Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Applications	SERFF Tr Num: ARBB-127350731	State: Arkansas
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 49450
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)	Co Tr Num: U65 LB IA,U65 LB DR,U65 LB FB, U65 APP IA,U65 APP DR,U65 APP FB, NON-UNDCHG, UNDCHG (R10/11)	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Christi Kittler, Yvonne McNaughton, Rita Thatcher, Evelyn Laney	Disposition Date: 08/02/2011
	Date Submitted: 08/02/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name:
Project Number: U65 LB IA,U65 LB DR,U65LB FB,U65 APP IA,U65 APP DR, U65 APP FB, Non-UndChg, UndChg (R10/11)
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Evelyn Laney
PPACA: Not PPACA-Related
PPACA Notes: null

Status of Filing in Domicile: Pending
Date Approved in Domicile:

Domicile Status Comments: Arkansas is state of domicile.
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 08/02/2011
State Status Changed: 08/02/2011
Created By: Evelyn Laney
Corresponding Filing Tracking Number:

Filing Description:

Attached please find forms List Bill IA, List Bill DR, List Bill FB, U-65 IA, U-65 DR, U-65 FB, NonUChReq and UndChgFm for your review and approval if indicated.

These forms were revised due to several technical changes in the applications such as clarification of certain information, adding new questions to some sections, updating bank draft form and etc.

The applications were Flesch scored with the Comprehensive Blue PPO III policy (approved on October 14, 2010) for which they will be used.

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. I further certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the policies to which these amendments are attached.

Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst
320 West Capitol, Ste 211
Little Rock, AR 72201

exlaney@arkbluecross.com
501-378-2165 [Phone]
501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield	CoCode: 83470	State of Domicile: Arkansas
601 S. Gaines Street	Group Code:	Company Type:
Little Rock, AR 72201	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0226428	

Filing Fees

Fee Required?	Yes
Fee Amount:	$400.00
Retaliatory?	No
Fee Explanation:	$50.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	$400.00	08/02/2011	50278832

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/02/2011	08/02/2011

Disposition

Disposition Date: 08/02/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ARBB-127350731*	*State:*	*Arkansas*
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*49450*
Company Tracking Number:	*U65 LB IA,U65 LB DR,U65 LB FB, U65 APP IA,U65 APP DR,U65 APP FB, NON-UNDCHG, UNDCHG (R10/11)*		
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005A Individual - Preferred Provider (PPO)*
Product Name:	*Applications*		
Project Name/Number:	*/U65 LB IA,U65 LB DR,U65LB FB,U65 APP IA,U65 APP DR, U65 APP FB, Non-UndChg, UndChg (R10/11)*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

Form Schedule

Lead Form Number: U-65 LB IA (R10/11)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/02/2011	U-65 List Bill IA (R10/11)	Application/	Application Enrollment Form	Revised	Replaced Form #: U-65 List Bill IA (R11/10) Previous Filing #: U-65 List Bill IA (R11/10)		LBill_IA_(R10-11).pdf
Approved-Closed 08/02/2011	U-65 List Bill DR (R10/11)	Application/	Application Enrollment Form	Revised	Replaced Form #: U-65 List Bill DR (R11/10) Previous Filing #: U-65 List Bill DR (R11/10)		LBill_DR (R10-11).pdf
Approved-Closed 08/02/2011	U-65 List Bill FB (R10/11)	Application/	Application Enrollment Form	Revised	Replaced Form #: U-65 List Bill DR (R11/10) Previous Filing #: U-65 List Bill DR (R11/10)		LBill_FB_(R10-11).pdf
Approved-Closed 08/02/2011	U-65 APP IA (R10/11)	Application/	Application Enrollment Form	Revised	Replaced Form #: U-65 APP IA (R11/10) Previous Filing #: U-65 APP IA (R11/10)		U65 IA_(R10-11).pdf
Approved-Closed 08/02/2011	U-65 APP DR (R10/11)	Application/	Application Enrollment Form	Revised	Replaced Form #: U-65 APP DR (R11/10) Previous Filing #: U-65 APP DR (R11/10)		U65 DR_(R10-11).pdf
Approved-Closed	U-65 APP FB	Application/	Application Enrollment	Revised	Replaced Form #: U-65 APP FB (R11/10)		U65 FB_(R10-

08/02/2011	(R10/11)	Form		Previous Filing #: U-65 APP FB (R11/10)	11).pdf
Approved-Closed 08/02/2011	Non-UndChg Form (R10/11)	Application/ Application Enrollment Form	Revised	Replaced Form #: Non-UndChg Form (R11/10) Previous Filing #: Non-UndChg Form (R11/10)	NonUChReq_ (R10-11).pdf
Approved-Closed 08/02/2011	UndChg Form (R10/11)	Application/ Application Enrollment Form	Revised	Replaced Form #: UndChg Form (R11/10) Previous Filing #: UndChg Form (R11/10)	UndChgFm (R10-11).pdf

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

List Bill Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "*Relationship*" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 15 – TYPE OF COVERAGE

- If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.

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

Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq.*, the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq.* Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

Applicants age 18 and older

This authorization must be signed by each applicant age 18 or older.

Print Name(s)	Signature	Date
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____

Applicants under age 18

List applicants under age 18 (Print Name).

_____

_____

_____

_____

_____ _____ ____/____/____

Parent/Legal Guardian's Signature (if policy for a minor) Date

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

Application for Health Insurance

For Arkansas Blue Cross Use Only
This application was received by:
☐ C ☐ NW ☐ NE ☐ WC
☐ SC ☐ SW ☐ SE ☐ Customer Service
☐ Retail Store
Date Stamp _____

1 WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				Self				___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.

2 PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship **(Check One)**
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

3 MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

4 U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 4 before completing.

☐ Yes ☐ No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name:_____ Name:_____

5 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street	City	State	Zip
		AR	

6 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip

7 BILLING MODE

List Bill #: _____

8 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-mail Address	How do you prefer we communicate with you?
( )	( )	AM PM		☐ E-mail ☐ Phone

9 HOUSEHOLD INFORMATION

☐ Yes ☐ No a. Do all applicants reside in the same household? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

☐ Yes ☐ No b. Do all applicants reside in Arkansas? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason:_____

OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

(Continued on page 2)

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: _____ Employer: _____

Job Duties: _____

Name: _____ Employer: _____

Job Duties: _____

11 CURRENT/PREVIOUS INSURANCE INFORMATION

☐ Yes ☐ No a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

i. If "yes," please provide name of carrier:_____

ii. If "yes," does the **coverage** have a specified termination date? If so, please provide date: __/__/__.

☐ Yes ☐ No iii. If "yes," and the coverage does **not** have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?

☐ Yes ☐ No b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No d. Will any applicants be **continuing** any other health insurance? If yes, please provide:
Name: _____ Carrier Name: _____ ID# _____
Name: _____ Carrier Name: _____ ID# _____

☐ Yes ☐ No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below:
Name: _____
Name: _____

☐ Yes ☐ No f. Are any applicants covered by Medicare? If "yes,"please provide name(s) below:
Name: _____
Name: _____

12 DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]

Name: _____ License No. : _____ State:_____

Name: _____ License No.: _____ State:_____

Name: _____ License No.: _____ State:_____

In the past 5 years, has any applicant:

☐ Yes ☐ No a. Had his or her driver's license suspended or revoked?
☐ Yes ☐ No b. Had two or more moving traffic violations?
☐ Yes ☐ No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?

If you answered "yes," to any of the above questions, you **MUST** provide the following information**:**

Name: _____ Date: _____/_____/_____ Violation(s): _____

Name: _____ Date: _____/_____/_____ Violation(s): _____

13 SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name: _____ Please explain: _____

Name: _____ Please explain: _____

14 TRAVEL OUTSIDE THE USA

☐ Yes ☐ No Is any applicant planning to travel or work outside the USA within the next two years?
If "yes," please provide the following:

Name (list **all** that apply): _____

Country: _____ Expected Length of Stay: _____ Departure date: _____Return date: _____

Reason for Travel: _____

_____

(Continued on page 3)

15 TYPE OF COVERAGE

☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Individual, Spouse and Child(ren)

☐ Yes ☐ No If you are applying for coverage other than "Individual," are you interested in coverage if one or more applicants is declined or ineligible?

16 BENEFITS SELECTION

MUST CHOOSE ONE BOX ONLY

Comprehensive Blue PPO III

- ☐ $ 1, 000 deductible
- ☐ $ 1, 500 deductible
- ☐ $ 2,500 deductible
- ☐ $ 5,000 deductible
- ☐ $ 7,500 deductible
- ☐ $10,000 deductible
- ☐ $15,000 deductible
- ☐ $20,000 deductible
- ☐ $25,000 deductible

HSA Blue PPO II

- ☐ $ 1,500 individual/ $ 3,000 family deductible
- ☐ $ 2,500 individual/ $ 5,000 family deductible
- ☐ $ 5,000 individual/ $10,000 family deductible

17 OPTIONAL BENEFITS SELECTION

OPTIONAL MATERNITY BENEFITS

☐ Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. There is no per pregnancy dollar maximum. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

(Continued on page 4)

17 OPTIONAL BENEFITS SELECTION (continued)

OPTIONAL TERM LIFE

Underwritten by USAble Life and billed with your health insurance. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life policy referenced here.

Term Life is available only on the proposed insured and spouse. (Proposed insured must be 19 - 64 years of age.)

Choose only one of the following:

☐ Proposed Insured

☐ Proposed Insured **and** Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts: ☐ $10,000 ☐ $30,000 ☐ $50,000

If both the proposed insured and spouse choose Term Life, the coverage amounts will be the same.

- Benefits will be paid to the designated beneficiary(ies) in one lump sum.
- Premiums are based on the age of the oldest person applying for coverage and increase when that person's age moves to the next age bracket. Your monthly premiums will be billed with your Arkansas Blue Cross and Blue Shield health insurance coverage.
- Your Term Life coverage will become effective at the same time as your Arkansas Blue Cross and Blue Shield health insurance coverage.

Beneficiary Designation for Optional Term Life Insurance Benefits

I hereby designate the following beneficiary(ies) for the USAble Life Term Life insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive will share equally unless specified otherwise.

The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of proposed insured.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
					+
					+
		Total must equal 100% =			

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
					+
					+
		Total must equal 100% =			

(Continued on page 5)

18 EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is any **male** applying for coverage an expectant father or a potential adoptive father?

☐ Yes ☐ No Is any **female** applying for coverage pregnant or a potential adoptive mother?

If "yes," please provide the following: Name: _____ Expected Delivery/Adoption Date: ____/_____/_____

19 INFERTILITY

Has any applicant or spouse of a proposed applicant **(whether applying for coverage or not)**:

☐ Yes ☐ No a. Ever been diagnosed or treated for infertility?

☐ Yes ☐ No b. Had surgical sterilization? If "yes" to question a. or b., please provide the following:

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

20 TOBACCO USAGE

☐ Yes ☐ No Has any applicant to be covered used any form of tobacco within the last 12 months? If "yes," please provide the following:

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

21 PREVIOUS INSURANCE EXPERIENCE

☐ Yes ☐ No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:

Name: _____ Carrier Name: _____ Year: _____ Details: _____

Name: _____ Carrier Name: _____ Year: _____ Details: _____

22 PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any proposed applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years?**

If you answered "yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated**. A print out from the pharmacy is **not** acceptable. **Please provide the name that would have been used at the time of the prescription — e.g., a maiden name may have been used**.

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				

(Continued on page 6)

23 MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked.** When multiple medical conditions are listed, please circle **all conditions that apply.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cerebral palsy
- ☐ Concussion or brain injury
- ☐ Convulsions, epilepsy or seizures
- ☐ Headaches or migraines
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above apply to any applicant(s)**

B. CIRCULATORY

- ☐ Abnormal cholesterol/lipids
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Valve repair/replacement
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above apply to any applicant(s)**

C. DIGESTIVE

- ☐ Cirrhosis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Hernia, hemorrhoids
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above apply to any applicant(s)**

D. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Cesarean section or miscarriage
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the male reproductive organs, including prostate
- ☐ Any other disorder of the female reproductive organs, including ovaries or breasts
- ☐ **None of the above apply to any applicant(s)**

E. RESPIRATORY

- ☐ Allergies, asthma or bronchitis
- ☐ Chronic pulmonary disease, emphysema, lung disease or respiratory synctyial virus (RSV)
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea, cpap, bipap or vpap
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above apply to any applicant(s)**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer, leukemia or malignancy of any kind
- ☐ Hodgkin's or Non-Hodgkin's disease
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ **None of the above apply to any applicant(s)**

G. GLANDULAR DISORDERS

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Goiter or thyroid disease
- ☐ Any disorder of the pancreas
- ☐ **None of the above apply to any applicant(s)**

H. MUSCULOSKELETAL

- ☐ Arthritis, osteoarthritis, degenerative joint or disc disease
- ☐ Back pain and/or neck pain
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- ☐ Fibromyalgia, bursitis or tendonitis

MUSCULOSKELETAL (cont.)

- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Gout
- ☐ Lupus, systemic
- ☐ Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- ☐ Any other disorder of the muscles, bones or joints to include chiropractic care
- ☐ **None of the above apply to any applicant(s)**

I. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Nasal septal defect
- ☐ Sinusitis, tonsillitis or otitis media
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above apply to any applicant(s)**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- ☐ Attempted suicide
- ☐ Counseling or psychiatric treatment (in-patient or out-patient)
- ☐ Bipolar disorder, obsessive compulsive disorder or developmental disorder
- ☐ Eating disorder
- ☐ Any other mental, emotional disorder or situation, including ADD/ADHD
- ☐ **None of the above apply to any applicant(s)**

K. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Pending Surgery Surgery Date: __/__/__
- ☐ Sarcoidosis
- ☐ Breast implants
  ☐ Saline ☐ Silicone Surgery Date: __/__/__
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above apply to any applicant(s)**

(Continued on page 7)

23 MEDICAL QUESTIONNAIRE (continued)

2. Has any applicant ever:

☐ Yes ☐ No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?

☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?

☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?

☐ Yes ☐ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain:_____

☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 23. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.**

Question Number(s)	Person Treated	Specific Disorder/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					

24 PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit**	Treatment/ Results**

*Please write **NO VISIT** in this box if the applicant has never seen the physician. **Use "Comments" section on Page 9 if more room is needed for details.

(Continued on page 8)

PLEASE READ BEFORE SIGNING

By completing this list bill application, which authorizes my employer to remit my premium to Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), I understand and agree: (1) My employer will payroll deduct my premium from my compensation and remit the premium amount to COMPANY. (2) My employer is not acting as an agent of COMPANY but is, instead, at all times acting as my representative. (3) I am responsible for the payment of the premium. Therefore, if my employer fails to submit the required amounts when due, all coverage will terminate as of the due date. (4) If my employer fails to submit the required amounts when due, COMPANY has no obligation to seek payment directly from me. (5) I will not hold COMPANY liable for loss of coverage or benefits due to failure by my employer to remit payment in a timely manner. (6) My coverage is not dependent upon this billing arrangement; therefore, I may change to having COMPANY bill me directly with 15 days advance written notice to my employer and COMPANY. (7) I understand that termination of my employment shall terminate payroll deduction and employer remittance of premium to COMPANY. (8) I understand that my employer or COMPANY may terminate this arrangement by giving me written notice, but this will not terminate my insurance coverage. (9) If this payroll deduction and premium remittance is terminated, in order for me to keep my insurance coverage in force, I must make premium payments directly to COMPANY.

