



<b>Type of Enrollment</b>		<b>Change Request</b>
<b>Health Coverage (check one)</b> <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and children <input type="checkbox"/> Self + 1 child <input type="checkbox"/> Self + 2 or more children	<b>Dental Coverage (check one)</b> <input type="checkbox"/> Self only <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self, spouse and children <input type="checkbox"/> Self + 1 child <input type="checkbox"/> Self + 2 or more children	<b>Change current enrollment because of the following event:</b> <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Death <input type="checkbox"/> Court order (copy of court order required) <input type="checkbox"/> Other _____  Date event occurred _____ / _____ / _____ <div style="text-align: center;">mm      dd      yy</div>

**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 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](http://www.bcidaho.com).
- Preexisting condition waiting period: There are no benefits available under this contract 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.

- 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 contract 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 contract, 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.**