract carefully and contact your agent if you have further questions.

Questions and Answers

We're pleased you've selected a Blue Cross and Blue Shield of Florida Individual Under 65 insurance product.

After looking through the product information supplied to you by your agent, you may have some questions about our application acceptance process. If so, we encourage you to read these frequently asked questions and answers.

We want to make sure that you understand all aspects of the application and medical underwriting process. If you have other questions, please don't hesitate to contact your agent.

Again, thank you for your interest in Blue Cross and Blue Shield of Florida. We look forward to being a part of your health care coverage solution.

Medical Underwriting Frequently Asked Questions (FAQ)

Insurance and HMO

Q. My client is replacing coverage with another insurance carrier. How far in advance can I request as the effective date of coverage?

A. An advance effective date of up to 90 days from the application signing date is allowed.

Q. How much premium should I collect with an application?

A. Two month's premium is required, with one exception. If the applicant requests the Automatic Payment Option (APO) and completes a Cash Receipt, then only one monthly premium is required.

Q. My client wants to purchase child only coverage for his children. Can one application be completed to enroll the children?

A. No. A separate application must be completed for each child.

Q. My client wants to purchase health insurance coverage for his children, who live with their mother in another part of the state. How do I do this?

A. Separate child only applications must be completed. You should contact the mother to complete the medical history portion of the application since the children live with her. The home address should be that of the children with the billing address that of the father. The father should sign the application.

Insurance Only

Q. When can riders and ratings be removed from a contract?

A. Riders and ratings are permanent. An applicant may request a rider/rating be removed from a contract only after it has been in force for at least two years. See pages 62 and 63 of the Field Underwriting Guidelines for additional requirements.

Q. Who signs the Medical Exclusionary Rider?

A. The approved contractholder.