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) **If I am age 19 or older, I will not have any benefits provided for 12 months for the treatment of any condition which existed before the effective date of my coverage**. (3) The agent or broker involved in this insurance transaction may receive compensation from the COMPANY or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (4) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (5) The COMPANY may phone me for additional information that may help with the timely processing of my application. (6) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Continued on page 9)

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured **OR** Parent/Legal Guardian's **(if policy for a minor)**	X	Date Signed
Spouse **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed

CUSTODIAL PARENT SECTION

If any dependents, under age 19, named on this application do NOT reside with the proposed insured, the custodial parent's signature is required.

Custodial Parent's Name and Address **(please print)**	X	Telephone No.
Custodial Parent's Signature	X	Date Signed

This section to be completed by sales representative

☐ Yes ☐ No To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

Sales Rep License No. (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. (if applicable)	Sales Representative's Signature X	Date Signed

Comments:

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 1st of the **month after next** if the application is approved on the 11th through the end of the **current month**.

Approval Date	Effective Date	Examples
1st - 10th	1st of the following month	Approved Jan. 2; effective Feb. 1
11th - last day of the month	1st of the month after next	Approved Jan. 27; effective Mar. 1

Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181
www.ArkansasBlueCross.com

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

List Bill Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "*Relationship*" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 15 – TYPE OF COVERAGE

- If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.

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

Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq.*, the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq.* Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

Applicants age 18 and older

This authorization must be signed by each applicant age 18 or older.

Print Name(s)	Signature	Date
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

Applicants under age 18

List applicants under age 18 (Print Name).

_____

_____

_____

_____

_____ _____ ____/____/____

Parent/Legal Guardian's Signature (if policy for a minor) — Date

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

Application for Health Insurance

1 WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				Self				___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.

2 PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship **(Check One)**
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

3 MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

4 U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 4 before completing.

☐ Yes ☐ No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name:_____ Name:_____

5 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street	City	State	Zip
		AR	

6 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip

7 BILLING MODE

List Bill #: _____

8 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-mail Address	How do you prefer we communicate with you?
( )	( )	AM PM		☐ E-mail ☐ Phone

9 HOUSEHOLD INFORMATION

☐ Yes ☐ No a. Do all applicants reside in the same household? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

☐ Yes ☐ No b. Do all applicants reside in Arkansas? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason:_____

OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

(Continued on page 2)

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: _____ Employer: _____

Job Duties: _____

Name: _____ Employer: _____

Job Duties: _____

11 CURRENT/PREVIOUS INSURANCE INFORMATION

☐ Yes ☐ No a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

i. If "yes," please provide name of carrier:_____

ii. If "yes," does the **coverage** have a specified termination date? If so, please provide date: __/__/__.

☐ Yes ☐ No iii. If "yes," and the coverage does **not** have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?

☐ Yes ☐ No b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No d. Will any applicants be **continuing** any other health insurance? If yes, please provide:
Name: _____ Carrier Name: _____ ID# _____
Name: _____ Carrier Name: _____ ID# _____

☐ Yes ☐ No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below:
Name: _____
Name: _____

☐ Yes ☐ No f. Are any applicants covered by Medicare? If "yes,"please provide name(s) below:
Name: _____
Name: _____

12 DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]

Name: _____ License No. : _____ State:_____

Name: _____ License No.: _____ State:_____

Name: _____ License No.: _____ State:_____

In the past 5 years, has any applicant:

☐ Yes ☐ No a. Had his or her driver's license suspended or revoked?
☐ Yes ☐ No b. Had two or more moving traffic violations?
☐ Yes ☐ No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?

If you answered "yes," to any of the above questions, you **MUST** provide the following information**:**

Name: _____ Date: _____/_____/_____ Violation(s): _____

Name: _____ Date: _____/_____/_____ Violation(s): _____

13 SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name: _____ Please explain: _____

Name: _____ Please explain: _____

14 TRAVEL OUTSIDE THE USA

☐ Yes ☐ No Is any applicant planning to travel or work outside the USA within the next two years?
If "yes," please provide the following:

Name (list **all** that apply): _____

Country: _____ Expected Length of Stay: _____ Departure date: _____Return date: _____

Reason for Travel: _____

_____

(Continued on page 3)

15 TYPE OF COVERAGE

☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Individual, Spouse and Child(ren)

☐ Yes ☐ No If you are applying for coverage other than "Individual," are you interested in coverage if one or more applicants is declined or ineligible?

16 BENEFITS SELECTION

MUST CHOOSE ONE BOX ONLY

Comprehensive Blue PPO III

- ☐ $ 1, 000 deductible
- ☐ $ 1, 500 deductible
- ☐ $ 2,500 deductible
- ☐ $ 5,000 deductible
- ☐ $ 7,500 deductible
- ☐ $10,000 deductible
- ☐ $15,000 deductible
- ☐ $20,000 deductible
- ☐ $25,000 deductible

HSA Blue PPO II

- ☐ $ 1,500 individual/ $ 3,000 family deductible
- ☐ $ 2,500 individual/ $ 5,000 family deductible
- ☐ $ 5,000 individual/ $10,000 family deductible

17 OPTIONAL BENEFITS SELECTION

OPTIONAL MATERNITY BENEFITS

☐ Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. There is no per pregnancy dollar maximum. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

(Continued on page 4)

17 OPTIONAL BENEFITS SELECTION (continued)

OPTIONAL TERM LIFE

Underwritten by USAble Life and billed with your health insurance. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life policy referenced here.

Term Life is available only on the proposed insured and spouse. (Proposed insured must be 19 - 64 years of age.)

Choose only one of the following:

☐ Proposed Insured

☐ Proposed Insured **and** Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts: ☐ $10,000 ☐ $30,000 ☐ $50,000

If both the proposed insured and spouse choose Term Life, the coverage amounts will be the same.

- Benefits will be paid to the designated beneficiary(ies) in one lump sum.
- Premiums are based on the age of the oldest person applying for coverage and increase when that person's age moves to the next age bracket. Your monthly premiums will be billed with your Arkansas Blue Cross and Blue Shield health insurance coverage.
- Your Term Life coverage will become effective at the same time as your Arkansas Blue Cross and Blue Shield health insurance coverage.

Beneficiary Designation for Optional Term Life Insurance Benefits

I hereby designate the following beneficiary(ies) for the USAble Life Term Life insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive will share equally unless specified otherwise.

The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of proposed insured.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
					+
					+
		Total must equal 100% =			

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
					+
					+
		Total must equal 100% =			

(Continued on page 5)

18 EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is any **male** applying for coverage an expectant father or a potential adoptive father?

☐ Yes ☐ No Is any **female** applying for coverage pregnant or a potential adoptive mother?

If "yes," please provide the following: Name: _____ Expected Delivery/Adoption Date: ____/_____/_____

19 INFERTILITY

Has any applicant or spouse of a proposed applicant **(whether applying for coverage or not)**:

☐ Yes ☐ No a. Ever been diagnosed or treated for infertility?

☐ Yes ☐ No b. Had surgical sterilization? If "yes" to question a. or b., please provide the following:

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

20 TOBACCO USAGE

☐ Yes ☐ No Has any applicant to be covered used any form of tobacco within the last 12 months? If "yes," please provide the following:

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

21 PREVIOUS INSURANCE EXPERIENCE

☐ Yes ☐ No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:

Name: _____ Carrier Name: _____ Year: _____ Details: _____

Name: _____ Carrier Name: _____ Year: _____ Details: _____

22 PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any proposed applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years?**

If you answered "yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated**. A print out from the pharmacy is **not** acceptable. **Please provide the name that would have been used at the time of the prescription — e.g., a maiden name may have been used**.

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				

(Continued on page 6)

23 MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked.** When multiple medical conditions are listed, please circle **all conditions that apply.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cerebral palsy
- ☐ Concussion or brain injury
- ☐ Convulsions, epilepsy or seizures
- ☐ Headaches or migraines
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above apply to any applicant(s)**

B. CIRCULATORY

- ☐ Abnormal cholesterol/lipids
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Valve repair/replacement
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above apply to any applicant(s)**

C. DIGESTIVE

- ☐ Cirrhosis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Hernia, hemorrhoids
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above apply to any applicant(s)**

D. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Cesarean section or miscarriage
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the male reproductive organs, including prostate
- ☐ Any other disorder of the female reproductive organs, including ovaries or breasts
- ☐ **None of the above apply to any applicant(s)**

E. RESPIRATORY

- ☐ Allergies, asthma or bronchitis
- ☐ Chronic pulmonary disease, emphysema, lung disease or respiratory synctyial virus (RSV)
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea, cpap, bipap or vpap
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above apply to any applicant(s)**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer, leukemia or malignancy of any kind
- ☐ Hodgkin's or Non-Hodgkin's disease
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ **None of the above apply to any applicant(s)**

G. GLANDULAR DISORDERS

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Goiter or thyroid disease
- ☐ Any disorder of the pancreas
- ☐ **None of the above apply to any applicant(s)**

H. MUSCULOSKELETAL

- ☐ Arthritis, osteoarthritis, degenerative joint or disc disease
- ☐ Back pain and/or neck pain
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- ☐ Fibromyalgia, bursitis or tendonitis

MUSCULOSKELETAL (cont.)

- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Gout
- ☐ Lupus, systemic
- ☐ Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- ☐ Any other disorder of the muscles, bones or joints to include chiropractic care
- ☐ **None of the above apply to any applicant(s)**

I. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Nasal septal defect
- ☐ Sinusitis, tonsillitis or otitis media
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above apply to any applicant(s)**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- ☐ Attempted suicide
- ☐ Counseling or psychiatric treatment (in-patient or out-patient)
- ☐ Bipolar disorder, obsessive compulsive disorder or developmental disorder
- ☐ Eating disorder
- ☐ Any other mental, emotional disorder or situation, including ADD/ADHD
- ☐ **None of the above apply to any applicant(s)**

K. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Pending Surgery Surgery Date: __/__/__
- ☐ Sarcoidosis
- ☐ Breast implants
  ☐ Saline ☐ Silicone Surgery Date: __/__/__
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above apply to any applicant(s)**

(Continued on page 7)

23 MEDICAL QUESTIONNAIRE (continued)

2. Has any applicant ever:

☐ Yes ☐ No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?

☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?

☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?

☐ Yes ☐ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain:_____

☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 23. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.**

Question Number(s)	Person Treated	Specific Disorder/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					

24 PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit**	Treatment/ Results**

*Please write **NO VISIT** in this box if the applicant has never seen the physician. **Use "Comments" section on Page 9 if more room is needed for details.

(Continued on page 8)

PLEASE READ BEFORE SIGNING

By completing this list bill application, which authorizes my employer to remit my premium to Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), I understand and agree: (1) My employer will payroll deduct my premium from my compensation and remit the premium amount to COMPANY. (2) My employer is not acting as an agent of COMPANY but is, instead, at all times acting as my representative. (3) I am responsible for the payment of the premium. Therefore, if my employer fails to submit the required amounts when due, all coverage will terminate as of the due date. (4) If my employer fails to submit the required amounts when due, COMPANY has no obligation to seek payment directly from me. (5) I will not hold COMPANY liable for loss of coverage or benefits due to failure by my employer to remit payment in a timely manner. (6) My coverage is not dependent upon this billing arrangement; therefore, I may change to having COMPANY bill me directly with 15 days advance written notice to my employer and COMPANY. (7) I understand that termination of my employment shall terminate payroll deduction and employer remittance of premium to COMPANY. (8) I understand that my employer or COMPANY may terminate this arrangement by giving me written notice, but this will not terminate my insurance coverage. (9) If this payroll deduction and premium remittance is terminated, in order for me to keep my insurance coverage in force, I must make premium payments directly to COMPANY.

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) **If I am age 19 or older, I will not have any benefits provided for 12 months for the treatment of any condition which existed before the effective date of my coverage**. (3) The agent or broker involved in this insurance transaction may receive compensation from the COMPANY or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (4) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (5) The COMPANY may phone me for additional information that may help with the timely processing of my application. (6) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Continued on page 9)

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured **OR** Parent/Legal Guardian's **(if policy for a minor)**	X	Date Signed
Spouse **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed

CUSTODIAL PARENT SECTION

If any dependents, under age 19, named on this application do NOT reside with the proposed insured, the custodial parent's signature is required.

Custodial Parent's Name and Address **(please print)**	X	Telephone No.
Custodial Parent's Signature	X	Date Signed

Comments:

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 1st of the **month after next** if the application is approved on the 11th through the end of the **current month**.

Approval Date	Effective Date	Examples
1st - 10th	1st of the following month	Approved Jan. 2; effective Feb. 1
11th - last day of the month	1st of the month after next	Approved Jan. 27; effective Mar. 1

Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181
www.ArkansasBlueCross.com

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

FARM BUREAU ARKANSAS

List Bill Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "*Relationship*" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 15 – TYPE OF COVERAGE

- If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.

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

Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq.*, the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq.* Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

Applicants age 18 and older

This authorization must be signed by each applicant age 18 or older.

Print Name(s)	Signature	Date
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____

Applicants under age 18

List applicants under age 18 (Print Name).

_____

_____

_____

_____

_____ _____ ____/____/____

Parent/Legal Guardian's Signature (if policy for a minor) Date

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

Application for Health Insurance

FARM BUREAU ARKANSAS

1 WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				Self				___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.

2 PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship **(Check One)**
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

3 MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

4 U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 4 before completing.

☐ Yes ☐ No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name:_____ Name:_____

5 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street	City	State	Zip
		AR	

6 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip

7 BILLING MODE

List Bill #: _____

8 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-mail Address	How do you prefer we communicate with you?
( )	( )	AM PM		☐ E-mail ☐ Phone

9 HOUSEHOLD INFORMATION

☐ Yes ☐ No a. Do all applicants reside in the same household? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

☐ Yes ☐ No b. Do all applicants reside in Arkansas? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason:_____

OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

(Continued on page 2)

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: _____ Employer: _____

Job Duties: _____

Name: _____ Employer: _____

Job Duties: _____

11 CURRENT/PREVIOUS INSURANCE INFORMATION

☐ Yes ☐ No a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

i. If "yes," please provide name of carrier:_____

ii. If "yes," does the **coverage** have a specified termination date? If so, please provide date: __/__/__.

☐ Yes ☐ No iii. If "yes," and the coverage does **not** have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?

☐ Yes ☐ No b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No d. Will any applicants be **continuing** any other health insurance? If yes, please provide:
Name: _____ Carrier Name: _____ ID# _____
Name: _____ Carrier Name: _____ ID# _____

☐ Yes ☐ No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below:
Name: _____
Name: _____

☐ Yes ☐ No f. Are any applicants covered by Medicare? If "yes,"please provide name(s) below:
Name: _____
Name: _____

12 DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]

Name: _____ License No. : _____ State:_____

Name: _____ License No.: _____ State:_____

Name: _____ License No.: _____ State:_____

In the past 5 years, has any applicant:

☐ Yes ☐ No a. Had his or her driver's license suspended or revoked?
☐ Yes ☐ No b. Had two or more moving traffic violations?
☐ Yes ☐ No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?

