Blue Cross of Idaho

Large Group Health Application With Health Statement

Requested Effective Date *(subject to BCI approval)* _____

Group Number _____

Please complete each section of this application in ink.

❑ **PPO** ❑ **Traditional** ❑ **Managed Care** ❑ **HSA**

Applicant Information (Employee)

Your Name *(first, initial, last)*	Blue Cross ID No. (if currently enrolled)	Social Security No. / /	Date of Birth / /	❑ Male ❑ Female
Mailing Address	City, State, Zip Code	Phone Number ( )	Email Address	
Full-time Hire Date / /	Name of Employer	Job Title	Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Height / Weight
For Managed Care Plans Only	Name of Primary Care Physician (PCP)	Existing Patient of PCP? ❑ Yes ❑ No	***Office Use Only*** PCP	

Family Member Information

List all family members you wish to enroll. Children must be under 23, or 25 if full-time student, never married and dependent on you for support.

	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Height	Weight		***For Managed Care Plans Only*** Name of Primary Care Physician (PCP) (For the highest benefit level you must select a PCP)	Existing Patient of PCP?	*Office Use Only PCP*
Family Member's Name (first, initial, last)	/ /		/ /			❑ Male ❑ Female		❑ Yes ❑ No	
Full-time Student ❑ Yes ❑ No	Name of school if student is over age 23								
Family Member's Name (first, initial, last)	/ /		/ /			❑ Male ❑ Female		❑ Yes ❑ No	
Full-time Student ❑ Yes ❑ No	Name of school if student is over age 23								
Family Member's Name (first, initial, last)	/ /		/ /			❑ Male ❑ Female		❑ Yes ❑ No	
Full-time Student ❑ Yes ❑ No	Name of school if student is over age 23								
Family Member's Name (first, initial, last)	/ /		/ /			❑ Male ❑ Female		❑ Yes ❑ No	
Full-time Student ❑ Yes ❑ No	Name of school if student is over age 23								

Do you or any of your family members have other medical and/or dental coverage? ❑ YES ❑ NO

Coordinating your insurance benefits could reduce the amount you owe a provider.

Prior and/or Current Coverage Information ***(Please complete the information below to receive accurate credit for your prior waiting periods.)***

Is any person listed on this application now covered, or has he or she been covered, by any other health insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy during the 12 months prior to the requested effective date of this application (excluding any employee's probationary period?) ❑ Yes ❑ No

If **YES**, further information may be requested to maximize your benefits. Please complete all information below for **each** person listed on this application.

Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy: Start Date (mm/dd/yy)	Date of Policy: End Date (mm/dd/yy)	Will Current Policy Continue?
Employee				/ /	/ /	❑ Yes ❑ No
Spouse				/ /	/ /	❑ Yes ❑ No
Child				/ /	/ /	❑ Yes ❑ No
Child				/ /	/ /	❑ Yes ❑ No
Child				/ /	/ /	❑ Yes ❑ No

(Please use extra paper if necessary.)

If any person listed on this application is covered by Medicare, please complete the following:

_____ *Name*

_____ *Medicare Beneficiary Number*

_____ *Reason for Medicare Entitlement (age, disability or ESRD)*

Date of Medicare Entitlement — *Part A* _____/_____/_____ (*mm dd yy*) — *Part B* _____/_____/_____ (*mm dd yy*)

- If you have had other coverage with another carrier within 63 days (excluding any employee's probationary period) of this request, please attach a copy of your **Certificate of Coverage**; this will ensure proper credit for any preexisting conditions, if applicable, which can be obtained from your current or prior carrier.

Are you or any of your dependents currently disabled? ❑ YES ❑ NO (If YES, complete information below.)

_____ *Nature of Disability*

_____ *Name of Disabled Person*

_____ *Physician's Name*

_____ *Physician's Phone Number*

_____ *Date of Disability*

_____ *Physician's Address*

Please read the reverse side and sign and date this application. **OVER ☛**

FOR OFFICE USE ONLY

Group Number	Subgroup	HIPAA: Credit Days	HIPAA: Start	HIPAA: End	Effective Date	Plan ID: M	Plan ID: D	Plan ID: V	Class	Reason Code

3000 E. Pine Ave. • Meridian, Idaho 83642 • (208) 345-4550

***Mailing Address*: P.O. Box 7408 • Boise, ID 83707-1408**

Auditor _____

Form No. 3-300 (07-08)

An Independent Licensee of the Blue Cross and Blue Shield Association

Type of Enrollment

❑ Self only ❑ Self + 1 child

❑ Self and spouse ❑ Self + 2 or more children

❑ Self, spouse and children

Change Request

Change current enrollment because of the following event:

❑ Marriage ❑ Divorce ❑ Birth ❑ Involuntary loss of coverage

❑ Death ❑ Court order (copy of court order required)

❑ Other _____

Date event occurred _____/_____/_____
mm dd yy

Health Statement *(Complete this health statement if you apply for coverage for yourself or a family member after the original eligibility period.)*

1. Have you or any family member listed on this application ever been advised to have any surgical operation(s) that you or any family member have not yet had?

   ❑ **YES** ❑ **NO**

2. Do you or any family member listed on this application suffer from any chronic or recurring ailments, illnesses or other departures from good health, regardless of whether a physician or other health care professional has been consulted?

   ❑ **YES** ❑ **NO**

3. During the past 12 months, have you or any family member listed on this application received a prescription for medication from a physician or taken any prescribed medication?

   ❑ **YES** ❑ **NO**

4. Are you, or any family member, *whether or not listed on this application*, now pregnant?

   ❑ **YES** ❑ **NO** If pregnant, what is the anticipated delivery date? _____

5. Have you or any family member listed on this application ever been refused or issued restricted health insurance coverage or been offered a program with a rider attached that restricted or excluded benefits for certain conditions?

   ❑ **YES** ❑ **NO**

6. Have you or any family member listed on this application been hospitalized during the last 5 years?

   ❑ **YES** ❑ **NO**

7. Have you or any family member listed on this application ever had, been told he or she had, been counseled or treated for any of the following: alcohol/drug use or abuse, cancer, heart problem/disorder, diabetes, digestive disorder, immune disorder, renal/kidney disease, strokes, mental or nervous disorders or respiratory disorders?

   ❑ **YES** ❑ **NO**

If you checked YES to any question above, please provide details below *(please use extra paper if necessary)*:

Item No.	Person Affected	Mo. / Year	Name of Disease, Symptom or Condition – Include Type of Treatment	Name of Hospital and Number of Days	Date Last Treated	Was Recovery Complete?	Drugs – Include Type or Name, Dosage, Strength and Duration	Name of Physician

Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurer, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The insurer may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the insurer discovers any intentional misrepresentation, omission or concealment of fact in obtaining coverage that was or would have been material to the insurer's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim, the insurer may take action against my employer, including but not limited to increasing premiums.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by the insurer.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***www.bcidaho.com***.
- Preexisting condition waiting period: There are no benefits available under this policy for services, supplies, drugs or other charges that are provided within 12 months after an insured's enrollment date for any preexisting condition.

  A preexisting condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the six months immediately preceding the enrollment date. A pregnancy existing on the enrollment date is not a preexisting condition under this policy. Genetic information shall not be considered as a preexisting condition in the absence of a diagnosis of the condition related to such information.

  In certain circumstances, qualifying previous coverage will be credited toward the preexisting condition waiting period.
- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, your current employer or Blue Cross of Idaho can assist you.
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the insurer.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- I understand that this application will become part of the contract between the insurer and my employer.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**

X _____
Applicant's Signature

_____
Date

This application must be signed and dated.