



An independent licensee of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

Application and/or Waiver of Coverage for Group Benefit Plans

BLUE CROSS AND BLUE SHIELD OF MONTANA (BCBSMT)
PO BOX 4309
HELENA MT 59604

Important Notices

Please Read Prior to Completing this Application

Special Enrollment Rights: If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage, you may in the future be eligible to enroll yourself and/or your dependents in this plan, provided you request enrollment within 31 days after your other coverage ends due to loss of eligibility or the employer ceases contribution toward that coverage. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be eligible to enroll yourself and/or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Preexisting Condition Exclusion Period: The plan in which you are enrolling may have a preexisting condition exclusion period before preexisting conditions are covered. The preexisting condition exclusion period does not apply to members under 19 years of age. Your employer will give you a notice of any preexisting condition exclusion period when you receive this application. **Please do not sign this application until your employer provides you with a notice of the preexisting condition exclusion period.**

Applicant/Subscriber Name:

APPLICATION AND/OR WAIVER OF COVERAGE FOR GROUP BENEFIT PLANS
PLEASE PRINT IN BLACK INK

| | | | | |
|----------------|---|--------------------------|--|--|
| Purpose | <input type="checkbox"/> New Enrollment <input type="checkbox"/> Add Family Member <input type="checkbox"/> Transfer (Current ID Number) <input type="checkbox"/> Waive Coverage | Plan Applying For | | IMPORTANT ALL FAMILY MEMBERS MUST BE LISTED. Generally, this is your spouse and legally dependent children or stepchildren as defined in your group's contract. Application is required to add a family member as a result of birth, marriage, adoption, or placement for adoption. |
| | <input type="checkbox"/> Traditional <input type="checkbox"/> PPO <input type="checkbox"/> Other | | <input type="checkbox"/> Managed Care <input type="checkbox"/> Big Sky Select <input type="checkbox"/> Blue Select | |

Warning! Waiver of coverage may result in you and/or your dependents being treated as a "late enrollee." Future enrollment may be limited to special enrollment and open enrollment time periods, should they occur. Additionally, you and/or your dependents 19 years of age or older may be subject to a preexisting condition exclusion period.

| | | | | | | | | | |
|-----------------------------|--|----------------|------------------|-------------------|-----------|---|--|--|----------------|
| Applicant/Subscriber | ENROLLING | WAIVING | Last Name | First Name | MI | Social Security Number (SSN) <small>Your SSN may be included in your Subscriber Identification Number.</small> | Date of Birth <small>(mo day yr)</small> | Male/ Female | |
| | | | | | | | | | |
| | Applicant/Subscriber Mailing Address | | | | | City | State | ZIP Code | Home Telephone |
| | Email Address | | | | | | | | |
| | Personal Care Physician (PCP) Name and City <small>(required only for Managed Care Plans)</small> | | | | | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married* <small>*Complete spouse's information below.</small> | | Date of Marriage <small>(mo day yr)</small> | |

| | | | | | | | | | |
|--------------------------------|------------------|----------------|--|-------------------|-----------|--------------------|--|--|--|
| Spouse and Dependent(s) | ENROLLING | WAIVING | All family members must be listed. Indicate for each family member whether enrolling or waiving coverage. | | | Male/Female | | | |
| | | | Last Name | First Name | MI | | | | |
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|---|---|--|
| Waiving Coverage | Is the Applicant/Subscriber covered under another health plan or agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | If yes, is the Applicant/Subscriber covered under another health plan or agreement as a dependent spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | If waiving coverage, is it due to coverage under a group health plan or agreement as a dependent spouse/child? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| By my signature, I AM WAIVING COVERAGE FOR MYSELF AND ALL FAMILY MEMBERS. (If not waiving coverage, complete the application.) Applicant/Subscriber, sign here <u>only</u> if Waiver of Coverage is for <u>all</u> family members: _____ Date: (mo day yr) _____ | | |
| If you have signed above to waive coverage for yourself and all family members, it is not necessary to complete the rest of this form; however, your employer must complete the employer section on page 4 prior to submitting the form to BCBSMT. | | |

| | | | | | |
|-------------------------------|----------------------|----------------|-------|---|--------------------|
| BCBSMT OFFICE USE ONLY | Group Number | | | Small Group <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> New Employee <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Late Enrollee <input type="checkbox"/> New Group | BCBSMT Date Stamps |
| | CT | Package | Dept. | | |
| | Probationary Period | Effective Date | | | |
| | Underwriter Initials | | | | |
| BC: _____ Mailed: _____ | | | | | |