If you answered "yes," to any of the above questions, you **MUST** provide the following information**:**

Name: _____ Date: _____/_____/_____ Violation(s): _____

Name: _____ Date: _____/_____/_____ Violation(s): _____

13 SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name: _____ Please explain: _____

Name: _____ Please explain: _____

14 TRAVEL OUTSIDE THE USA

☐ Yes ☐ No Is any applicant planning to travel or work outside the USA within the next two years?
If "yes," please provide the following:

Name (list **all** that apply): _____

Country: _____ Expected Length of Stay: _____ Departure date: _____Return date: _____

Reason for Travel: _____

_____

(Continued on page 3)

15 TYPE OF COVERAGE

☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Individual, Spouse and Child(ren)

☐ Yes ☐ No If you are applying for coverage other than "Individual," are you interested in coverage if one or more applicants is declined or ineligible?

16 BENEFITS SELECTION

MUST CHOOSE ONE BOX ONLY

Comprehensive Blue PPO III

- ☐ $ 1, 000 deductible
- ☐ $ 1, 500 deductible
- ☐ $ 2,500 deductible
- ☐ $ 5,000 deductible
- ☐ $ 7,500 deductible
- ☐ $10,000 deductible
- ☐ $15,000 deductible
- ☐ $20,000 deductible
- ☐ $25,000 deductible

HSA Blue PPO II

- ☐ $ 1,500 individual/ $ 3,000 family deductible
- ☐ $ 2,500 individual/ $ 5,000 family deductible
- ☐ $ 5,000 individual/ $10,000 family deductible

17 OPTIONAL BENEFITS SELECTION

OPTIONAL MATERNITY BENEFITS

☐ Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. There is no per pregnancy dollar maximum. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

(Continued on page 4)

18 EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is any **male** applying for coverage an expectant father or a potential adoptive father?

☐ Yes ☐ No Is any **female** applying for coverage pregnant or a potential adoptive mother?

If "yes," please provide the following: Name: _____ Expected Delivery/Adoption Date: ____/_____/_____

19 INFERTILITY

Has any applicant or spouse of a proposed applicant **(whether applying for coverage or not)**:

☐ Yes ☐ No a. Ever been diagnosed or treated for infertility?

☐ Yes ☐ No b. Had surgical sterilization? If "yes" to question a. or b., please provide the following:

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

20 TOBACCO USAGE

☐ Yes ☐ No Has any applicant to be covered used any form of tobacco within the last 12 months? If "yes," please provide the following:

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

21 PREVIOUS INSURANCE EXPERIENCE

☐ Yes ☐ No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:

Name: _____ Carrier Name: _____ Year: _____ Details: _____

Name: _____ Carrier Name: _____ Year: _____ Details: _____

22 PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any proposed applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years?**

If you answered "yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated**. A print out from the pharmacy is **not** acceptable. **Please provide the name that would have been used at the time of the prescription — e.g., a maiden name may have been used**.

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				

(Continued on page 5)

23 MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked.** When multiple medical conditions are listed, please circle **all conditions that apply.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cerebral palsy
- ☐ Concussion or brain injury
- ☐ Convulsions, epilepsy or seizures
- ☐ Headaches or migraines
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above apply to any applicant(s)**

B. CIRCULATORY

- ☐ Abnormal cholesterol/lipids
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Valve repair/replacement
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above apply to any applicant(s)**

C. DIGESTIVE

- ☐ Cirrhosis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Hernia, hemorrhoids
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above apply to any applicant(s)**

D. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Cesarean section or miscarriage
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the male reproductive organs, including prostate
- ☐ Any other disorder of the female reproductive organs, including ovaries or breasts
- ☐ **None of the above apply to any applicant(s)**

E. RESPIRATORY

- ☐ Allergies, asthma or bronchitis
- ☐ Chronic pulmonary disease, emphysema, lung disease or respiratory synctyial virus (RSV)
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea, cpap, bipap or vpap
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above apply to any applicant(s)**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer, leukemia or malignancy of any kind
- ☐ Hodgkin's or Non-Hodgkin's disease
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ **None of the above apply to any applicant(s)**

G. GLANDULAR DISORDERS

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Goiter or thyroid disease
- ☐ Any disorder of the pancreas
- ☐ **None of the above apply to any applicant(s)**

H. MUSCULOSKELETAL

- ☐ Arthritis, osteoarthritis, degenerative joint or disc disease
- ☐ Back pain and/or neck pain
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- ☐ Fibromyalgia, bursitis or tendonitis

MUSCULOSKELETAL (cont.)

- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Gout
- ☐ Lupus, systemic
- ☐ Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- ☐ Any other disorder of the muscles, bones or joints to include chiropractic care
- ☐ **None of the above apply to any applicant(s)**

I. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Nasal septal defect
- ☐ Sinusitis, tonsillitis or otitis media
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above apply to any applicant(s)**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- ☐ Attempted suicide
- ☐ Counseling or psychiatric treatment (in-patient or out-patient)
- ☐ Bipolar disorder, obsessive compulsive disorder or developmental disorder
- ☐ Eating disorder
- ☐ Any other mental, emotional disorder or situation, including ADD/ADHD
- ☐ **None of the above apply to any applicant(s)**

K. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Pending Surgery Surgery Date: __/__/__
- ☐ Sarcoidosis
- ☐ Breast implants
  ☐ Saline ☐ Silicone Surgery Date: __/__/__
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above apply to any applicant(s)**

(Continued on page 6)

23 MEDICAL QUESTIONNAIRE (continued)

2. Has any applicant ever:

☐ Yes ☐ No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?

☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?

☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?

☐ Yes ☐ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain:_____

☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 23. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.**

Question Number(s)	Person Treated	Specific Disorder/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					

24 PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit**	Treatment/ Results**

*Please write **NO VISIT** in this box if the applicant has never seen the physician. **Use "Comments" section on Page 9 if more room is needed for details.

(Continued on page 7)

Applicant must read and initial all sections

Initials

12-Month Pre-Existing Conditions Exclusion Period

I understand that all persons, age 19 or older, approved for coverage will have a 12-month pre-existing exclusions waiting period. A pre-existing condition or disease is one that causes symptoms, before the effective date of the policy, that would have caused an ordinarily prudent person to seek diagnosis, care or treatment. This also applies to aggravations of such conditions or diseases.

Initials

Fraud or Misrepresentation

I understand that if I knowingly present intentional misrepresentations of material fact provided by me on this application, my policy may be reformed or rescinded.

Initials

Maternity Rider

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. There is no per pregnancy dollar maximum. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

Agent Initials

I have thoroughly reviewed all of the information above with the applicant(s).

(Continued on page 8)

PLEASE READ BEFORE SIGNING

By completing this list bill application, which authorizes my employer to remit my premium to Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), I understand and agree: (1) My employer will payroll deduct my premium from my compensation and remit the premium amount to COMPANY. (2) My employer is not acting as an agent of COMPANY but is, instead, at all times acting as my representative. (3) I am responsible for the payment of the premium. Therefore, if my employer fails to submit the required amounts when due, all coverage will terminate as of the due date. (4) If my employer fails to submit the required amounts when due, COMPANY has no obligation to seek payment directly from me. (5) I will not hold COMPANY liable for loss of coverage or benefits due to failure by my employer to remit payment in a timely manner. (6) My coverage is not dependent upon this billing arrangement; therefore, I may change to having COMPANY bill me directly with 15 days advance written notice to my employer and COMPANY. (7) I understand that termination of my employment shall terminate payroll deduction and employer remittance of premium to COMPANY. (8) I understand that my employer or COMPANY may terminate this arrangement by giving me written notice, but this will not terminate my insurance coverage. (9) If this payroll deduction and premium remittance is terminated, in order for me to keep my insurance coverage in force, I must make premium payments directly to COMPANY.

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) **If I am age 19 or older, I will not have any benefits provided for 12 months for the treatment of any condition which existed before the effective date of my coverage**. (3) The agent or broker involved in this insurance transaction may receive compensation from the COMPANY or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (4) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (5) The COMPANY may phone me for additional information that may help with the timely processing of my application. (6) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(Continued on page 9)

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured **OR** Parent/Legal Guardian's **(if policy for a minor)**	X	Date Signed
Spouse **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed

CUSTODIAL PARENT SECTION

If any dependents, under age 19, named on this application do NOT reside with the proposed insured, the custodial parent's signature is required.

Custodial Parent's Name and Address **(please print)**	X	Telephone No.
Custodial Parent's Signature	X	Date Signed

This section to be completed by sales representative

☐ Yes ☐ No To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

Sales Rep License No. (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. **71-0179203**	Sales Representative's Signature X	Date Signed

Comments:

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 1st of the **month after next** if the application is approved on the 11th through the end of the **current month**.

Approval Date	Effective Date	Examples
1st - 10th	1st of the following month	Approved Jan. 2; effective Feb. 1
11th - last day of the month	1st of the month after next	Approved Jan. 27; effective Mar. 1

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 2181, Little Rock, AR 72203-2181
www.ArkansasBlueCross.com

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

Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "*Relationship*" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 12 – REQUESTED EFFECTIVE DATE

- The applicant should check preference for 1st or 15th of the month effective date. This is the applicant's opportunity to request the effective date coordinates with the termination of current health insurance coverage. While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If the application is approved, the effective date will be assigned based on the date of approval. This means retroactive effective dates will not be assigned.

SECTION 16 – TYPE OF COVERAGE

- If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.

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

Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

Applicants age 18 and older

This authorization must be signed by each applicant age 18 or older.

Print Name(s)	Signature	Date
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____

Applicants under age 18

List applicants under age 18 (Print Name).

_____

_____

_____

_____

_____ _____ ____/____/____

Parent/Legal Guardian's Signature (if policy for a minor) — Date

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

Application for Health Insurance

For Arkansas Blue Cross Use Only
This application was received by:
☐ C ☐ NW ☐ NE ☐ WC
☐ SC ☐ SW ☐ SE ☐ Customer Service
☐ Retail Store
Date Stamp _____

1 WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				Self				___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.

2 PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship **(Check One)**
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

3 MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

4 U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 4 before completing.

☐ Yes ☐ No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name:_____ Name:_____

5 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street	City	State	Zip
		AR	

6 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip

7 BILLING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip

8 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-mail Address	How do you prefer we communicate with you?
( )	( )	AM PM		☐ E-mail ☐ Phone

9 HOUSEHOLD INFORMATION

☐ Yes ☐ No a. Do all applicants reside in the same household? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

☐ Yes ☐ No b. Do all applicants reside in Arkansas? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason:_____

OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

(Continued on page 2)

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: _____ Employer: _____

Job Duties: _____

Name: _____ Employer: _____

Job Duties: _____

11 CURRENT/PREVIOUS INSURANCE INFORMATION

☐ Yes ☐ No a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

i. If "yes," please provide name of carrier:_____

ii. If "yes," does the **coverage** have a specified termination date? If so, please provide date: __/__/__.

☐ Yes ☐ No iii. If "yes," and the coverage does **not** have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?

☐ Yes ☐ No b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No d. Will any applicants be **continuing** any other health insurance? If yes, please provide:
Name: _____ Carrier Name: _____ ID# _____
Name: _____ Carrier Name: _____ ID# _____

☐ Yes ☐ No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below:
Name: _____
Name: _____

☐ Yes ☐ No f. Are any applicants covered by Medicare? If "yes,"please provide name(s) below:
Name: _____
Name: _____

12 REQUESTED EFFECTIVE DATE

Arkansas Blue Cross and Blue Shield gives 1st of the month and 15th of the month effective dates. This is your opportunity to request an effective date that coordinates with the termination of current health insurance coverage.* While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If your application is approved, the effective date will be assigned based on the date of approval **(see back page for effective date guidelines)**. This means retroactive effective dates will not be assigned. **Please check the day you would like your coverage to become effective:**

☐ 1st of the month ☐ 15th of the month ☐ No preference ☐ ***Requested** effective date: ___/___/_____

13 DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]

Name: _____ License No. : _____ State:_____
Name: _____ License No.: _____ State:_____
Name: _____ License No.: _____ State:_____

In the past 5 years, has any applicant:

☐ Yes ☐ No a. Had his or her driver's license suspended or revoked?
☐ Yes ☐ No b. Had two or more moving traffic violations?
☐ Yes ☐ No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?

If you answered "yes," to any of the above questions, you **MUST** provide the following information**:**

Name: _____ Date: _____/_____/_____ Violation(s): _____

Name: _____ Date: _____/_____/_____ Violation(s): _____

14 SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name: _____ Please explain: _____

Name: _____ Please explain: _____

 (Continued on page 3)

15 TRAVEL OUTSIDE THE USA

☐ Yes ☐ No Is any applicant planning to travel or work outside the USA within the next two years?
If "yes," please provide the following:

Name (list **all** that apply): _____

Country: _____ Expected Length of Stay: _____ Departure date: _____Return date: _____

Reason for Travel: _____

16 TYPE OF COVERAGE

Read instructions for Section 16 before completing.

☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Individual, Spouse and Child(ren)

☐ Yes ☐ No If you are applying for coverage other than "Individual," do you want to continue the application process if one or more applicants is declined or ineligible?

17 BILLING MODE

☐ Monthly Bank Draft
(Must complete attached bank draft form)

☐ Quarterly Invoice

☐ Semi-Annual Invoice

☐ Annual Invoice

MUST CHOOSE ONE BOX ONLY

Comprehensive Blue PPO III

- ☐ $ 1,000 deductible
- ☐ $ 1,500 deductible
- ☐ $ 2,500 deductible
- ☐ $ 5,000 deductible
- ☐ $ 7,500 deductible
- ☐ $10,000 deductible
- ☐ $15,000 deductible
- ☐ $20,000 deductible
- ☐ $25,000 deductible

HSA Blue PPO II

- ☐ $ 1,500 individual/ $ 3,000 family deductible
- ☐ $ 2,500 individual/ $ 5,000 family deductible
- ☐ $ 5,000 individual/ $10,000 family deductible

19 OPTIONAL BENEFITS SELECTION

OPTIONAL MATERNITY BENEFITS

☐ Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

(Continued on page 4)

19 OPTIONAL BENEFITS SELECTION (continued)

OPTIONAL CRITICAL ILLNESS COVERAGE

IMPORTANT NOTE: To be eligible for a Health Savings Account (HSA), you cannot be covered by insurance other than an HSA-compatible plan. Our critical illness policy should be considered "other insurance."

Underwritten and billed separately by USAble Life. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the critical illness coverage policy referenced here.

Critical Illness Coverage is available only on the proposed insured and spouse. (Proposed insured must be 19-64 years of age.) This coverage pays a lump sum cash benefit upon the first positive diagnosis of a covered critical illness.

Choose only one of the following:

☐ Proposed Insured

☐ Proposed Insured **and** Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts: ☐ $10,000 ☐ $20,000 ☐ $30,000

If both the proposed insured and spouse choose Critical Illness Coverage, the coverage amounts will be the same.

Replacement: Is this insurance to replace or change other insurance? ☐ Yes ☐ No

If "yes," give details including name of company _____

I understand no person to be insured is also covered by any Title XIX program — Medicaid or any similar name.

OPTIONAL TERM LIFE

Underwritten by USAble Life and billed with your health insurance. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life policy referenced here.

Term Life is available only on the proposed insured and spouse. (Proposed insured must be 19 - 64 years of age.)

Choose only one of the following:

☐ Proposed Insured

☐ Proposed Insured **and** Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts: ☐$10,000 ☐ $30,000 ☐ $50,000

If both the proposed insured and spouse choose Term Life, the coverage amounts will be the same.

