

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Individual Applications
Project Name/Number: Applications/EBF/STB DR (01/13),EBF/STB AG (01/13),

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield
Product Name: Individual Applications
State: Arkansas
TOI: H16I Individual Health - Major Medical
Sub-TOI: H16I.005C Individual - Other
Filing Type: Form
Date Submitted: 12/14/2012
SERFF Tr Num: ARBB-128812895
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: EBF/STB DR (01/13)

Implementation: 12/01/2012
Date Requested:
Author(s): Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 12/17/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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General Information

Project Name: Applications	Status of Filing in Domicile: Pending
Project Number: EBF/STB DR (01/13),EBF/STB AG (01/13),	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Arkansas is state of domicile.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type: Individual
Overall Rate Impact:	Filing Status Changed: 12/17/2012
	State Status Changed: 12/17/2012
Deemer Date:	Created By: Evelyn Laney
Submitted By: Evelyn Laney	Corresponding Filing Tracking Number:
	PPACA: Not PPACA-Related
PPACA Notes: null	
Include Exchange Intentions:	No

Filing Description:

Enclosed please find forms EBF/STB DR (01/13), EBF/STB AG (01/13), U-65 APP AG, U-65 APP DR, U-65 APP LB, U-65APP LB DR, and UndChg Form (R01-13) for your review and approval if indicated. These forms replace the ones approved on July 31, 2012. None of these forms have been used.

On the individual Essential Blue Freedom Application form number EBF/STB DR (01/13), we removed Regional box from the top right corner of page 1 and on both forms we updated text on page 3 relating to the number of days Essential Blue Freedom covers.

In forms U-65 APP AG, U-65 APP DR, U-65 APP LB, U-65APP LB DR, and UndChg Form (R01-13) we removed the maternity option and updated Form ID's.

By way of this letter, I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.

I certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 is incorporated in the policy.

I further certify that the consumer information notice required by Arkansas Code Annotated §23-79-138 is incorporated in the policy 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	exlaney@arkbluecross.com
320 West Capitol, Ste 211	501-378-2165 [Phone]
Little Rock, AR 72201	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	

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Filing Fees

Fee Required? Yes
Fee Amount: \$350.00
Retaliatory? No
Fee Explanation: \$50.00 per form
Per Company: No

Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	\$350.00	12/14/2012	65763311

SERFF Tracking #:

ARBB-128812895

State Tracking #:

Company Tracking #:

EBF/STB DR (01/13)

State:

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005C Individual - Other

Product Name:

Individual Applications

Project Name/Number:

Applications/EBF/STB DR (01/13),EBF/STB AG (01/13),

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	12/17/2012	12/17/2012

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005C Individual - Other
Product Name: Individual Applications
Project Name/Number: Applications/EBF/STB DR (01/13),EBF/STB AG (01/13),

Disposition

Disposition Date: 12/17/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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

State: Arkansas

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Product Name: Individual Applications

Project Name/Number: Applications/EBF/STB DR (01/13),EBF/STB AG (01/13),

Form Schedule

Lead Form Number: EBF/STB DR (01/13)									
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved-Closed 12/17/2012	Application	EBF/STB DR (01/13)	AEF	Revised	Previous Filing Number:	ARBB- 128607245		EBF_STB_DR_(01-13)rev3.pdf
						Replaced Form Number:	EBF/STB DR (01/13)		
2	Approved-Closed 12/17/2012	Application	EBF/STB AG (01/13)	AEF	Revised	Previous Filing Number:	ARBB- 128607245		EBF_STB_AG_(01-13)rev3.pdf
						Replaced Form Number:	EBF/STB AG (01/13)		
3	Approved-Closed 12/17/2012	Application	U-65 APP AG (R01/13)	AEF	Revised	Previous Filing Number:	ARBB- 128378859		U- 65_APP_AG_(R01-13) pdf.pdf
						Replaced Form Number:	U-65 APP AG (R01/13)		
4	Approved-Closed 12/17/2012	Application	U-65 APP DR (R01/13)	AEF	Revised	Previous Filing Number:	ARBB- 128378859		U- 65_APP_DR_(R01-13) pdf.pdf
						Replaced Form Number:	U-65 APP DR (R01/13)		
5	Approved-Closed 12/17/2012	Application	U-6U-65 APP LB AG (R01/13)	AEF	Revised	Previous Filing Number:	ARBB- 128378859		U- 65_APP_LB_AG_(R01-13) pdf.pdf
						Replaced Form Number:	U-6U-65 APP LB AG (R01/13)		
6	Approved-Closed 12/17/2012	Application	U-65 APP LB DR (R01/13)	AEF	Revised	Previous Filing Number:	ARBB- 128378859		U- 65_APP_LB_DR_(R01-13) pdf.pdf
						Replaced Form Number:	U-65 APP LB DR (R01/13)		

State: Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

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Lead Form Number: EBF/STB DR (01/13)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
7	Approved-Closed 12/17/2012	Application	UndChg Form (R01- 13)	AEF	Revised	Previous Filing Number:	ARBB- 128657133		UndChg_Form_(R 01-13)rev.pdf
						Replaced Form Number:	UndChg Form (R01-13)		

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



Application for Essential Blue Freedom OR Short-Term Blue

You must apply for only one product — Essential Blue Freedom or Short-Term Blue.