Applicant/Subscriber Name:

This section must be completed for all Applicants/Subscribers.

| Other Coverage Information | <p>Creditable Coverage:</p> <ul style="list-style-type: none"> ◆ Including, but not limited to Medicare, Medicaid, employer-based insurance, or health insurance coverage. ◆ Does not include limited benefit plans such as a cancer policy, a hospital indemnity plan, or a life insurance policy. <p>Creditable Coverage: If you or your dependents, 19 years of age and older, had health coverage within the last 63 days or within 63 days of the date on which a certificate of creditable coverage was issued (not including days required to satisfy the employer's probationary waiting period before the member is eligible to apply), the preexisting condition exclusion period will be reduced by the combination of the periods of Creditable Coverage that the member had as of the enrollment date of this plan. In addition, please attach verification of Creditable Coverage to this form OR complete the following information for you and your dependents. The previous health insurance carrier must provide a certificate of Creditable Coverage with the end date of that coverage. BCBSMT will assist you or your dependents, if necessary, in obtaining this certificate or the necessary information from previous health insurance carriers.</p> <p>Have you or your dependents had health coverage within the last 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach verification of Creditable Coverage to this form OR complete the following information for you and your dependents.</p> <p>Loss of Eligibility for Other Coverage: If you are enrolling because you lost eligibility for other health coverage or the employer ceased the employer's contribution toward that coverage, please indicate below for each person applying due to a loss of eligibility. Application for enrollment based on loss of eligibility must be received by BCBSMT within 31 days of the date the eligibility for the other health coverage ends.</p> <p>Please fill out the following to verify Creditable Coverage or loss of eligibility if applicable.</p> <p style="text-align: center;">Warning: Omissions or incomplete answers may cause delay</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|---|--|--|--|--|-----------------------|--------------------|----------------|--|----------------|----------------|-------------------------|-----------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| | Name of Person Covered (include last name if different from Applicant/Subscriber) | Self: ID #*: | Spouse: ID #*: | Dependent: ID #*: | Dependent: ID #*: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Loss of Eligibility | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Full Name of Insurance Company or Carrier | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Check Type of Coverage | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | <input type="checkbox"/> Medical <input type="checkbox"/> Dental | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | (mo day yr) | (mo day yr) | (mo day yr) | (mo day yr) | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Date of Enrollment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Date of Cancellation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Will this coverage be continued? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | *ID # is your identification number under previous or current insurance company or carrier. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>This section is required for employees enrolling themselves and/or their dependents on a small employer[†] group plan.</p> <p>[†]Ask your employer whether you need to complete the Medical History section.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Please do not provide any information regarding any genetic tests you or any family member have had, the results of such tests, or any family medical history (other than medical history requested in this application) that may indicate genetic predisposition to any disease or disorder.</p> <p>If additional space is needed to provide complete information, use a separate sheet of paper, signed and dated.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical History | <p>A. List current height and weight for all persons to be covered age 6 months and older.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Name of Person</th> <th style="width: 10%;">Current Height</th> <th style="width: 10%;">Current Weight</th> <th style="width: 25%;">Name of Person</th> <th style="width: 10%;">Current Height</th> <th style="width: 10%;">Current Weight</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table> | | | | | Name of Person | Current Height | Current Weight | Name of Person | Current Height | Current Weight | | | | | | | | | | | | | | | | | | | | |
| | Name of Person | Current Height | Current Weight | Name of Person | Current Height | Current Weight | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | <p>B. Within the last three (3) years, have medications (except antibiotics) been prescribed for, been provided for (e.g., samples, injections), and/or been taken by any person to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain below.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2" style="width: 20%;">Name of Person</th> <th rowspan="2" style="width: 20%;">Name of Medication</th> <th rowspan="2" style="width: 15%;">Daily Dosage</th> <th rowspan="2" style="width: 20%;">Condition for Which Medication Was Prescribed or Taken</th> <th colspan="2" style="width: 25%;">Dates</th> </tr> <tr> <th style="width: 10%;">From (mo day yr)</th> <th style="width: 15%;">To (mo day yr)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td style="text-align: center;"> </td><td style="text-align: center;"> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td style="text-align: center;"> </td><td style="text-align: center;"> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td style="text-align: center;"> </td><td style="text-align: center;"> </td></tr> </tbody> </table> | | | | | Name of Person | Name of Medication | Daily Dosage | Condition for Which Medication Was Prescribed or Taken | Dates | | From (mo day yr) | To (mo day yr) | | | | | | | | | | | | | | | | | | |
| | Name of Person | Name of Medication | Daily Dosage | Condition for Which Medication Was Prescribed or Taken | Dates | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | From (mo day yr) | To (mo day yr) | | | | | | | | | | | | | | | | | | | | | | | | | |
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Applicant/Subscriber Name:

If additional space is needed to provide complete information, use a separate sheet of paper or the additional page at the back of this application. Please sign and date the additional information.