- Benefits will be paid to the designated beneficiary(ies) in one lump sum.
- Premiums are based on the age of the oldest person applying for coverage and increase when that person's age moves to the next age bracket. Your monthly premiums will be billed with your Arkansas Blue Cross and Blue Shield health insurance coverage.
- Your Term Life coverage will become effective at the same time as your Arkansas Blue Cross and Blue Shield health insurance coverage.

Beneficiary Designation for Optional Term Life Insurance Benefits

I hereby designate the following beneficiary(ies) for the USAble Life Term Life insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive will share equally unless specified otherwise.

The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of proposed insured.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
				Total must equal 100% =	

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
				Total must equal 100% =	

(Continued on page 5)

20 EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is any **male** applying for coverage an expectant father or a potential adoptive father?

☐ Yes ☐ No Is any **female** applying for coverage pregnant or a potential adoptive mother?

If "yes," please provide the following: Name: _____ Expected Delivery/Adoption Date: ____/_____/_____

21 INFERTILITY

Has any applicant or spouse of a proposed applicant **(whether applying for coverage or not)**:

☐ Yes ☐ No a. Ever been diagnosed or treated for infertility?

☐ Yes ☐ No b. Had surgical sterilization? If "yes" to question a. or b., please provide the following:

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

22 TOBACCO USAGE

☐ Yes ☐ No Has any applicant to be covered used any form of tobacco within the last 12 months? If "yes," please provide the following:

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

23 PREVIOUS INSURANCE EXPERIENCE

☐ Yes ☐ No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:

Name: _____ Carrier Name: _____ Year: _____ Details: _____

Name: _____ Carrier Name: _____ Year: _____ Details: _____

24 PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any proposed applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years?**

If you answered "yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated**. A print out from the pharmacy is **not** acceptable. **Please provide the name that would have been used at the time of the prescription — e.g., a maiden name may have been used**.

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				

(Continued on page 6)

25 MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked.** When multiple medical conditions are listed, please **circle all conditions that apply.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cerebral palsy
- ☐ Concussion or brain injury
- ☐ Convulsions, epilepsy or seizures
- ☐ Headaches or migraines
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above apply to any applicant(s)**

B. CIRCULATORY

- ☐ Abnormal cholesterol/lipids
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Valve repair/replacement
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above apply to any applicant(s)**

C. DIGESTIVE

- ☐ Cirrhosis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Hernia, hemorrhoids
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above apply to any applicant(s)**

D. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Cesarean section or miscarriage
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the male reproductive organs, including prostate
- ☐ Any other disorder of the female reproductive organs, including ovaries or breasts
- ☐ **None of the above apply to any applicant(s)**

E. RESPIRATORY

- ☐ Allergies, asthma or bronchitis
- ☐ Chronic pulmonary disease, emphysema, lung disease or respiratory synctyial virus (RSV)
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea, cpap, bipap or vpap
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above apply to any applicant(s)**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer, leukemia or malignancy of any kind
- ☐ Hodgkin's or Non-Hodgkin's disease
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ **None of the above apply to any applicant(s)**

G. GLANDULAR DISORDERS

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Goiter or thyroid disease
- ☐ Any disorder of the pancreas
- ☐ **None of the above apply to any applicant(s)**

H. MUSCULOSKELETAL

- ☐ Arthritis, osteoarthritis, degenerative joint or disc disease
- ☐ Back pain and/or neck pain
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- ☐ Fibromyalgia, bursitis or tendonitis

MUSCULOSKELETAL (cont.)

- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Gout
- ☐ Lupus, systemic
- ☐ Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- ☐ Any other disorder of the muscles, bones or joints to include chiropractic care
- ☐ **None of the above apply to any applicant(s)**

I. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Nasal septal defect
- ☐ Sinusitis, tonsillitis or otitis media
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above apply to any applicant(s)**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- ☐ Attempted suicide
- ☐ Counseling or psychiatric treatment (in-patient or out-patient)
- ☐ Bipolar disorder, obsessive compulsive disorder or developmental disorder
- ☐ Eating disorder
- ☐ Any other mental, emotional disorder or situation, including ADD/ADHD
- ☐ **None of the above apply to any applicant(s)**

K. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Pending Surgery Surgery Date: __/__/__
- ☐ Sarcoidosis
- ☐ Breast implants
  ☐ Saline ☐ Silicone Surgery Date: __/__/__
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above apply to any applicant(s)**

(Continued on page 7)

25 MEDICAL QUESTIONNAIRE (continued)

2. Has any applicant ever:

☐ Yes ☐ No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?

☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?

☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?

☐ Yes ☐ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain:_____

☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 25. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.**

Question Number(s)	Person Treated	Specific Disorder/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					

26 PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit**	Treatment/ Results**

*Please write **NO VISIT** in this box if the applicant has never seen the physician. **Use "Comments" section on Page 8 if more room is needed for details.

(Continued on page 8)

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. I will also be subject to a 12-month pre-existing waiting period. **This means conditions existing prior to the effective date of the policy will not be covered until the policy has been in effect for 12 months.** If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (3) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (4) The COMPANY may phone me for additional information that may help with the timely processing of my application. (5) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured OR Parent/Legal Guardian's **(if policy for a minor)**	X	Date Signed
Spouse **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the proposed insured or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name and Address **(please print)**	X	Telephone No.
Custodial Parent's Signature	X	Date Signed

This section to be completed by sales representative

☐ Yes ☐ No To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

Sales Rep License No. (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. (If applicable)	Sales Representative's Signature X	Date Signed

Comments:

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Pre-Authorized Bank Draft | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Complete the information below.

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and/or the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

PROPOSED INSURED'S INFORMATION

First Name:_____ Last Name: _____

Address: _____
Street Apt. No.

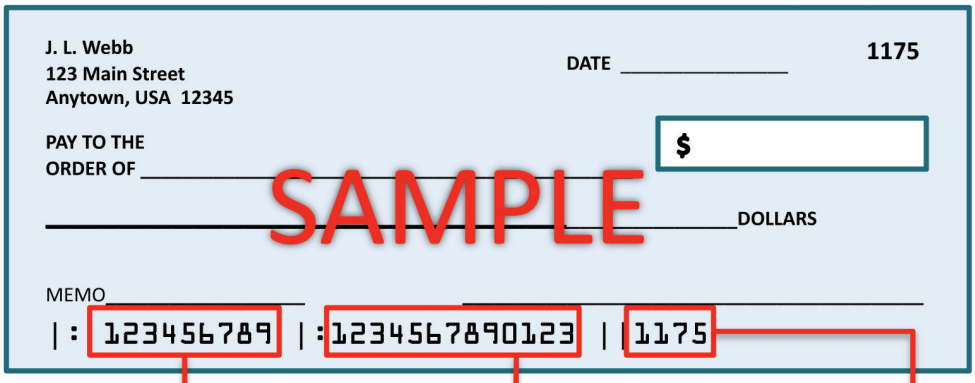
_____
City State Zip

BANK ACCOUNT INFORMATION

Bank Name:_____ Name on Account: _____
(If different than the proposed insured)

Routing Number:_____ Account Number: _____

Type of Account: ☐ Checking ☐ Savings



SIGNATURE

Signature: _____ Date: _____
Signature of Bank Account Holder

After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

For Office Use Only (please do not write in this space)

ID NO.	EFFECTIVE DATE

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

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life and critical illness policies referenced in your policy.

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 15th of the **following month** if the application is approved on the 11th - 25th of the **current month** OR the first of the month **after next** if the application is approved on the 26th - end of the **current month**. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

Approval Date	Effective Date	Examples
1st - 10th	1st of the following month	Approved Jan. 2; effective Feb. 1
11th - 25th	15th of the following month	Approved Jan. 12; effective Feb. 15
26th - last day of the month	1st of the month after next	Approved Jan. 27; effective Mar. 1

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

P.O. Box 2181, Little Rock, AR 72203-2181
www.ArkansasBlueCross.com

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

Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "*Relationship*" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 12 – REQUESTED EFFECTIVE DATE

- The applicant should check preference for 1st or 15th of the month effective date. This is the applicant's opportunity to request the effective date coordinates with the termination of current health insurance coverage. While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If the application is approved, the effective date will be assigned based on the date of approval. This means retroactive effective dates will not be assigned.

SECTION 16 – TYPE OF COVERAGE

- If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.

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

Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

Applicants age 18 and older

This authorization must be signed by each applicant age 18 or older.

Print Name(s)	Signature	Date
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____

Applicants under age 18

List applicants under age 18 (Print Name).

_____

_____

_____

_____

_____ _____ ____/____/____

Parent/Legal Guardian's Signature (if policy for a minor) — Date

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

Application for Health Insurance

1 WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				Self				___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.

2 PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship **(Check One)**
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

3 MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

4 U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 4 before completing.

☐ Yes ☐ No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name:_____ Name:_____

5 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street	City	State	Zip
		AR	

6 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip

7 BILLING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip

8 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-mail Address	How do you prefer we communicate with you?
( )	( )	AM PM		☐ E-mail ☐ Phone

9 HOUSEHOLD INFORMATION

☐ Yes ☐ No a. Do all applicants reside in the same household? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

☐ Yes ☐ No b. Do all applicants reside in Arkansas? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason:_____

OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

(Continued on page 2)

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: _____ Employer: _____

Job Duties: _____

Name: _____ Employer: _____

Job Duties: _____

11 CURRENT/PREVIOUS INSURANCE INFORMATION

☐ Yes ☐ No a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

i. If "yes," please provide name of carrier:_____

ii. If "yes," does the **coverage** have a specified termination date? If so, please provide date: __/__/__.

☐ Yes ☐ No iii. If "yes," and the coverage does **not** have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?

☐ Yes ☐ No b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No d. Will any applicants be **continuing** any other health insurance? If yes, please provide:
Name: _____ Carrier Name: _____ ID# _____
Name: _____ Carrier Name: _____ ID# _____

☐ Yes ☐ No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below:
Name: _____
Name: _____

☐ Yes ☐ No f. Are any applicants covered by Medicare? If "yes,"please provide name(s) below:
Name: _____
Name: _____

12 REQUESTED EFFECTIVE DATE

Arkansas Blue Cross and Blue Shield gives 1st of the month and 15th of the month effective dates. This is your opportunity to request an effective date that coordinates with the termination of current health insurance coverage.* While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If your application is approved, the effective date will be assigned based on the date of approval **(see back page for effective date guidelines)**. This means retroactive effective dates will not be assigned. **Please check the day you would like your coverage to become effective:**

☐ 1st of the month ☐ 15th of the month ☐ No preference ☐ ***Requested** effective date: ___/___/_____

13 DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]

Name: _____ License No. : _____ State:_____
Name: _____ License No.: _____ State:_____
Name: _____ License No.: _____ State:_____

In the past 5 years, has any applicant:

☐ Yes ☐ No a. Had his or her driver's license suspended or revoked?
☐ Yes ☐ No b. Had two or more moving traffic violations?
☐ Yes ☐ No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?

If you answered "yes," to any of the above questions, you **MUST** provide the following information**:**

Name: _____ Date: _____/_____/_____ Violation(s): _____

Name: _____ Date: _____/_____/_____ Violation(s): _____

14 SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name: _____ Please explain: _____

Name: _____ Please explain: _____

 (Continued on page 3)

15 TRAVEL OUTSIDE THE USA

☐ Yes ☐ No Is any applicant planning to travel or work outside the USA within the next two years?
If "yes," please provide the following:

Name (list **all** that apply): _____

Country: _____ Expected Length of Stay: _____ Departure date: _____Return date: _____

Reason for Travel: _____

16 TYPE OF COVERAGE

Read instructions for Section 16 before completing.

☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Individual, Spouse and Child(ren)

☐ Yes ☐ No If you are applying for coverage other than "Individual," do you want to continue the application process if one or more applicants is declined or ineligible?

17 BILLING MODE

☐ Monthly Bank Draft
(Must complete attached bank draft form)

☐ Quarterly Invoice

☐ Semi-Annual Invoice

☐ Annual Invoice

MUST CHOOSE ONE BOX ONLY

Comprehensive Blue PPO III

☐ **$ 1,000 deductible**

☐ **$ 1,500 deductible**

☐ **$ 2,500 deductible**

☐ **$ 5,000 deductible**

☐ **$ 7,500 deductible**

☐ **$10,000 deductible**

☐ **$15,000 deductible**

☐ **$20,000 deductible**

☐ **$25,000 deductible**

HSA Blue PPO II

☐ **$ 1,500 individual/ $ 3,000 family deductible**

☐ **$ 2,500 individual/ $ 5,000 family deductible**

☐ **$ 5,000 individual/ $10,000 family deductible**

19 OPTIONAL BENEFITS SELECTION

OPTIONAL MATERNITY BENEFITS

☐ Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

(Continued on page 4)

19 OPTIONAL BENEFITS SELECTION (continued)

OPTIONAL CRITICAL ILLNESS COVERAGE

IMPORTANT NOTE: To be eligible for a Health Savings Account (HSA), you cannot be covered by insurance other than an HSA-compatible plan. Our critical illness policy should be considered "other insurance."

Underwritten and billed separately by USAble Life. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the critical illness coverage policy referenced here.

Critical Illness Coverage is available only on the proposed insured and spouse. (Proposed insured must be 19-64 years of age.) This coverage pays a lump sum cash benefit upon the first positive diagnosis of a covered critical illness.

Choose only one of the following:

☐ Proposed Insured

☐ Proposed Insured **and** Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts: ☐ $10,000 ☐ $20,000 ☐ $30,000

If both the proposed insured and spouse choose Critical Illness Coverage, the coverage amounts will be the same.

Replacement: Is this insurance to replace or change other insurance? ☐ Yes ☐ No

If "yes," give details including name of company _____

I understand no person to be insured is also covered by any Title XIX program — Medicaid or any similar name.

OPTIONAL TERM LIFE

Underwritten by USAble Life and billed with your health insurance. USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life policy referenced here.

Term Life is available only on the proposed insured and spouse. (Proposed insured must be 19 - 64 years of age.)

Choose only one of the following:

☐ Proposed Insured

☐ Proposed Insured **and** Spouse (Spouse must also be applying for health insurance coverage on this application.)

Choose one of the following coverage amounts: ☐$10,000 ☐ $30,000 ☐ $50,000

If both the proposed insured and spouse choose Term Life, the coverage amounts will be the same.

- Benefits will be paid to the designated beneficiary(ies) in one lump sum.
- Premiums are based on the age of the oldest person applying for coverage and increase when that person's age moves to the next age bracket. Your monthly premiums will be billed with your Arkansas Blue Cross and Blue Shield health insurance coverage.
- Your Term Life coverage will become effective at the same time as your Arkansas Blue Cross and Blue Shield health insurance coverage.

Beneficiary Designation for Optional Term Life Insurance Benefits

I hereby designate the following beneficiary(ies) for the USAble Life Term Life insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive will share equally unless specified otherwise.

The beneficiary for the Term Life insurance on a covered spouse will be the proposed insured.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of proposed insured.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
				Total must equal 100% =	

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.)

Name (First, MI, Last)	Address	Social Security No.	Date of Birth	Relationship	Percentage Distribution
					+
					+
					+
				Total must equal 100% =	

(Continued on page 5)

20 EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is any **male** applying for coverage an expectant father or a potential adoptive father?

☐ Yes ☐ No Is any **female** applying for coverage pregnant or a potential adoptive mother?

If "yes," please provide the following: Name: _____ Expected Delivery/Adoption Date: ____/_____/_____

21 INFERTILITY

Has any applicant or spouse of a proposed applicant **(whether applying for coverage or not)**:

☐ Yes ☐ No a. Ever been diagnosed or treated for infertility?