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY 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.
- 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 primary applicant, 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.

SECTIONS 3, 4 AND 5 – ADDRESS INFORMATION

- You are required to provide address information when submitting this application. Please note there are three separate listings for this information. Complete all that apply.
 - **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 11 – TYPE OF COVERAGE (For Essential Blue Freedom only)

- 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.

SECTION 12 – U.S. CITIZENSHIP STATUS (For Essential Blue Freedom only)

- 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 and must have a primary care physician in the U.S. 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.



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

***For Essential Blue Freedom Only:**

IMPORTANT:

We cannot process your Essential Blue Freedom 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, pharmacy benefits manager, 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. I understand that information re-disclosed may no longer be protected by federal privacy regulations. 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, PO Box 2181, Little Rock, AR 72203-2181. 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).

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

Print Name(s)

Signature

Date

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

Applicants age 18 and older

List applicants under age 18 (Print Name).

Applicants under age 18

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 Essential Blue Freedom OR Short Term Blue

You must apply for only one product — Essential Blue Freedom or Short-Term Blue.

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)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Stepfather

3 MARITAL STATUS

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

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

Street _____ City _____ State _____ Zip _____
AR

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

Street or P.O. Box _____ City _____ State _____ Zip _____

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

Street or P.O. Box _____ City _____ State _____ Zip _____

7 CONTACT INFORMATION

Primary Phone Number ()	Alternate Phone Number ()	E-mail Address	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> Phone
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8 HOUSEHOLD INFORMATION

Yes No a. Do all applicants under the age of 19 reside in the same household?
If "no," please provide reason and his/her name and address:
Name: _____ Address: _____
Reason: _____

Yes No b. Are all applicants permanent, legal residents of Arkansas?
If "no," please 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
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Application for Short-Term Blue

Short-Term Blue is a short-term, limited-duration health insurance policy that provides health insurance coverage for 30 to 182 days.

To apply for Short-Term Blue, please complete and return pages 1, 2 and 8.

9 SHORT-TERM COVERAGE INFORMATION

Deductible: \$500 \$1,000

Type of Coverage:

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

Requested Effective Date: ___/___/___

The effective date cannot be more than 30 days from the sign date on the application.

Number of Days: _____ (30 minimum / 182 maximum) X Daily Rate _____ = \$ _____

*See rate calculation page in Short-Term Blue brochure.

Enclose a check made payable to Arkansas Blue Cross and Blue Shield in the amount of the premium for the entire term of the policy.

10 SHORT-TERM ELIGIBILITY QUESTIONS

The following questions must be answered in relation to each person applying for coverage.

1. Is any male applying for coverage an expectant parent? Yes No
If you answer "Yes", you and any other family members who are not pregnant may apply for "Individual" coverage; however, you must complete separate applications.

If question 2, 3 or 4 is answered "Yes", you are not eligible for Short-Term Blue and no policy will be issued.

2. Is any female applying for coverage pregnant? Yes No

3. Will there be any other health insurance in force on the effective date of this coverage? Yes No

4. Within the last five (5) years, have you or anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for **any of the following**: liver disorders, kidney disorders, chronic obstructive pulmonary disease (COPD), emphysema, diabetes, cancer (other than skin cancer), heart or circulatory system disorders, alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection? Yes No

13 CURRENT/PREVIOUS INSURANCE INFORMATION (continued)

Yes No e. Are any applicants covered by Medicaid (including AR Kids First)? If "yes," please provide name(s) below:

Applicant Name: _____

Applicant Name: _____

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

Applicant Name: _____

Applicant Name: _____

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

Name: _____ Employer: _____

Job duties: _____

Name: _____ Employer: _____

Job duties: _____

15 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): _____

16 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: _____

17 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: _____

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 an 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 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 printout 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				