Have you or anyone on this application been diagnosed or treated for any condition related to the following conditions.

Note: All of the information you provide is for quoting and enrollment purposes only and will be kept confidential.

Medical History

| | | |
|---|--|--|
| 1. Nervous System <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| <input type="checkbox"/> Multiple sclerosis, <input type="checkbox"/> Parkinson disease <input type="checkbox"/> ALS/Lou Gehrig's disease | <input type="checkbox"/> Alzheimer's disease , <input type="checkbox"/> Seizure disorder/Epilepsy <input type="checkbox"/> Peripheral neuropathy/other neuropaths | <input type="checkbox"/> Other nervous system/neurological disorder |
| 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area. |
| 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? |
| 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? |
| 8. Have you been hospitalized or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you received physical, speech, occupational therapy, and/or counseling for this condition? |
| 10. What was the last date of treatment or the last physician visit for this condition? | | |
| 1. Name of Person | | |
| 2. Date of Diagnosis | | 3. Description of condition to include affected area. |
| 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? |
| 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? |
| 8. Have you been hospitalized or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you received physical, speech, occupational therapy, and/or counseling for this condition? |
| 10. What was the last date of treatment or the last physician visit for this condition? | | |
| 2. Digestive System <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| <input type="checkbox"/> Gastric bypass (Only answer 1,10 and 11) <input type="checkbox"/> Reflux <input type="checkbox"/> Stomach disorders <input type="checkbox"/> Celiac sprue | <input type="checkbox"/> Crohn's disorder <input type="checkbox"/> Colon/Intestine disorder <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Other digestive system disorder |
| 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area. |
| 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? |
| 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? |
| 8. Have you been hospitalized or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you received physical, speech, occupational therapy, and/or counseling for this condition? |
| 10. What was the last date of treatment or the last physician visit for this condition? | | |
| 11. Gastric Bypass – When was the gastric bypass procedure performed? | | |
| 12. Crohn's Disorder – What part of the digestive tract is the disease affecting? | | |
| 1. Name of Person | | |
| 2. Date of Diagnosis | | 3. Description of condition to include affected area. |
| 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? |
| 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? |
| 8. Have you been hospitalized or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you received physical, speech, occupational therapy, and/or counseling for this condition? |
| 10. What was the last date of treatment or the last physician visit for this condition? | | |
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| 12. Crohn's Disorder – What part of the digestive tract is the disease affecting? | | |

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| Medical History | 3. Respiratory System <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | <input type="checkbox"/> Asthma <input type="checkbox"/> Sleep apnea | | <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> COPD <input type="checkbox"/> Other lung/respiratory system condition |
| | 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area. |
| | 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? |
| | 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking,, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? |
| | 8. Have you been hospitalized or been to the emergency room for treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you had surgery for sleep apnea? |
| | 10. Have you received medical equipment for this condition? (oxygen, CPAP, nebulizer) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. If you have sleep apnea, do you use a CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 12. What was the last date of treatment or the last physician visit for this condition? | | |
| | 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area. |
| | 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? |
| 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking,, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? | |
| 8. Have you been hospitalized or been to the emergency room for treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you had surgery for sleep apnea? | |
| 10. Have you received medical equipment for this condition? (Oxygen, CPAP, nebulizer) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. If you have sleep apnea, do you use a CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 12. What was the last date of treatment or the last physician visit for this condition? | | | |
| 4. Circulatory System <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| <input type="checkbox"/> Heart murmur/valve disorder (mitral, tricuspid, etc.) <input type="checkbox"/> Heart palpitations/tachycardia/atrial fibrillation <input type="checkbox"/> High blood pressure/hypertension <input type="checkbox"/> Angina | | <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Aneurysm <input type="checkbox"/> Heart conduction disorder/pacemaker/defibrillator | <input type="checkbox"/> Heart attack/myocardial infarction <input type="checkbox"/> Vein disorder <input type="checkbox"/> Artery disorder <input type="checkbox"/> Other circulatory system condition |
| 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area. | |
| 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| 6. Have you been hospitalized, had surgery or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What was the treatment for the condition? | |
| 8. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you received medical equipment for this condition? (oxygen, CPAP, nebulizer)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10. What was the last date of treatment or the last physician visit for this condition? | | | |
| 11. Congestive Heart Failure – Do you have chronic swelling in lower extremities? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 12. Stroke/TIA – Do you have any ongoing issues? | | | |
| 13. Aneurysm – Where was the aneurysm located? | | | |
| 14. Heart Attack/Myocardial Infarction – Please explain condition. | | | |
| 15. High Blood Pressure/Hypertension – Please answer the following questions. | | | |
| a. What are the most recent 3 readings, at least a month apart? | Blood pressure readings | b. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| c. Are you diabetic/hypoglycemic? | <input type="checkbox"/> Yes <input type="checkbox"/> No | c. What was the treatment for this condition? | |