☐ Yes ☐ No b. Had surgical sterilization? If "yes" to question a. or b., please provide the following:

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

22 TOBACCO USAGE

☐ Yes ☐ No Has any applicant to be covered used any form of tobacco within the last 12 months? If "yes," please provide the following:

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

23 PREVIOUS INSURANCE EXPERIENCE

☐ Yes ☐ No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:

Name: _____ Carrier Name: _____ Year: _____ Details: _____

Name: _____ Carrier Name: _____ Year: _____ Details: _____

24 PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any proposed applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years?**

If you answered "yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated**. A print out from the pharmacy is **not** acceptable. **Please provide the name that would have been used at the time of the prescription — e.g., a maiden name may have been used**.

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				

(Continued on page 6)

25 MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked.** When multiple medical conditions are listed, please **circle all conditions that apply.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cerebral palsy
- ☐ Concussion or brain injury
- ☐ Convulsions, epilepsy or seizures
- ☐ Headaches or migraines
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above apply to any applicant(s)**

B. CIRCULATORY

- ☐ Abnormal cholesterol/lipids
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Valve repair/replacement
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above apply to any applicant(s)**

C. DIGESTIVE

- ☐ Cirrhosis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Hernia, hemorrhoids
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above apply to any applicant(s)**

D. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Cesarean section or miscarriage
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the male reproductive organs, including prostate
- ☐ Any other disorder of the female reproductive organs, including ovaries or breasts
- ☐ **None of the above apply to any applicant(s)**

E. RESPIRATORY

- ☐ Allergies, asthma or bronchitis
- ☐ Chronic pulmonary disease, emphysema, lung disease or respiratory synctyial virus (RSV)
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea, cpap, bipap or vpap
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above apply to any applicant(s)**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer, leukemia or malignancy of any kind
- ☐ Hodgkin's or Non-Hodgkin's disease
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ **None of the above apply to any applicant(s)**

G. GLANDULAR DISORDERS

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Goiter or thyroid disease
- ☐ Any disorder of the pancreas
- ☐ **None of the above apply to any applicant(s)**

H. MUSCULOSKELETAL

- ☐ Arthritis, osteoarthritis, degenerative joint or disc disease
- ☐ Back pain and/or neck pain
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- ☐ Fibromyalgia, bursitis or tendonitis

MUSCULOSKELETAL (cont.)

- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Gout
- ☐ Lupus, systemic
- ☐ Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- ☐ Any other disorder of the muscles, bones or joints to include chiropractic care
- ☐ **None of the above apply to any applicant(s)**

I. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Nasal septal defect
- ☐ Sinusitis, tonsillitis or otitis media
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above apply to any applicant(s)**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- ☐ Attempted suicide
- ☐ Counseling or psychiatric treatment (in-patient or out-patient)
- ☐ Bipolar disorder, obsessive compulsive disorder or developmental disorder
- ☐ Eating disorder
- ☐ Any other mental, emotional disorder or situation, including ADD/ADHD
- ☐ **None of the above apply to any applicant(s)**

K. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Pending Surgery Surgery Date: __/__/__
- ☐ Sarcoidosis
- ☐ Breast implants
  ☐ Saline ☐ Silicone Surgery Date: __/__/__
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above apply to any applicant(s)**

(Continued on page 7)

25 MEDICAL QUESTIONNAIRE (continued)

2. Has any applicant ever:

☐ Yes ☐ No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?

☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?

☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?

☐ Yes ☐ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain:_____

☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 25. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.**

Question Number(s)	Person Treated	Specific Disorder/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					

26 PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit**	Treatment/ Results**

*Please write **NO VISIT** in this box if the applicant has never seen the physician. **Use "Comments" section on Page 8 if more room is needed for details.

(Continued on page 8)

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. I will also be subject to a 12-month pre-existing waiting period. **This means conditions existing prior to the effective date of the policy will not be covered until the policy has been in effect for 12 months.** If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (3) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (4) The COMPANY may phone me for additional information that may help with the timely processing of my application. (5) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured OR Parent/Legal Guardian's **(if policy for a minor)**	X	Date Signed
Spouse **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the proposed insured or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name and Address **(please print)**	X	Telephone No.
Custodial Parent's Signature	X	Date Signed

Comments:

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Pre-Authorized Bank Draft | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Complete the information below.

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and/or the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

PROPOSED INSURED'S INFORMATION

First Name:_____ Last Name: _____

Address: _____
Street Apt. No.

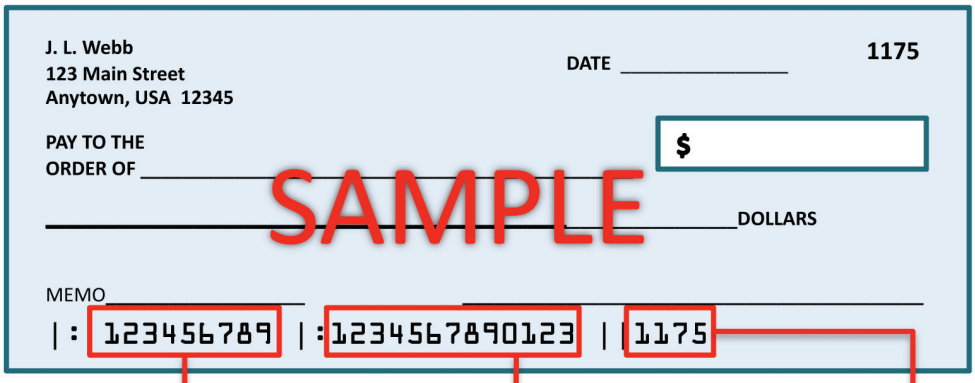
_____
City State Zip

BANK ACCOUNT INFORMATION

Bank Name:_____ Name on Account: _____
(If different than the proposed insured)

Routing Number:_____ Account Number: _____

Type of Account: ☐ Checking ☐ Savings



SIGNATURE

Signature: _____ Date: _____
Signature of Bank Account Holder

After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

For Office Use Only (please do not write in this space)

ID NO.	EFFECTIVE DATE

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

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life and critical illness policies referenced in your policy.

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 15th of the **following month** if the application is approved on the 11th - 25th of the **current month** OR the first of the month **after next** if the application is approved on the 26th - end of the **current month**. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

Approval Date	Effective Date	Examples
1st - 10th	1st of the following month	Approved Jan. 2; effective Feb. 1
11th - 25th	15th of the following month	Approved Jan. 12; effective Feb. 15
26th - last day of the month	1st of the month after next	Approved Jan. 27; effective Mar. 1

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

P.O. Box 2181, Little Rock, AR 72203-2181
www.ArkansasBlueCross.com

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

FARM BUREAU ARKANSAS

Individual/Family Health Insurance Application

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This application is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This application must be completed in dark blue or black ink. Applications completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this application.
- Any **attachments** submitted with the application must be signed and dated.
- **Do not send any money with this application.**
- Please ensure all required parties have signed and dated the application prior to submission.
- **We strongly recommend you make a copy of this completed application for your records.**

SECTION 1 – WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 (*Parent/Guardian*).
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "*Relationship*" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 8).
- If any dependents are under age 19 and do NOT reside with the proposed insured, the custodial parent must also sign the application (see *Signature Section* on Page 8).

SECTION 2 – PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 12 – REQUESTED EFFECTIVE DATE

- The applicant should check preference for 1st or 15th of the month effective date. This is the applicant's opportunity to request the effective date coordinates with the termination of current health insurance coverage. While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If the application is approved, the effective date will be assigned based on the date of approval. This means retroactive effective dates will not be assigned.

SECTION 16 – TYPE OF COVERAGE

- If applicant is applying for coverage other than "Individual," please indicate if still interested in coverage if one or more applicants is declined or ineligible. If "Yes" is selected, Arkansas Blue Cross will continue the underwriting process if one or more applicants is declined or ineligible. If "No" is selected, Arkansas Blue Cross will close out the application if one or more applicants is declined or ineligible.

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

Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

Applicants age 18 and older

This authorization must be signed by each applicant age 18 or older.

Print Name(s)	Signature	Date
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____

Applicants under age 18

List applicants under age 18 (Print Name).

_____

_____

_____

_____

_____ _____ ____/____/____

Parent/Legal Guardian's Signature (if policy for a minor) — Date

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

Application for Health Insurance

FARM BUREAU ARKANSAS

1 WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
				Self				___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.
								___ft.___in.	_____lbs.

2 PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship **(Check One)**
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

3 MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

4 U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 4 before completing.

☐ Yes ☐ No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name:_____ Name:_____

5 RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

Street	City	State	Zip
		AR	

6 MAILING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip

7 BILLING ADDRESS (Complete only if different from residential address)

Street or P.O. Box	City	State	Zip

8 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-mail Address	How do you prefer we communicate with you?
( )	( )	AM PM		☐ E-mail ☐ Phone

9 HOUSEHOLD INFORMATION

☐ Yes ☐ No a. Do all applicants reside in the same household? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

☐ Yes ☐ No b. Do all applicants reside in Arkansas? If "no," provide reason and his/her name and address:

Name: _____ Address: _____

Reason:_____

OFFICE USE ONLY (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

(Continued on page 2)

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: _____ Employer: _____

Job Duties: _____

Name: _____ Employer: _____

Job Duties: _____

11 CURRENT/PREVIOUS INSURANCE INFORMATION

☐ Yes ☐ No a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

i. If "yes," please provide name of carrier:_____

ii. If "yes," does the **coverage** have a specified termination date? If so, please provide date: __/__/__.

☐ Yes ☐ No iii. If "yes," and the coverage does **not** have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?

☐ Yes ☐ No b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No d. Will any applicants be **continuing** any other health insurance? If yes, please provide:
Name: _____ Carrier Name: _____ ID# _____
Name: _____ Carrier Name: _____ ID# _____

☐ Yes ☐ No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below:
Name: _____
Name: _____

☐ Yes ☐ No f. Are any applicants covered by Medicare? If "yes,"please provide name(s) below:
Name: _____
Name: _____

12 REQUESTED EFFECTIVE DATE

Arkansas Blue Cross and Blue Shield gives 1st of the month and 15th of the month effective dates. This is your opportunity to request an effective date that coordinates with the termination of current health insurance coverage.* While we cannot guarantee a specific requested effective date, we will make every effort to accommodate the request. If your application is approved, the effective date will be assigned based on the date of approval **(see back page for effective date guidelines)**. This means retroactive effective dates will not be assigned. **Please check the day you would like your coverage to become effective:**

☐ 1st of the month ☐ 15th of the month ☐ No preference ☐ ***Requested** effective date: ___/___/_____

13 DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]

Name: _____ License No. : _____ State:_____
Name: _____ License No.: _____ State:_____
Name: _____ License No.: _____ State:_____

In the past 5 years, has any applicant:

☐ Yes ☐ No a. Had his or her driver's license suspended or revoked?
☐ Yes ☐ No b. Had two or more moving traffic violations?
☐ Yes ☐ No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?

If you answered "yes," to any of the above questions, you **MUST** provide the following information**:**

Name: _____ Date: _____/_____/_____ Violation(s): _____

Name: _____ Date: _____/_____/_____ Violation(s): _____

14 SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name: _____ Please explain: _____

Name: _____ Please explain: _____

 (Continued on page 3)

15 TRAVEL OUTSIDE THE USA

☐ Yes ☐ No Is any applicant planning to travel or work outside the USA within the next two years?
If "yes," please provide the following:

Name (list **all** that apply): _____

Country: _____ Expected Length of Stay: _____ Departure date: _____ Return date: _____

Reason for Travel: _____

16 TYPE OF COVERAGE

Read instructions for Section 16 before completing.

☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Individual, Spouse and Child(ren)

☐ Yes ☐ No If you are applying for coverage other than "Individual," do you want to continue the application process if one or more applicants is declined or ineligible?

17 BILLING MODE

☐ Monthly Bank Draft (Must complete attached bank draft form)

☐ Quarterly Invoice

☐ Semi-Annual Invoice

☐ Annual Invoice

MUST CHOOSE ONE BOX ONLY

Comprehensive Blue PPO III

- ☐ $ 1,000 deductible
- ☐ $ 1,500 deductible
- ☐ $ 2,500 deductible
- ☐ $ 5,000 deductible
- ☐ $ 7,500 deductible
- ☐ $10,000 deductible
- ☐ $15,000 deductible
- ☐ $20,000 deductible
- ☐ $25,000 deductible

HSA Blue PPO II

- ☐ $ 1,500 individual/ $ 3,000 family deductible
- ☐ $ 2,500 individual/ $ 5,000 family deductible
- ☐ $ 5,000 individual/ $10,000 family deductible

19 OPTIONAL BENEFITS SELECTION

OPTIONAL MATERNITY BENEFITS

☐ Yes, I want to apply for the maternity benefits.

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

(Continued on page 4)

20 EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is any **male** applying for coverage an expectant father or a potential adoptive father?

☐ Yes ☐ No Is any **female** applying for coverage pregnant or a potential adoptive mother?

If "yes," please provide the following: Name: _____ Expected Delivery/Adoption Date: ____/_____/_____

21 INFERTILITY

Has any applicant or spouse of a proposed applicant **(whether applying for coverage or not)**:

☐ Yes ☐ No a. Ever been diagnosed or treated for infertility?

☐ Yes ☐ No b. Had surgical sterilization? If "yes" to question a. or b., please provide the following:

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

22 TOBACCO USAGE

☐ Yes ☐ No Has any applicant to be covered used any form of tobacco within the last 12 months? If "yes," please provide the following:

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

23 PREVIOUS INSURANCE EXPERIENCE

☐ Yes ☐ No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:

Name: _____ Carrier Name: _____ Year: _____ Details: _____

Name: _____ Carrier Name: _____ Year: _____ Details: _____

24 PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any proposed applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years?**

If you answered "yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated**. A print out from the pharmacy is **not** acceptable. **Please provide the name that would have been used at the time of the prescription — e.g., a maiden name may have been used**.

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				
				____/____ mo year ____/____ mo year				

(Continued on page 5)

25 MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked.** When multiple medical conditions are listed, please **circle all conditions that apply.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cerebral palsy
- ☐ Concussion or brain injury
- ☐ Convulsions, epilepsy or seizures
- ☐ Headaches or migraines
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above apply to any applicant(s)**

B. CIRCULATORY

- ☐ Abnormal cholesterol/lipids
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Valve repair/replacement
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above apply to any applicant(s)**

C. DIGESTIVE

- ☐ Cirrhosis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Hernia, hemorrhoids
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above apply to any applicant(s)**

D. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Cesarean section or miscarriage
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the male reproductive organs, including prostate
- ☐ Any other disorder of the female reproductive organs, including ovaries or breasts
- ☐ **None of the above apply to any applicant(s)**

E. RESPIRATORY

- ☐ Allergies, asthma or bronchitis
- ☐ Chronic pulmonary disease, emphysema, lung disease or respiratory synctyial virus (RSV)
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea, cpap, bipap or vpap
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above apply to any applicant(s)**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer, leukemia or malignancy of any kind
- ☐ Hodgkin's or Non-Hodgkin's disease
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ **None of the above apply to any applicant(s)**

G. GLANDULAR DISORDERS

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Goiter or thyroid disease
- ☐ Any disorder of the pancreas
- ☐ **None of the above apply to any applicant(s)**

H. MUSCULOSKELETAL

- ☐ Arthritis, osteoarthritis, degenerative joint or disc disease
- ☐ Back pain and/or neck pain
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- ☐ Fibromyalgia, bursitis or tendonitis

MUSCULOSKELETAL (cont.)

- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Gout
- ☐ Lupus, systemic
- ☐ Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- ☐ Any other disorder of the muscles, bones or joints to include chiropractic care
- ☐ **None of the above apply to any applicant(s)**

I. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Nasal septal defect
- ☐ Sinusitis, tonsillitis or otitis media
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above apply to any applicant(s)**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- ☐ Attempted suicide
- ☐ Counseling or psychiatric treatment (in-patient or out-patient)
- ☐ Bipolar disorder, obsessive compulsive disorder or developmental disorder
- ☐ Eating disorder
- ☐ Any other mental, emotional disorder or situation, including ADD/ADHD
- ☐ **None of the above apply to any applicant(s)**

K. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Pending Surgery Surgery Date: __/__/__
- ☐ Sarcoidosis
- ☐ Breast implants
  ☐ Saline ☐ Silicone Surgery Date: __/__/__
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above apply to any applicant(s)**

(Continued on page 6)

25 MEDICAL QUESTIONNAIRE (continued)

2. Has any applicant ever:

☐ Yes ☐ No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?

☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?

☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?

☐ Yes ☐ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain:_____

☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 25. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.**

Question Number(s)	Person Treated	Specific Disorder/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					

26 PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit**	Treatment/ Results**

*Please write **NO VISIT** in this box if the applicant has never seen the physician. **Use "Comments" section on Page 8 if more room is needed for details.

(Continued on page 7)

Applicant must read and initial all sections

Initials

12-Month Pre-Existing Conditions Exclusion Period

I understand that all persons, age 19 or older, approved for coverage will have a 12-month pre-existing exclusions waiting period. A pre-existing condition or disease is one that causes symptoms, before the effective date of the policy, that would have caused an ordinarily prudent person to seek diagnosis, care or treatment. This also applies to aggravations of such conditions or diseases.

Initials

Fraud or Misrepresentation

I understand that if I knowingly present intentional misrepresentations of material fact provided by me on this application, my policy may be reformed or rescinded.

Initials

Maternity Rider

Maternity benefits are payable once the maternity coverage has been in effect for 12 months. There is no per pregnancy dollar maximum. This benefit is only available to females age 19 or older. Dependents other than a covered spouse cannot purchase the maternity rider.

Agent Initials

I have thoroughly reviewed all of the information above with the applicant(s).

(Continued on page 8)

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application will be medically underwritten in order to assess the potential financial risk of each individual on the application. As the result of the assessment, if I am age 19 or older, my application may be approved with no changes, approved but charged a higher premium, I may have particular conditions or body parts excluded, or I may be declined for coverage. I will also be subject to a 12-month pre-existing waiting period. **This means conditions existing prior to the effective date of the policy will not be covered until the policy has been in effect for 12 months.** If I am under age 19, my application may be approved with no changes, approved with a higher premium, and/or offered coverage with non-medical exclusions. (2) The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (3) Any coverage which may be issued to me shall be invalid if based on intentional misrepresentation of material fact provided by me on the application. (4) The COMPANY may phone me for additional information that may help with the timely processing of my application. (5) The Health insurance and Term Life insurance applied for will not be effective on any proposed insured if there has been a change in the health of any proposed insured between the date this application is signed and the effective date of coverage.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (c) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (d) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (e) agree that this application shall be valid without time limit; (f) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Please sign appropriate line only)

Proposed Insured OR Parent/Legal Guardian's **(if policy for a minor)**	X	Date Signed
Spouse **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the proposed insured or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name and Address **(please print)**	X	Telephone No.
Custodial Parent's Signature	X	Date Signed

This section to be completed by sales representative

☐Yes ☐ No To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?

Sales Rep License No. (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. **71-0179203**	Sales Representative's Signature X	Date Signed

Comments:

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Pre-Authorized Bank Draft | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified in writing prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Complete the information below.

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and/or the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

PROPOSED INSURED'S INFORMATION

First Name:_____ Last Name: _____

Address: _____
Street Apt. No.

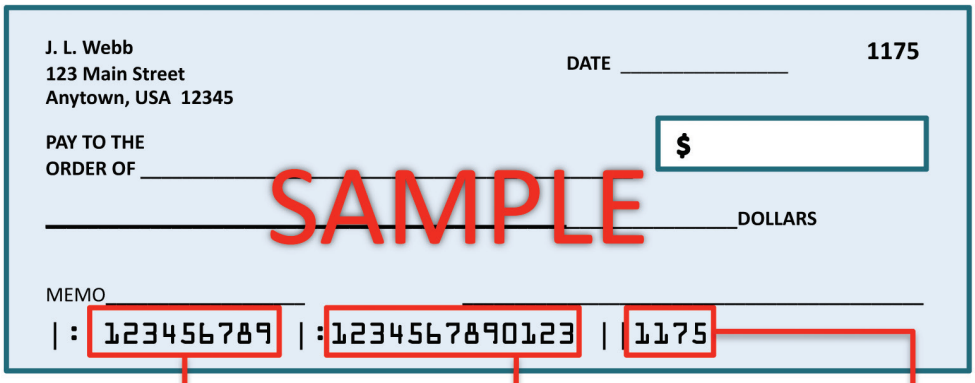
_____
City State Zip

BANK ACCOUNT INFORMATION

Bank Name:_____ Name on Account: _____
(If different than the proposed insured)

Routing Number:_____ Account Number: _____

Type of Account: ☐ Checking ☐ Savings



SIGNATURE

Signature: _____ Date: _____
Signature of Bank Account Holder

After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

For Office Use Only (please do not write in this space)

ID NO.	EFFECTIVE DATE

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

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life and critical illness policies referenced in your policy.

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

POLICY EFFECTIVE DATE

The policy effective date will be the first of the **following month** if the application is approved on the 1st-10th of the **current month**. The policy effective date will be the 15th of the **following month** if the application is approved on the 11th - 25th of the **current month** OR the first of the month **after next** if the application is approved on the 26th - end of the **current month**. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

Approval Date	Effective Date	Examples
1st - 10th	1st of the following month	Approved Jan. 2; effective Feb. 1
11th - 25th	15th of the following month	Approved Jan. 12; effective Feb. 15
26th - last day of the month	1st of the month after next	Approved Jan. 27; effective Mar. 1

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

P.O. Box 2181, Little Rock, AR 72203-2181
www.ArkansasBlueCross.com

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

Individual/Family Health Insurance Non-Underwriting Change Form

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. CHANGE FORM MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This form is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This change form must be completed in dark blue or black ink. Forms completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this form.
- Any **attachments** submitted with the change form must be signed and dated.
- **Do not send any money with this change form.**
- Please ensure all required parties have signed and dated the change form prior to submission.
- **We strongly recommend you make a copy of this completed change form for your records.**

****IMPORTANT INFORMATION REGARDING GRANDFATHERED PLANS****

Your Arkansas Blue Cross and Blue Shield coverage **may** be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Arkansas Blue Cross and Blue Shield Customer Service at 1-800-238-8379. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

INSTRUCTION SHEET

Changes to your policy can only be made during the annual open enrollment period, unless the change is a result of a qualifying life event, such as birth of a child, adoption, loss of other coverage, marriage, etc.

When you are completing this form, please refer to your Arkansas Blue Cross and Blue Shield identification card *for your Member ID and Group #. This information must be entered correctly under Section 1 in order to process your request*.

Effective Date: The effective date for any changes requested from a "qualifying life event" will be the next available effective date following approval. Changes requested during the annual open enrollment period will become effective the following January (the 1st or 15th of the month, depending on your billing date).

Billing Change: Any request made to change your billing will be based on the current billing date of your policy.

Section 3 – Address Changes

Any change to your current address information can be completed in **Section 3 – Address Changes**. We have provided three separate listings for this information. Only complete for addresses that are changing.

Residential – This address will be noted as your physical place of residence.

Mailing – Correspondence such as letters and Explanations of Benefits (EOBs) will be mailed to this address.

Billing – All billing invoices will be mailed to this address.

Section 5 – Name Change

Documentation is required for any name change request. Please complete **Section 5** – **Name Change** and attach appropriate documentation such as, a copy of your Marriage License, Divorce Decree, Adoption papers or other court papers to support the change.

Section 7 – Delete Person(s) From The Policy

Qualifying life event changes allow you to make changes to your policy outside of the annual open enrollment period. Such events include, but are not limited to (**please ensure all documentation is included**):

- Divorce/Legal Separation (requires a copy of divorce decree/legal separation)
- No longer an Arkansas resident (requires a date of move or date of notification)
- Marriage (requires a copy of the marriage certificate)
- Becoming eligible for other coverage (requires proof of eligibility of other coverage)
- Death (requires a copy of death certificate)

In the event you would like to **terminate coverage** for a covered person, including the policyholder, you can do so by completing **Section 7 – Delete Person(s) From The Policy.**

OR

You have the option to **maintain the person's coverage** by splitting him/her off onto a new individual policy with identical coverage. This will completely remove him/her from your coverage and create a new policy for the covered person. You can make this change by completing **Section 9 – Split Policy**. A signature is **required** by **both** the current policyholder and new policyholder. **Important Note:** Complete one change form for each new policy you are requesting.

Section 8 – Ownership Changes

If both the policyholder and spouse are retaining coverage, but you would like to change the ownership of the policy from the current policyholder to the spouse, complete **Section 8 – Ownership Change**. Both the current policyholder and new policyholder must sign the change form.

Section 11 – Benefit Changes

- This section reflects all benefit options available for your policy.
- Please complete **only** the section for your specific policy.
- If you are unsure of your product name, use the product group numbers listed as a reference. Your product group number can be found on your identification card under **Group #**. It will be the first six numbers before the dash.
- If you still have questions, call customer service at **1-800-238-8379**.

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

Non-Underwriting Change Form For Current Policy

Return To: Arkansas Blue Cross and Blue Shield, Attn: Change Request, P.O. Box 2181, Little Rock, AR 72203-2181

1 CURRENT POLICYHOLDER INFORMATION

Member ID:_____ Group Number:_____ Date of Birth:____/____/____

First Name: _____ M.I.:_____ Last Name: _____

2 CONTACT INFORMATION

Primary Phone Number ( )	Alternate Phone Number ( )	Best Time to Call AM PM	E-mail Address	How do you prefer we communicate with you? ☐ E-mail ☐ Phone

CHANGES TO BE MADE

Please skip sections that do not apply to the change(s) you are making.

3 ADDRESS CHANGES

Residential Address: Street_____

City_____ State_____ Zip_____

Mailing Address: Street_____

City_____ State_____ Zip_____

Billing Address: Street_____

City_____ State_____ Zip_____

4 POLICY CHANGE ELIGIBILITY

Check all applicable boxes below that support your change request.

☐ 1-Annual Open Enrollment Period
☐ 2-Birth
☐ 3-Adoption
☐ 4-Death
☐ 5-Marriage
☐ 6-Divorce or Legal Separation
☐ 7-New Guardianship/Legal custody/court order to add child
☐ 8-Loss of employer-sponsored health coverage
☐ 9-Involuntary loss of other health coverage
☐ 10-Military Leave/Reinstatement
☐ 11-Other (Give specific details) _____

NOTE: If Change Form is **not** received during Open Enrollment Period, you must submit appropriate documentation with Change Form to confirm qualifying life event (i.e. copy of birth or death certificate, copy of marriage license, Certificate of Creditable Coverage from previous insurance company, guardianship/custody documentation, etc.)

5 NAME CHANGE

Additional documentation required. Read instructions for Section 5 before completing.

From: First Name _____ M.I._____ Last Name_____

To: First Name_____ M.I._____ Last Name_____

6 BILLING CHANGE

☐ Monthly Bank Draft (Must complete attached bank draft form) ☐ Quarterly Invoice ☐ Semi-Annual Invoice ☐ Annual Invoice

7 DELETE PERSON(S) FROM THE POLICY

First Name	M.I.	Last Name	Suffix	Date of Birth

(Continued on page 2)

8 OWNERSHIP CHANGE

From: First Name_____ M.I._____ Last Name_____

To: First Name_____ M.I._____ Last Name_____

9 SPLIT POLICY

Indicate the name of the covered person(s) you want covered on a separate policy with identical coverage.

First Name	M.I.	Last Name	Suffix	Date of Birth

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-Mail Address
( )	( )	AM PM	

Please provide Address Information for new Policyholder ONLY:

Residential Address: Street_____

City_____ State_____ Zip_____

Mailing Address: Street_____

City_____ State_____ Zip_____

Billing Address: Street_____

City_____ State_____ Zip_____

Please set up the billing mode for my new policy:

☐ Monthly Bank Draft (Must complete attached bank draft form) ☐ Quarterly Invoice ☐ Semi-Annual Invoice ☐ Annual Invoice

10 DELETE BENEFITS (see Products in section 11 for other optional riders)

☐ Term Life Insurance ☐ Maternity Rider ☐ Mental Health Parity

(Only applicable for Comprehensive Blue PPO and Comprehensive Blue PPO II)

11 BENEFIT CHANGES

IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

AccessBlue PPO **Group # 700101-700104 or 700201-700204 - Grandfathered**

Increase my calendar-year deductible to: ☐ $1,000 ☐ $2,500

AccessBlue PPO **Group # 300101-300104 or 300201-300204 - Non-Grandfathered**

Increase my calendar-year deductible to: ☐ $1,000 ☐ $2,500

Basic Blue PPO **Group # 710000 or 720000 - Grandfathered**

Delete the following benefit: ☐ Physician Office Visits Rider ☐ Prescription Drugs Rider

BlueCare PPO **Group # 600010-600016 or 600020-600026 - Grandfathered**
BlueCare PPO Plus **Group # 600030-600036 or 600040-600046 - Grandfathered**

Increase my calendar-year deductible to: ☐ $1,000 ☐ $1,500 ☐ $2,500*

Increase my calendar-year coinsurance maximum to: ☐ $5,000

*$2,500 has no coinsurance maximum

(Continued on page 3)

11 BENEFIT CHANGES (continued)

IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

Blue Choice Group # 771000-771023 or 781000-781020 - Grandfathered

Increase my calendar-year deductible and benefit to:

$500 Deductible Options
- ☐ $1,000 OOP* coinsurance maximum and EC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and CC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and EC Rx plan

$1,000 Deductible Options
- ☐ $1,000 OOP* coinsurance maximum and CC Rx plan
- ☐ $1,000 OOP* coinsurance maximum and EC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and CC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and EC Rx plan

$2,500 Deductible Options
- ☐ No OOP* coinsurance and CC Rx plan
- ☐ No OOP* coinsurance and EC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and CC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and EC Rx plan

*Out-of-Pocket

$5,000 Deductible Options
- ☐ $30/$50 copay and CC Rx plan
- ☐ $30/$50 copay and EC Rx plan
- ☐ No physician copays** and CC Rx plan
- ☐ No physician copays** and EC Rx plan

$10,000 Deductible Options
- ☐ $30/$50 copay and CC Rx plan
- ☐ $30/$50 copay and EC Rx plan
- ☐ No physician copays** and CC Rx plan
- ☐ No physician copays** and EC Rx plan

$25,000 Deductible Options
- ☐ $30/$50 copay and CC Rx plan
- ☐ $30/$50 copay and EC Rx plan
- ☐ No physician copays** and CC Rx plan
- ☐ No physician copays** and EC Rx plan