Applicant/Subscriber Name: _____

| | | | | | | |
|--|--|---|--|---|---|--|
| Medical History | 1. Name of Person | | 2. Date of Diagnosis | | 3. Description of condition to include affected area. | |
| | 4. Are you taking medication for this condition? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| | 6. Have you been hospitalized, had surgery or been to the emergency room for treatment? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 7. What was the treatment for the condition? | |
| | 8. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 9. Have you received medical equipment for this condition? (oxygen, CPAP, nebulizer)? | |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | 10. What was the last date of treatment or the last physician visit for this condition? | | | | | |
| | 11. Congestive Heart Failure – Do you have chronic swelling in lower extremities? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | 12. Stroke/TIA – Do you have any ongoing issues? | | | | | |
| | 13. Aneurysm – Where was the aneurysm located? | | | | | |
| | 14. Heart Attack/Myocardial Infarction – Please explain condition. | | | | | |
| | 15. High Blood Pressure/Hypertension – Please answer the following questions. | | | | | |
| | a. What are the most recent 3 readings, at least a month apart? | | Blood pressure readings | | b. Are you pregnant? | |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | c. Are you diabetic/hypoglycemic? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | c. What was the treatment for this condition? | |
| | | | | | | |
| | 5. Genetic, Endocrine, Metabolic, Nutritional Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| | <input type="checkbox"/> Diabetes 16, 17, 18 | | <input type="checkbox"/> Pituitary disorders/dwarfism | | <input type="checkbox"/> High cholesterol | |
| | <input type="checkbox"/> Metabolic/PCOS | | <input type="checkbox"/> Adrenal disorders | | <input type="checkbox"/> Other endocrine disorder not listed | |
| | <input type="checkbox"/> Thyroid disorders | | <input type="checkbox"/> Genetic/chromosomal conditions | | | |
| | 1. Name of Person | | 2. Date of Diagnosis | | 3. Description of condition to include affected area. | |
| 4. Are you taking medication for this condition? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | | |
| 6. Have you been hospitalized, had surgery or been to the emergency room for treatment? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 7. What was the treatment for the condition? | | |
| 8. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 9. Have you received medical equipment for this condition? (oxygen, CPAP, nebulizer)? | | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10. What was the equipment for this condition? | | | | | | |
| 11. What was the last date of treatment or the last physician visit for this condition? | | | | | | |
| 12. Diabetes – Please answer the following questions. | | | | | | |
| a. Type of diabetes | | <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Gestational | | b. Are you pregnant? | | |
| | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| c. Do you have high blood pressure/hypertension? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | | | | | | |

Applicant/Subscriber Name: _____

| | | | | | | |
|---|---|--|---|--|--|--|
| Medical History | 1. Name of Person | | 2. Date of Diagnosis | | 3. Description of condition to include affected area. | |
| | 4. Are you taking medication for this condition? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| | 6. Have you been hospitalized, had surgery or been to the emergency room for treatment? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 7. What was the treatment for the condition? | |
| | 8. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 9. Have you received medical equipment for this condition? (oxygen, CPAP, nebulizer?) | |
| | 10. What was the equipment for this condition? | | | | | |
| | 11. What was the last date of treatment or the last physician visit for this condition? | | | | | |
| | 12. Diabetes – Please answer the following questions. | | | | | |
| | a. Type of diabetes | | <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Gestational | | b. Are you pregnant? | |
| | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | c. Do you have high blood pressure/hypertension? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| | 6. Psychological Disorder (anxiety, depression, bipolar, etc.) Counseling, Tobacco Use, Substance Abuse, Eating Disorder | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia | | <input type="checkbox"/> Tobacco use – also answer question 11 below <input type="checkbox"/> Substance abuse/alcohol abuse <input type="checkbox"/> Eating disorder <input type="checkbox"/> Counseling | | <input type="checkbox"/> Post traumatic stress disorder <input type="checkbox"/> Suicide attempt <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Other psychological disorder not listed | |
| 1. Name of Person | | 2. Date of Diagnosis | | 3. Description of condition to include affected area. | | |
| 4. Are you taking medication for this condition? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | | |
| 6. Are you taking one or more medications for this condition? | | <input type="checkbox"/> 1 medication <input type="checkbox"/> 2 medications <input type="checkbox"/> 3 medications or more <input type="checkbox"/> None | | 7. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | | |
| 8. Have you been hospitalized or been to the emergency room for treatment? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 9. What was the treatment for this condition? | | |
| | | | | <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> ER visit for treatment | | |
| 10. What was the last date of treatment or the last physician visit for this condition? | | | | | | |
| 11. Tobacco use – How long have you used tobacco products? | | | | | | |
| 1. Name of Person | | 2. Date of Diagnosis | | 3. Description of condition to include affected area. | | |
| 4. Are you taking medication for this condition? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | | |
| 6. Are you taking one or more medications for this condition? | | <input type="checkbox"/> 1 medication <input type="checkbox"/> 2 medications <input type="checkbox"/> 3 medications or more <input type="checkbox"/> None | | 7. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | | |
| 8. Have you been hospitalized or been to the emergency room for treatment? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | | 9. What was the treatment for this condition? | | |
| | | | | <input type="checkbox"/> Inpatient hospital <input type="checkbox"/> ER visit for treatment | | |
| 10. What was the last date of treatment or the last physician visit for this condition? | | | | | | |
| 11. Tobacco use – How long have you used tobacco products? | | | | | | |

Applicant/Subscriber Name:

| | | | |
|---|---|---|--|
| Medical History | 7. Conditions Affecting the Blood or an Autoimmune Disorder | | |
| | <input type="checkbox"/> Allergies <input type="checkbox"/> HIV/AIDS and related complex <input type="checkbox"/> Immune deficiency <input type="checkbox"/> Anemia <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Lupus <input type="checkbox"/> Scleroderma <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Gout <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Clotting disorder/coagulation disorder <input type="checkbox"/> Acne <input type="checkbox"/> Other blood or autoimmune disorders |
| | 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area. |
| | 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? |
| | 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? |
| | 8. Have you been hospitalized, had surgery, or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. What was the treatment for this condition? |
| | 10. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Have you received medical equipment for this condition? (oxygen, CPAP, nebulizer, wheelchair, braces, PIC line, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | 12. What was the equipment for this condition? | | |
| | 13. What was the last date of treatment or the last physician visit for this condition? | | |
| | 14. Immune Deficiency – What type of immune deficiency do you have? | | |
| | 15. Anemia – What type of anemia do you have? | | |
| | 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area. |
| | 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? |
| | 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? |
| | 8. Have you been hospitalized, had surgery, or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. What was the treatment for this condition? |
| 10. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Have you received medical equipment for this condition? (oxygen, CPAP, nebulizer, wheelchair, braces, PIC line, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 12. What was the equipment for this condition? | | | |
| 13. What was the last date of treatment or the last physician visit for this condition? | | | |
| 14. Immune Deficiency – What type of immune deficiency do you have? | | | |
| 15. Anemia – What type of anemia do you have? | | | |
| 8. Genitourinary System <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| <input type="checkbox"/> Prostate <input type="checkbox"/> Male reproductive organs <input type="checkbox"/> Female reproductive organs | <input type="checkbox"/> Infertility <input type="checkbox"/> Bladder <input type="checkbox"/> Kidney failure | <input type="checkbox"/> Kidney stones <input type="checkbox"/> Urinary tract disorder <input type="checkbox"/> Other genitourinary system disorder | |
| 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area. | |
| 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| 6. Have you been hospitalized, had surgery, or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What was the treatment for this condition? | |
| 8. What was the last date of treatment or the last physician visit for this condition? | | | |
| 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area. | |
| 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| 6. Have you been hospitalized, had surgery, or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What was the treatment for this condition? | |
| 8. What was the last date of treatment or the last physician visit for this condition? | | | |