**Physician visits subject to deductible.

Blue Select Group # 601000-601007 or 602000-602007 - Grandfathered

Increase my calendar-year deductible to: ☐ $1,000 ☐ $1,500 ☐ $2,500

Increase my calendar-year coinsurance maximum to: ☐ $5,000

Delete the following benefit: ☐ SAE – Supplemental Accident Endorsement

Blue Solution Group # 770000-770003 or 780000-780003 - Grandfathered

Increase my calendar-year deductible to: ☐ $1,500 ☐ $3,000 ☐ $5,000

Comprehensive Blue PPO Group # 790000-790007 or 700000-700007 - Grandfathered
Comprehensive Blue PPO II Group # 791000-798000 or 701000-708000 - Grandfathered

Increase my calendar-year deductible to: ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000

Comprehensive Blue PPO Group # 300000-300007 or 390000-390007 - Non-Grandfathered
Comprehensive Blue PPO II Group # 391000-398000 or 301000-308000 - Non-Grandfathered

Increase my calendar-year deductible to: ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000

Comprehensive Blue PPO III Group # 700008-700016 or 790008-790016

Increase my calendar-year deductible to: ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000

Conversion Group # 902100-902140 - Grandfathered
Conversion Group # 302100-302140 - Non- Grandfathered

Increase my calendar-year deductible and benefit to:
- ☐ $ 500 Deductible, 80/20% Coinsurance, $5,000 Calendar-Year Coinsurance Maximum
- ☐ $1,000 Deductible, 80/20% Coinsurance, $5,000 Calendar-Year Coinsurance Maximum
- ☐ $1,000 Deductible, 80/20% Coinsurance, No Calendar-Year Coinsurance Maximum

HSA Blue PPO Group # 730000-730021 or 740000-740021 - Grandfathered
HSA Blue PPO Plus Group # 750000-750021 or 760000-760021 - Grandfathered

Increase my calendar-year deductible to:
- ☐ $3,000 Individual/$5,950 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum
- ☐ $3,000 Individual/$5,950 Family Deductible, 80/20% Coinsurance, $10,000 Individual/$20,000 Calendar-Year Coinsurance Maximum
- ☐ $5,950 Individual/$11,900 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

(Continued on page 4)

11 BENEFIT CHANGES (continued)

IMPORTANT NOTE: Increasing the calendar-year deductible means that any claims processed by Arkansas Blue Cross after the effective date of change, regardless of the date of the service(s), will be applied to the new higher deductible.

HSA Blue PPO II **Group # 711000-711005 or 722000-722005 - Grandfathered**

Increase my calendar-year deductible to:
- ☐ $2,500 Individual/$5,000 Family Deductible
- ☐ $5,000 Individual/$10,000 Family Deductible

HSA Blue PPO II **Group # 811000-811005 or 822000-822005 - Non-Grandfathered**

Increase my calendar-year deductible to:
- ☐ $2,500 Individual/$5,000 Family Deductible
- ☐ $5,000 Individual/$10,000 Family Deductible

Uniquecare **Group # 610100-611000, 620100-621000 or 650100-651000, or 660100-661000 - Grandfathered**
Uniquecare Blue **Group # 600100-600114, 600200-600214 or 600300-600311, or 600400-600410 - Grandfathered**
Uniquecare Blue Preferred **Group # 622001-622016, 633001-633016 or 622017-622024 or 633017-633025 - Grandfathered**
Farm Bureau Flexplan **Group # 809031-809046 or 809047-809058 - Grandfathered**
Farm Bureau Flexplan Preferred **Group # 808001-808027 or 808004-808028 - Grandfathered**

Decrease my calendar-year deductible and benefit to:

Deductible: ☐ $1,000* ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $25,000
*Not available with Part A (100% Coinsurance)

Choice of Plan: ☐ Plan A: 100%** Coinsurance ☐ Plan B: 80/20% Coinsurance ☐ Plan C: 50% Coinsurance
**Coinsurance Maximum amount not applicable

Calendar-Year Coinsurance Maximum: ☐ $10,000 ☐ $50,000
NOTE: Your coinsurance maximum must be greater than your deductible.

Delete the following Benefit: SAE – Supplemental Accident Endorsement

PLEASE READ BEFORE SIGNING

I understand: (1) This application may be rejected if the applicant is age 19 or older. (2) If accepted, the insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (3) If my application is accepted relying on my representations in this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (4) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (5) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. In signing below, I: represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded.

I certify that I signed this change form in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Please sign appropriate line only)

Current Policyholder **OR** Parent Legal/Guardian's (**if policy for a minor**)	(Please Print) X	Date Signed
	(Please Sign) X	
New Policyholder	X	Date Signed

COMMENTS

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Pre-Authorized Bank Draft

Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Just a few steps now help assure your payments are made accurately and timely.

1. **Complete the information below.**
2. **Mail this completed authorization form to:**

   Arkansas Blue Cross and Blue Shield
   Attn: Cashiers (Drafts)
   P.O. Box 3590
   Little Rock, AR 72203

Important: Please Read Before Signing

I authorize Arkansas Blue Cross and Blue Shield, USAble Life, and the BANK indicated below, to debit my Arkansas Blue Cross and/or USAble Life premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross and/or USAble Life coverage, UNLESS Arkansas Blue Cross and/or USAble Life has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

Insured's Information

First Name_____ Last Name _____

Address _____
Street Apt. No

_____
City State Zip

Arkansas Blue Cross and Blue Shield Member ID _____

Please check one of the following:

☐ Currently, the insured's premium is **not** drafted

☐ Currently, the insured's premium is drafted and the account information has changed

Bank Account Information

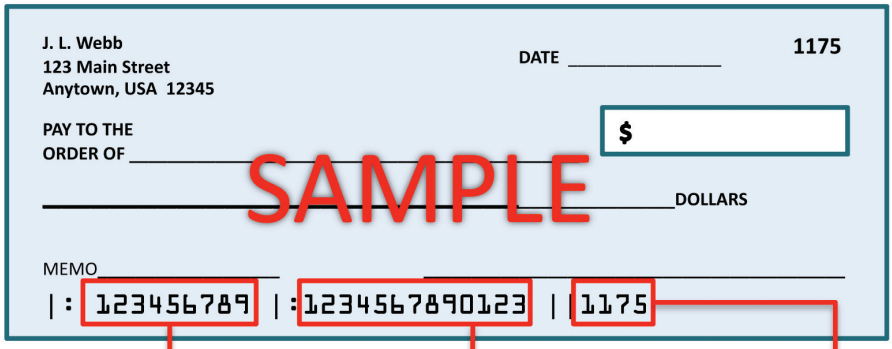
Bank Name_____

Routing Number_____

Name on Account _____
(If different than the insured)

Account Number _____

Type of Account: ☐ Checking ☐ Savings



Bank Routing Number **Bank Account Number** **Check Number**

Signature

Signature_____ Date_____
Signature of Bank Account Holder

After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

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

For Office Use Only (please do not write in this space)

ID NO.	EFFECTIVE DATE

USAble Life is an independent company and operates separately from Arkansas Blue Cross and Blue Shield. USAble Life does not sell or service Arkansas Blue Cross and Blue Shield products. USAble Life is solely responsible for the term life and critical illness policies referenced in your policy.

Arkansas
BlueCross BlueShield
P.O. Box 2181, Little Rock, AR 72203-2181

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

Individual/Family Health Insurance Underwriting Change Form

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS CHANGE FORM. CHANGE FORM MUST BE COMPLETED IN ITS ENTIRETY AND ALL PAGES MUST BE SUBMITTED IN ORDER TO BE PROCESSED.

- This form is a legal document. If you are approved for coverage, it will become a part of your contract. Therefore, all information provided must be accurate and legible.
- This change form must be completed in dark blue or black ink. Forms completed in **pencil** will not be accepted.
- If you make a mistake, mark through the incorrect information, initial it, date it, and provide the correct information.
- Do not use liquid paper, correction tape, or "white out" to correct any mistakes on this form.
- Any **attachments** submitted with the change form must be signed and dated.
- **Do not send any money with this change form.**
- Please ensure all required parties have signed and dated the change form prior to submission.
- **We strongly recommend you make a copy of this completed change form for your records.**

IMPORTANT INFORMATION REGARDING GRANDFATHERED PLANS

Your Arkansas Blue Cross and Blue Shield coverage **may** be a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Arkansas Blue Cross and Blue Shield Customer Service at 1-800-238-8379. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

INSTRUCTION SHEET

Changes to your policy can only be made during the annual open enrollment period, unless the change is a result of a qualifying life event such as birth of a child, adoption, loss of other coverage, marriage, etc.

When you are completing this form, please refer to your Arkansas Blue Cross and Blue Shield identification card *for your Member ID and Group #. This information must be entered correctly under Section 1 in order to process your request*.

Effective Date: The effective date for any changes requested as a result of a qualifying life event will be the next available effective date following approval. Changes requested during the annual open enrollment period will become effective the following January (the 1st or the 15th of the month, depending on your billing date).

SECTION 5 – U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or green card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

SECTION 6 – ADDING SPOUSE OR DEPENDENT(S)

Qualifying life event changes allow you to make changes to your policy outside of the annual open enrollment period. Such events include, but are not limited to:

- Obtaining guardianship, legal custody of a child, or court order requiring coverage for a dependent (requires proof of guardianship, legal custody or court order)
- Death of policyholder or covered member (requires a copy of death certificate)
- Loss of Eligibility (requires a Certificate of Creditable Coverage)
- Marriage (requires a copy of the marriage certificate)

SECTION 8 – BENEFIT CHANGES

- This section reflects all benefit options under your policy.
- Please complete **only** the section for your specific policy.
- If you are unsure of your product name, use the product group numbers listed as a reference. Your product group number can be found on your identification card under **Group #**. It will be the first six numbers before the dash.
- If you still have questions, call customer service at **1-800-238-8379**.

Detach and keep for you records.

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

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

Underwriting Change Form For Current Policy

Return To: Arkansas Blue Cross and Blue Shield, Attn: Individual Underwriting, P.O. Box 2181, Little Rock, AR 72203-2181

1 CURRENT POLICYHOLDER INFORMATION

Member ID:_____ Group Number:_____ Date of Birth: _____/_____/_____

First Name:_____ M.I.: ___ Last Name: _____ Social Security No.: _____

Residential Address: _____ City: _____ State: _____ Zip: _____

2 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-mail Address	How do you prefer we communicate with you?
( )	( )	AM PM		☐ E-mail ☐ Phone

CHANGES TO BE MADE

Regardless of the change(s) you are requesting, you must complete sections 9-21.

3 POLICY CHANGE ELIGIBILITY

Check all applicable boxes below that support your change request.

☐ 1-Annual Open Enrollment Period
☐ 2-Birth
☐ 3-Adoption
☐ 4-Death
☐ 5-Marriage
☐ 6-Divorce or Legal Separation
☐ 7-New Guardianship/Legal custody/court order to add child
☐ 8-Loss of employer-sponsored health coverage
☐ 9-Involuntary loss of other health coverage
☐ 10-Military Leave/Reinstatement
☐ 11-Other (Give specific details) _____

NOTE: If Change Form is **not** received during Open Enrollment Period, you must submit appropriate documentation with Change Form to confirm qualifying life event (i.e. copy of birth or death certificate, copy of marriage license, Certificate of Creditable Coverage from previous insurance company, guardianship/custody documentation, etc.)

4 POLICY APPEALS

☐ Request for Reinstatement: _____

☐ Remove Tobacco Surcharge: Name_____ Date Quit_____/_____/_____

☐ Remove Other Surcharge: Name_____

☐ Remove Exclusion: Name_____ Excluded Condition_____

Name_____ Excluded Condition_____

5 U.S. CITIZENSHIP STATUS

Additional information required. Read instructions for Section 5 before completing.

☐ Yes ☐ No Are all applicants U.S. citizens? If "no," please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name: _____ Name: _____

6 ADD SPOUSE OR DEPENDENT(S)

Read instructions for Section 6 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.	Height	Weight
								___ft.___in.	_____ lbs.
								___ft.___in.	_____ lbs.
								___ft.___in.	_____ lbs.
								___ft.___in.	_____ lbs.

(Continued on page 2)

7 ADD MATERNITY

AccessBlue PPO (Not an option)

- ☐ BlueCare PPO
- ☐ BlueCare PPO Plus
- ☐ Blue Choice
- ☐ Blue Select
  - ☐ $2,000 ☐ $3,000 ☐ $5,000
- ☐ Blue Solution PPO
- ☐ Comprehensive Blue PPO
- ☐ Comprehensive Blue PPO II
- ☐ Comprehensive Blue PPO III

Basic Blue PPO (Not an option)

Conversion (Not applicable)

- ☐ HSA Blue PPO
- ☐ HSA Blue PPO Plus
- ☐ HSA Blue PPO II
- ☐ UniqueCare
- ☐ UniqueCare Blue
  - ☐ $2,000 ☐ $3,000 ☐ $5,000
- ☐ UniqueCare Blue Preferred
- ☐ Farm Bureau FlexPlan
- ☐ Farm Bureau FlexPlan Preferred

8 BENEFIT CHANGES

AccessBlue PPO Group # 700101-700104 or 700201-700204 - Grandfathered

Decrease my calendar-year deductible to: ☐ $500 ☐ $1,000

AccessBlue PPO Group # 300101-300104 or 300201-300204 - Non-Grandfathered

Decrease my calendar-year deductible to: ☐ $500 ☐ $1,000

Basic Blue PPO Group # 710000 or 720000 - Grandfathered

Add benefit: ☐ Physician Office Visits Rider ☐ Prescription Drugs Rider

BlueCare PPO Group # 600010-600016 or 600020-600026 - Grandfathered
BlueCare PPO Plus Group # 600030-600036 or 600040-600046 - Grandfathered

Decrease my calendar-year deductible to: ☐ $500 ☐ $1,000 ☐ $1,500

Decrease my calendar-year coinsurance maximum to: ☐ $5,000 ☐ $10,000

Blue Choice Group # 771000-771023 or 781000-781020 - Grandfathered

Decrease my calendar-year deductible and benefit to:

$500 Deductible Options

- ☐ $1,000 OOP* coinsurance maximum and CC Rx plan
- ☐ $1,000 OOP* coinsurance maximum and EC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and CC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and EC Rx plan

$1,000 Deductible Options

- ☐ $1,000 OOP* coinsurance maximum and CC Rx plan
- ☐ $1,000 OOP* coinsurance maximum and EC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and CC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and EC Rx plan

$2,500 Deductible Options

- ☐ No OOP* coinsurance and CC Rx plan
- ☐ No OOP* coinsurance and EC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and CC Rx plan
- ☐ $2,000 OOP* coinsurance maximum and EC Rx plan

*Out-of-Pocket

$5,000 Deductible Options

- ☐ $30/$50 copay and CC Rx plan
- ☐ $30/$50 copay and EC Rx plan
- ☐ No physician copays** and CC Rx plan
- ☐ No physician copays** and EC Rx plan

$10,000 Deductible Options

- ☐ $30/$50 copay and CC Rx plan
- ☐ $30/$50 copay and EC Rx plan
- ☐ No physician copays** and CC Rx plan
- ☐ No physician copays** and EC Rx plan

$25,000 Deductible Options

- ☐ $30/$50 copay and CC Rx plan
- ☐ $30/$50 copay and EC Rx plan
- ☐ No physician copays** and CC Rx plan
- ☐ No physician copays** and EC Rx plan