| | | | | |
|---|---|--|--|---|
| 9. | Musculoskeletal and Connective Tissue Disorder | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | <input type="checkbox"/> Arthritis <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Hip disorder <input type="checkbox"/> Knee disorder | <input type="checkbox"/> Shoulder disorder <input type="checkbox"/> Elbow disorder <input type="checkbox"/> Wrist disorder <input type="checkbox"/> Hand disorder <input type="checkbox"/> Foot disorder <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Scoliosis <input type="checkbox"/> Chiropractic treatments (answer 1, 3 & 14) <input type="checkbox"/> Amputation <input type="checkbox"/> Any other musculoskeletal disorder not listed? | |
| Medical History | 1. Name of Person | | 2. Date of Diagnosis | |
| | | | 3. Description of condition to include affected area. | |
| | 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| | 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? | |
| | 8. Have you been hospitalized or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. What was the treatment for this condition? | |
| | 10. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Date of treatment. | |
| | 12. Do you have hardware such as pins, screws, rods, etc. present? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Have you received medical equipment for this condition such as a walker, wheelchair, or braces? What equipment have you received? | |
| | 14. What was the last date of treatment or the last physician visit for this condition? | | | |
| | 15. Arthritis – Do you have osteoarthritis or rheumatoid arthritis? | | | |
| | 16. Chiropractic – What was the beginning date of the chiropractic treatment? | | | |
| | 1. Name of Person | | 2. Date of Diagnosis | 3. Description of condition to include affected area. |
| | | | | |
| | 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| | 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? | |
| | 8. Have you been hospitalized or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. What was the treatment for this condition? | |
| | 10. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Date of treatment. | |
| 12. Do you have hardware such as pins, screws, rods, etc. present? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Have you received medical equipment for this condition such as a walker, wheelchair, or braces? What equipment have you received? | | |
| 14. What was the last date of treatment or the last physician visit for this condition? | | | | |
| 15. Arthritis – Osteoarthritis or rheumatoid arthritis? | | | | |
| 16. Chiropractic – What was the beginning date of the chiropractic treatment? | | | | |

Applicant/Subscriber Name: _____

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|---|---|--|--|
| Medical History | 10. Benign/Malignant Cancer, Tumors, Leukemia, Myeloma, Hodgkin's/Non-Hodgkin's Lymphoma <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | <input type="checkbox"/> Benign neoplasms | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Any other type of 'cancer' not listed |
| | <input type="checkbox"/> Malignant cancer | <input type="checkbox"/> Myeloma | |
| | <input type="checkbox"/> Other types of tumors | <input type="checkbox"/> Lymphoma | |
| | 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area |
| | 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? |
| | 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? |
| | 8. Have you been hospitalized, had surgery, or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you received medical equipment for this condition? (oxygen, nebulizer, wheelchair, braces, PIC line, etc.) |
| | 10. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. What was the equipment for this condition? |
| | 12. What was the treatment for the condition? <input type="checkbox"/> Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation Therapy | | |
| 13. What was the last date of treatment or the last physician visit for this condition? | | | |
| 1. Name of Person | 2. Date of Diagnosis | 3. Description of condition to include affected area | |
| 4. Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| 6. Are you taking injectable medication? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. What is the injectable medication you are taking, dosage (mg/ml) and frequency (1 shot, 2 shots, etc.)? | |
| 8. Have you been hospitalized, had surgery, or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Have you received medical equipment for this condition? (oxygen, nebulizer, wheelchair, braces, PIC line, etc.) | |
| 10. Have you received physical, speech, occupational therapy, and/or counseling for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. What was the equipment for this condition? | |
| 13. What was the treatment for the condition? <input type="checkbox"/> Surgery <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiation Therapy | | | |
| 14. What was the last date of treatment or the last physician visit for this condition? | | | |
| 11. Pregnancy – Are you, a spouse, or an enrolling dependent child pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| 1. Name of Person | 2. Date of Diagnosis | 3. Due Date | |
| 1. Name of Person | 2. Date of Diagnosis | 3. Due Date | |
| LIFESTYLE QUESTIONS | | | |
| Alcohol – Do you or anyone on this application consume alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of Person(s) | |
| <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Weekly <input type="checkbox"/> Daily | | | |
| Tobacco Use – Do you or anyone on this application use tobacco products? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of Person(s) | |
| Exercise – Do you or anyone on this application exercise? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of Person(s) | |
| <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Weekly <input type="checkbox"/> Daily | | | |
| ADDITIONAL HEALTH QUESTIONS | | | |
| Signs and Symptoms/Additional Health History (Please use this section to report any additional information) Have you or anyone on this application been diagnosed or treated for any conditions such as but not limited to: headaches, transplants, therapies, artificial openings such as a colostomy, premature birth/congenital abnormalities? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of person: | |
| Are you taking medication for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| Have you been hospitalized for or been to the emergency room for treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No | What was the last date of treatment or the last physician visit for this condition? | |

Applicant/Subscriber Name:

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|--|--|--|--|--|
| Medical History | Premature birth within 5 years | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of person | |
| | What was the date of birth? | | How many weeks premature? | |
| | Is there any ongoing treatment? | | | |
| | | | | |
| | Do you or anyone on this application have any condition requiring physical, speech, and/or occupational therapy? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of person | |
| | What is the condition requiring treatment? | <input type="checkbox"/> Physical <input type="checkbox"/> Speech <input type="checkbox"/> Occupational <input type="checkbox"/> Other | | |
| | Dates of treatment: From / / to / / Note: if "To date" is left blank, the treatment will be considered ongoing. | | | |
| | | | | |
| | Transplants | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of person | |
| | What type of transplant? <input type="checkbox"/> Heart <input type="checkbox"/> Lung <input type="checkbox"/> Liver <input type="checkbox"/> Kidney <input type="checkbox"/> Pancreas <input type="checkbox"/> Other | | | |
| | Date of onset | | | |
| | Are you taking medication for the transplant? | <input type="checkbox"/> Yes <input type="checkbox"/> No | What is the medication you are taking, dosage (mg/ml) and frequency (1 pill, 2 pills, etc.)? | |
| | | | | |
| | Artificial Opening such as Colostomy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of person: | |
| | <input type="checkbox"/> Respiratory <input type="checkbox"/> Digestive <input type="checkbox"/> Urinary <input type="checkbox"/> Other | | | |
| | Date of onset | | Is the artificial opening still present? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | |
| | Congenital Abnormalities and Other Related Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name of person: | |
| | What type of congenital defect is present? <input type="checkbox"/> Heart <input type="checkbox"/> Digestive <input type="checkbox"/> Respiratory <input type="checkbox"/> Nervous system <input type="checkbox"/> Hip dislocation <input type="checkbox"/> Cleft palate <input type="checkbox"/> Club foot <input type="checkbox"/> Reproductive <input type="checkbox"/> Urinary <input type="checkbox"/> Bone/Skeletal not listed above | | | |
| | Have you had treatment for this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | What was the treatment for this condition? <input type="checkbox"/> Surgery <input type="checkbox"/> Therapy (physical, speech, occupational, etc.) <input type="checkbox"/> Assistive devices such as walkers, braces, wheelchairs <input type="checkbox"/> Other | | | |
| | Date of onset of defect | | Date of last treatment for condition, including doctor visits | |
| | | | | |
| | Have you or anyone on this application accrued medical expenses greater than \$10,000 within the past 12 months? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | What is the condition that required medical services greater than \$10,000? Please provide dates of care and treatment. | | | |
| | Name of person | | | |
| | | | | |
| | Have you or anyone on this application received worker's compensation benefits or any type of insurance coverage for an ongoing condition? (disability, auto, etc.) | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Explain the condition for which you or anyone on this application received disability coverage, worker's compensation benefits, or any other type of insurance coverage. | | | | |
| Name of person | | What company paid the benefits? | | |
| | | | | |
| Has any person on this application received or been recommended to receive any medical treatment that has not been listed on this application, been fitted with implants, orthopedic devices, or use of durable medical equipment? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Explain the condition for which any person on this application received any medical treatment that has not been listed on this application, been fitted with implants, orthopedic devices, or use of durable medical equipment. | | | | |
| Name of person | | | | |
| | | | | |
| Have you or anyone on this application had a condition or diagnosis that has not been entered on this application or needs further explanation? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Name of person | | | | |
| Please provide date of care | | What was the treatment provided? | | |
| | | | | |

PLEASE PRINT IN BLACK INK

| | | | | | |
|---------------------------------|--|--|---|--|-------------------------------|
| To Be Completed by the Employer | Name of Group or Firm: | | Group Number: | | |
| | Name of Employee: | | Occupation: | | |
| | Current Number of Hours per Week | Date employee started working the required number of hours to become eligible for coverage. (This is the date BCBSMT will begin to calculate the probationary period for health care coverage.) | | | (mo day yr) |
| | Have you, the employer, induced or pressured an eligible employee or dependent of an eligible employee to decline coverage due to the individual's risk characteristics, including current health conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| | Signature of Group Leader or Authorized Signer | | Signature Date (mo day yr) | Please Print Name of Group Leader or Authorized Signer | |
| | <u>Informational</u> for Employee/Employer payroll deduction purposes only. EMPLOYER: Please refer to employee. Check Type of Coverage Applying for: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Children <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Spouse/Child <input type="checkbox"/> Employee/Child <input type="checkbox"/> Employee/Spouse/Children | | | | |