**Physician visits subject to deductible.

Blue Select Group # 601000-601007 or 602000-602007 - Grandfathered

Decrease my calendar-year deductible to: ☐ $500 ☐ $1,000 ☐ $1,500

Decrease my calendar-year coinsurance maximum to: ☐ $5,000

(Continued on page 3)

8 BENEFIT CHANGES (continued)

Blue Solution PPO Group # 770000-770003 or 780000-780003 - Grandfathered

Decrease my calendar-year deductible to: ☐ $750 ☐ $1,500 ☐ $3,000

Comprehensive Blue PPO Group # 790000-790007 or 700000-700007 - Grandfathered
Comprehensive Blue PPO II Group # 791000-798000 or 701000-708000 - Grandfathered

Decrease my calendar-year deductible to: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000

Comprehensive Blue PPO Group # 300000-300007 or 390000-390007 - Non-Grandfathered
Comprehensive Blue PPO II Group # 391000-398000 or 301000-308000 - Non-Grandfathered

Decrease my calendar-year deductible to: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $10,000

Comprehensive Blue PPO III Group # 700008-700016 or 790008-790016

Decrease my calendar-year deductible to: ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $15,000 ☐ $20,000

Conversion Group # 902100-902140 - Grandfathered
Conversion Group # 302100-302140 - Non-Grandfathered

Decrease my calendar-year deductible and benefit to:

☐ $ 100 Deductible, 80/20% Coinsurance, $5,000 Calendar-Year Coinsurance Maximum
☐ $ 500 Deductible, 80/20% Coinsurance, $5,000 Calendar-Year Coinsurance Maximum
☐ $1,000 Deductible, 80/20% Coinsurance, $5,000 Calendar-Year Coinsurance Maximum

HSA Blue PPO Group # 730000-730021 or 740000-740021 - Grandfathered
HSA Blue PPO Plus Group # 750000-750021 or 760000-760021 - Grandfathered

Decrease my calendar-year deductible and benefit to:

☐ $1,150 Individual/$2,300 Family Deductible, 80/20% Coinsurance, $10,000 Individual/$20,000 Family Coinsurance Maximum
☐ $3,000 Individual/$5,950 Family Deductible, 80/20% Coinsurance, $10,000 Individual/$20,000 Family Coinsurance Maximum
☐ $3,000 Individual/$5,950 Family Deductible, 0% Coinsurance, No Calendar-Year Coinsurance Maximum

HSA Blue PPO II Group # 711000-711005 or 722000-722005 - Grandfathered

Decrease my calendar-year deductible to: ☐ $1,500 Individual/$3,000 Family Deductible ☐ $2,500 Individual/$5,000 Family Deductible

HSA Blue PPO II Group # 311000-311005 or 322000-322005 - Non-Grandfathered

Decrease my calendar-year deductible to: ☐ $1,500 Individual/$3,000 Family Deductible ☐ $2,500 Individual/$5,000 Family Deductible

Uniquecare Group # 610100-611000, 620100-621000 or 650100-651000, 660100-661000 - Grandfathered
Uniquecare Blue Group # 600100-600114, 600200-600214 or 600300-600311, 600400-600410 - Grandfathered
Uniquecare Blue Preferred Group # 622001-622016, 633001-633016 or 622017-622024, 633017-633025 - Grandfathered
Farm Bureau Flexplan Group # 809031-809046 or 809047-809058 - Grandfathered
Farm Bureau Flexplan Preferred Group # 808001-808027 or 808004-808028 - Grandfathered

Decrease my calendar-year deductible and benefit to:

Deductible: ☐ $500* ☐ $1,000* ☐ $2,500 ☐ $5,000 ☐ $10,000
*Not available with Part A (100% Coinsurance)

Choice of Plan: ☐ Plan A: 100%** Coinsurance ☐ Plan B: 80/20% Coinsurance
**Coinsurance Maximum amount not applicable

Calendar-Year Coinsurance Maximum: ☐ $2,500 ☐ $10,000

NOTE: Your coinsurance maximum must be greater than your deductible.

(Continued on page 4)

9 HOUSEHOLD INFORMATION

☐ Yes ☐ No a. Do all applicants reside in the same household? If "no," please provide:
Name: _____ Address: _____
Reason: _____

☐ Yes ☐ No b. Do all applicants reside in Arkansas? If "no," please provide:
Name: _____ Address: _____
Reason: _____

10 APPLICANT(S) EMPLOYMENT INFORMATION [applicant(s) age 18 and older]

Name: _____ Employer: _____
Job Duties: _____
Name: _____ Employer: _____
Job Duties: _____

11 CURRENT INSURANCE COVERAGE

☐ Yes ☐ No a. Will the coverage applied for replace or change current hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant?
i. If "yes," please provide name of carrier:_____
ii. If "yes," does the **coverage** have a specified termination date? If so, please provide date: __/__/__.
☐ Yes ☐ No iii. If "yes," and the coverage does **not** have a specified termination date, will the coverage terminate if approved by Arkansas Blue Cross and accepted by the applicant?

☐ Yes ☐ No b. Have you recently lost employer-sponsored health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No c. Have you recently "involuntarily" lost other health coverage? If "yes," please provide:
Name: _____Carrier Name: _____ Termination Date: __/__/__.
Name: _____Carrier Name: _____ Termination Date: __/__/__.

☐ Yes ☐ No d. Will any applicants be **continuing** any other health insurance? If yes, please provide:
Name: _____ Carrier Name: _____ ID# _____
Name: _____ Carrier Name: _____ ID# _____

☐ Yes ☐ No e. Are any applicants covered by Medicaid (other than Women's Health/Family Planning coverage)? If "yes," please provide name(s) below:
Name: _____
Name: _____

☐ Yes ☐ No f. Are any applicants covered by Medicare? If "yes,"please provide name(s) below:
Name: _____
Name: _____

12 DRIVER'S LICENSE INFORMATION [applicant(s) age 14 and older]

Name: _____ License No. : _____ State:_____
Name: _____ License No.: _____ State:_____
Name: _____ License No.: _____ State:_____

In the past 5 years, has any applicant:

☐ Yes ☐ No a. Had his or her driver's license suspended or revoked?
☐ Yes ☐ No b. Had two or more moving traffic violations?
☐ Yes ☐ No c. Been convicted or charged with driving under the influence of alcohol or a controlled substance?
If you answered "yes," to any of the above questions, you **MUST** provide the following information**:**

Name: _____ Date: _____/_____/_____ Violation(s): _____
Name: _____ Date: _____/_____/_____ Violation(s): _____

13 SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding or any other hazardous sport, hobby or activity?

Name: _____ Please explain: _____
Name: _____ Please explain: _____

(Continued on page 5)

14 TRAVEL OUTSIDE THE USA

☐ Yes ☐ No **Is any applicant planning to travel or work outside the USA within the next two years?**
If "yes," please provide the following:

Name (list **all** that apply): _____

Country: _____ Expected Length of Stay: _____ Departure date: _____Return date: _____

Reason for Travel: _____

_____

15 EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is any **male** applying for coverage an expectant father or a potential adoptive father?

☐ Yes ☐ No Is any **female** applying for coverage pregnant or a potential adoptive mother?

If "yes," please provide the following: Name: _____Expected Delivery/Adoption Date: _____/_____/_____

16 INFERTILITY

Has any applicant or spouse of a proposed applicant **(whether applying for coverage or not)**:

☐ Yes ☐ No a. Ever been diagnosed or treated for infertility?

☐ Yes ☐ No b. Had surgical sterilization? If "yes," please provide the following:

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

Name: _____ Treatment/Procedure: _____ Date: _____/_____/_____

17 TOBACCO USAGE

☐ Yes ☐ No Has any applicant to be covered used any form of tobacco within the last 12 months? If "yes," please provide the following:

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

Name: _____ Type/Amount: _____ Date Last Used: _____/_____/_____

18 PREVIOUS INSURANCE EXPERIENCE

☐ Yes ☐ No Has any applicant ever been declined, rated, restricted or modified for the issuance of life, accident, health or long-term care insurance? If "yes," please provide the following:

Name: _____ Carrier Name: _____ Year: _____ Details: _____

Name: _____ Carrier Name: _____ Year: _____ Details: _____

19 PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any proposed applicant **currently** taking any prescription medication, or has any applicant taken prescription medication in the **last 3 years?**

If you answered "yes," please provide full details below. Use separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated**. A print out from the pharmacy is **not** acceptable.

Please provide the name that would have been used at the time of the prescription (e.g., a maiden name may have been used.)

Person Treated	Name of Drug	Dosage	Specific Disorder or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Prescribing Physician
					None	Partial	Full	
				mo / year mo / year				
				mo / year mo / year				
				mo / year mo / year				
				mo / year mo / year				
				mo / year mo / year				

(Continued on page 6)

20 MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

1. Has any applicant **ever** had or been told he/she had: **(Each section must have at least one box checked.** When multiple medical conditions are listed, please **circle all conditions that apply.)**

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cerebral palsy
- ☐ Concussion or brain injury
- ☐ Convulsions, epilepsy or seizures
- ☐ Headaches or migraines
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above apply to any applicant(s)**

B. CIRCULATORY

- ☐ Abnormal cholesterol/lipids
- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart or vein/artery surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Valve repair/replacement
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above apply to any applicant(s)**

C. DIGESTIVE

- ☐ Cirrhosis
- ☐ Crohn's disease or ulcerative colitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Hernia, hemorrhoids
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above apply to any applicant(s)**

D. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Cesarean section or miscarriage
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the male reproductive organs, including prostate
- ☐ Any other disorder of the female reproductive organs, including ovaries or breasts
- ☐ **None of the above apply to any applicant(s)**

E. RESPIRATORY

- ☐ Allergies, asthma or bronchitis
- ☐ Chronic pulmonary disease, emphysema, lung disease or respiratory synctyial virus (RSV)
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea, cpap, bipap or vpap
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above apply to any applicant(s)**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer, leukemia or malignancy of any kind
- ☐ Hodgkin's or Non-Hodgkin's disease
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any disorder of the skin
- ☐ **None of the above apply to any applicant(s)**

G. GLANDULAR DISORDERS

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Goiter or thyroid disease
- ☐ Any disorder of the pancreas
- ☐ **None of the above apply to any applicant(s)**

H. MUSCULOSKELETAL

- ☐ Arthritis, osteoarthritis, degenerative joint or disc disease
- ☐ Back pain and/or neck pain
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other
- ☐ Fibromyalgia, bursitis or tendonitis

MUSCULOSKELETAL (cont.)

- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Gout
- ☐ Lupus, systemic
- ☐ Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder
- ☐ Any other disorder of the muscles, bones or joints to include chiropractic care
- ☐ **None of the above apply to any applicant(s)**

I. EARS/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Nasal septal defect
- ☐ Sinusitis, tonsillitis or otitis media
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above apply to any applicant(s)**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder
- ☐ Attempted suicide
- ☐ Counseling or psychiatric treatment (in-patient or out-patient)
- ☐ Bipolar disorder, obsessive compulsive disorder or developmental disorder
- ☐ Eating disorder
- ☐ Any other mental, emotional disorder or situation, including ADD/ADHD
- ☐ **None of the above apply to any applicant(s)**

K. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Pending Surgery Surgery Date: __/__/__
- ☐ Sarcoidosis
- ☐ Breast implants
  ☐ Saline ☐ Silicone Surgery Date: __/__/__
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above apply to any applicant(s)**

(Continued on page 7)

20 MEDICAL QUESTIONNAIRE (continued)

2. Has any applicant ever:

☐ Yes ☐ No a. Consumed alcohol to excess, received treatment, or joined an organization for alcoholism or drug addictions?

☐ Yes ☐ No b. Used any addictive or non-addictive drug or substance for purposes other than recommended by your physician?

☐ Yes ☐ No c. Been treated for, diagnosed by or consulted a physician, psychotherapist, counselor or any other provider, or had any indication(s) of having a drug dependency/habit?

☐ Yes ☐ No d. Required the assistance of any other individual for performances of any activities of daily living? If "Yes," please explain:_____

☐ Yes ☐ No e. Been told that he/she has or has had hearing problems, ear disorder(s) or has need of hearing devices due to any kind of hearing or ear impairment, or does any applicant have an existing hearing aid device in place?

ADDITIONAL MEDICAL INFORMATION

Give full details to questions answered affirmatively (checked or answered "Yes") to explain answers to questions in SECTION 20. In addition to **condition/illness** please provide the **type of treatment** provided or planned – for example, surgery, X-rays, EKG, lab tests, hospitalization, emergency room visit, nursing home confinement, doctor visits, rehabilitation services, occupational therapy, physical therapy, speech therapy or chiropractic treatments. Please ensure you include **all** the treatments that apply. **Please use the name that would have been given at the time of the physician visit — e.g., a maiden name.**

Question Number(s)	Person Treated	Specific Disorder/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
						None	Partial	Full	
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					
			____/____ mo year	____/____ mo year					

21 PHYSICIAN INFORMATION (Please provide for each applicant for the last five years)

Applicant's Name	Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit**	Treatment/ Results**

***Please write NO VISIT in this box if the applicant has never seen the physician.** **Use "Comments" section on Page 8 if more room is needed for details.

(Continued on page 8)

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application may be rejected if the applicant is age 19 or older. (2) If accepted, the insurance applied for shall not become effective until the date shown on my schedule of benefits and the adjusted premium, if applicable, is paid in full. (3) If my application is accepted relying on my representations in this document, any coverage which may be issued to me shall be invalid if based on intentional misrepresentations of material fact or fraud. (4) Any members added to my policy will be subject to a 12-month pre-existing waiting period. This means conditions existing prior to the member's effective date of this policy will not be covered until his/her coverage has been in effect for 12 months. (5) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (6) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. In signing below, I: represent that the statements and answers given in this application and any signed and dated addendum to this application are true, complete and correctly recorded.

I certify that I signed this change form in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Please sign appropriate line only)

Current Policyholder **(required if policyholder is age 19 or older)** OR Parent/Guardian's **(if policy for a minor)**	(Please Print) X (Please Sign) X	Date Signed
Spouse **(required if applying)**	X	Date Signed
Dependent age 18 or older **(required if applying)**	X	Date Signed

CUSTODIAL PARENT SECTION

If any applicant under age 19 (primary applicant or dependent), named on this application, does NOT reside with the proposed insured or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name and Address **(please print)**	X	Telephone No.
Custodial Parent's Signature	X	Date Signed

This section to be completed by sales representative

To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? ☐ Yes ☐ No

Sales Rep License No. (required)	Sales Representative's Name (Please Print) X	Telephone No.
Agency Federal Tax ID No. (If applicable)	Sales Representative's Signature X	Date Signed

COMMENTS

THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, or other provider of health care serices or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

Applicants age 18 and older

This authorization must be signed by each applicant age 18 or older.

Print Name(s)	Signature	Date
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____
_____	_____	____/____/____

Applicants under age 18

List applicants under age 18 (Print Name).

_____

_____

_____

_____

_____ _____ ____/____/____

Parent/Legal Guardian's Signature (if policy for a minor) Date

Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181, Little Rock, AR 72203-2181

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	08/02/2011
Bypass Reason:	These were Flesch Scored with the Comp Blue PPO.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/02/2011
Bypass Reason:	Appliocations attached.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	08/02/2011
Bypass Reason:	Not required.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	08/02/2011
Bypass Reason:	Not required.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	08/02/2011
Bypass Reason:	Not PPACA related.		
Comments:			