The sections below must be completed by Applicant/Subscriber.

| Conditions of Enrollment | <p>I/We certify and understand the following:</p> <ol style="list-style-type: none"> I/We personally completed the Medical History section (if required) of this form, providing all requested information. All of the statements and responses in this application are complete, accurate, and current for the Applicant/Subscriber, and for the spouse and all dependents for whom coverage is requested This is an application only. No right is conferred to me or any person listed on this application until Blue Cross and Blue Shield of Montana enrolls me/us and dues (premiums) are paid. I/We understand that preexisting condition exclusion periods may apply although preexisting condition exclusion periods do not apply to members under 19 years of age. I/We, the undersigned, am/are applying for membership with Blue Cross and Blue Shield of Montana. I/We agree to the terms and conditions of any certificate issued to me/us by Blue Cross and Blue Shield of Montana. I/We understand that Blue Cross and Blue Shield of Montana maintains contracts with certain providers of medical services. I/We understand Blue Cross and Blue Shield of Montana will pay those providers and any other provider it chooses directly. I authorize my employer to pay dues (premiums) at the prevailing rates required by this application for membership with Blue Cross and Blue Shield of Montana. I understand that I may be required to pay a portion of the dues (premiums). | | | | | | | | | | | | | | | | |
|---|---|---|--|---|--|----------------------|-----------|--------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Conditions of Enrollment for Managed Care – Applicant/Subscriber Only | <p>This section applies to all Managed Care Plans.</p> <ol style="list-style-type: none"> For Managed Care Applicant/Subscriber: I/We have reviewed the Managed Care literature. I/We understand that this form of health care coverage is based on a partnership between me/us and my/our Personal Care Physician (PCP). I/We have reviewed and I/we understand the policies relating to urgent and emergency care, payment of services, and copayments. For Managed Care Applicant/Subscriber Living or Working Within 30 Miles of a Managed Care Network of PCPs: I/We acknowledge that Blue Cross and Blue Shield of Montana has a Managed Care Network of PCPs within 30 miles of my/our place(s) of residence or work. However, I/we have voluntarily chosen a Managed Care PCP located farther than 30 miles from my/our place(s) of residence or work. Please initial below: _____ Applicant/Subscriber _____ Spouse _____ Dependent 18 and over _____ Dependent 18 and over _____ Dependent 18 and over | | | | | | | | | | | | | | | | |
| Signature(s) | <p>I/We understand and agree that the coverage I/we am/are applying for is subject to the employer's eligibility requirements and the effective date will be assigned by Blue Cross and Blue Shield of Montana. I/We have read the Conditions of Enrollment. I/We understand and agree to them.</p> <p style="text-align: center;"><i>Must also have signature(s) of spouse and/or all dependent(s) 18 and over if applying.</i></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Signature(s) <small>DO NOT PRINT</small></th> <th style="width: 15%;">Signature Date <small>(mo day yr)</small></th> <th style="width: 25%;">Signature(s) <small>DO NOT PRINT</small></th> <th style="width: 35%;">Signature Date <small>(mo day yr)</small></th> </tr> </thead> <tbody> <tr> <td>Applicant/Subscriber</td> <td style="text-align: center;"> </td> <td>Spouse</td> <td style="text-align: center;"> </td> </tr> <tr> <td>Dependent</td> <td style="text-align: center;"> </td> <td>Dependent</td> <td style="text-align: center;"> </td> </tr> <tr> <td>Dependent</td> <td style="text-align: center;"> </td> <td>Dependent</td> <td style="text-align: center;"> </td> </tr> </tbody> </table> | Signature(s) <small>DO NOT PRINT</small> | Signature Date <small>(mo day yr)</small> | Signature(s) <small>DO NOT PRINT</small> | Signature Date <small>(mo day yr)</small> | Applicant/Subscriber | | Spouse | | Dependent | | Dependent | | Dependent | | Dependent | |
| Signature(s) <small>DO NOT PRINT</small> | Signature Date <small>(mo day yr)</small> | Signature(s) <small>DO NOT PRINT</small> | Signature Date <small>(mo day yr)</small> | | | | | | | | | | | | | | |
| Applicant/Subscriber | | Spouse | | | | | | | | | | | | | | | |
| Dependent | | Dependent | | | | | | | | | | | | | | | |
| Dependent | | Dependent | | | | | | | | | | | | | | | |