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.)**

<p>A. BRAIN OR NERVOUS SYSTEM DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alzheimer's disease or senile dementia <input type="checkbox"/> Amyotrophic lateral sclerosis (Lou Gehrig's disease) <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Concussion or brain injury <input type="checkbox"/> Convulsions, epilepsy or seizures <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Meningitis <input type="checkbox"/> Multiple sclerosis, muscular dystrophy or myasthenia gravis <input type="checkbox"/> Neuritis <input type="checkbox"/> Paralysis or palsy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Polyneuritis <input type="checkbox"/> Vertigo, fainting or dizziness <input type="checkbox"/> Any other disorder of the brain or nervous system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>D. KIDNEY, URINARY, REPRODUCTIVE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bladder or renal stones <input type="checkbox"/> Cesarean section or miscarriage <input type="checkbox"/> Dialysis <input type="checkbox"/> Nephritis <input type="checkbox"/> Nephrotic syndrome, renal disease or failure <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Sugar, blood or protein in urine <input type="checkbox"/> Any other disorder of the kidneys or urinary tract <input type="checkbox"/> Any other disorder of the male reproductive organs, including prostate <input type="checkbox"/> Any other disorder of the female reproductive organs, including ovaries or breasts <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>MUSCULOSKELETAL (cont.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fracture(s) or broken bone(s) Exposed bone <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Gout <input type="checkbox"/> Lupus, systemic <input type="checkbox"/> Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder <input type="checkbox"/> Any other disorder of the muscles, bones or joints to include chiropractic care <input type="checkbox"/> None of the above apply to any applicant(s)
<p>B. CIRCULATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal cholesterol/lipids <input type="checkbox"/> Angina, heart attack, myocardial infarction <input type="checkbox"/> Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty <input type="checkbox"/> Cerebrovascular accident (stroke), including transient ischemic attack (TIA) <input type="checkbox"/> Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever <input type="checkbox"/> Heart bypass surgery, pacemaker implant <input type="checkbox"/> Heart or vein/artery surgery <input type="checkbox"/> High blood pressure <input type="checkbox"/> Hemophilia <input type="checkbox"/> Valve repair/replacement <input type="checkbox"/> Any other disorder of the heart, blood, blood vessels or circulatory system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>E. RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies, asthma or bronchitis <input type="checkbox"/> Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV) <input type="checkbox"/> Obstructive or reactive airway disorder <input type="checkbox"/> Sleep apnea, cpap, bipap or vpap <input type="checkbox"/> Any other disorder of the lungs, bronchial tubes or respiratory system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>I. EARS/EYES/NOSE/THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cataracts or glaucoma <input type="checkbox"/> Meniere's disease <input type="checkbox"/> Nasal septal defect <input type="checkbox"/> Sinusitis, tonsillitis or otitis media <input type="checkbox"/> Any other disorder of the eyes, ears, nose, throat or esophagus <input type="checkbox"/> None of the above apply to any applicant(s)
<p>C. DIGESTIVE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Crohn's disease or ulcerative colitis <input type="checkbox"/> Gastric bypass surgery or other weight loss procedure <input type="checkbox"/> Gastric or duodenal ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia, hemorrhoids <input type="checkbox"/> Irritable bowel syndrome or gastric esophageal reflux disorder (GERD) <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Pyloric stenosis <input type="checkbox"/> Any other disorder of stomach, intestines, liver, gallbladder or rectum <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer, leukemia or malignancy of any kind <input type="checkbox"/> Hodgkin's or Non-Hodgkin's disease <input type="checkbox"/> Melanoma, neoplasm or tumor <input type="checkbox"/> Any other disorder of the lymphatic system <input type="checkbox"/> Any other disorder of the skin <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Counseling or psychiatric treatment (in-patient or out-patient) <input type="checkbox"/> Bipolar disorder, obsessive compulsive disorder or developmental disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Any other mental, emotional disorder or situation, including ADD/ADHD <input type="checkbox"/> None of the above apply to any applicant(s)
<p>G. GLANDULAR DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adrenal disorders <input type="checkbox"/> Diabetes, abnormal glucose <input type="checkbox"/> Goiter or thyroid disease <input type="checkbox"/> Any disorder of the pancreas <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>H. MUSCULOSKELETAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis, osteoarthritis, degenerative joint or disc disease <input type="checkbox"/> Back pain and/or neck pain <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Connective tissue disorder <input type="checkbox"/> Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other <input type="checkbox"/> Fibromyalgia, bursitis or tendonitis 	<p>K. OTHER</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current patient in a hospital or nursing home <input type="checkbox"/> Pending Surgery Surgery Date: __/__/__ <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Breast implants <input type="checkbox"/> Saline <input type="checkbox"/> Silicone Surgery Date: __/__/__ <input type="checkbox"/> Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) <input type="checkbox"/> Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV <input type="checkbox"/> Transplant recipient <input type="checkbox"/> Any injury, deformity, incapacitation, disease or condition not listed elsewhere <input type="checkbox"/> None of the above apply to any applicant(s)

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 8 if more room is needed for details.

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) 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.

In signing, 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) 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.

SHORT-TERM BLUE:

I UNDERSTAND that this application may be rejected. If persons proposed for coverage are eligible and coverage is offered, I understand: (1) The coverage shall not become effective until the date shown on my identification card and the premium is paid in full. (2) Once the policy is in effect and payment received, premiums will not be refunded for any reason. (3) Pre-existing conditions will not be covered. (4) No changes can be made to the policy after coverage is in effect. (5) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (6) Arkansas Blue Cross and Blue Shield may phone or e-mail me for additional information that may help with the timely processing of my application. **This application is valid for 30 days only when completed and signed.**

ESSENTIAL BLUE FREEDOM:

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, my application may be approved with no changes, approved but charged a higher premium and/ or approved with non-medical exclusions, 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 364 days.** (2) 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. (3) Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY) may phone me for additional information that may help with the timely processing of my application. (4) The Health 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. **This application is valid for 90 days only when completed and signed.**

In signing, I: (a) 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; (b) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (c) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (d) agree that this application shall be valid without time limit.

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.

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

SIGNATURE SECTION (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian (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 primary applicant or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name (please print)	X	Telephone No.
Custodial Parent's Address	Street or PO Box	City State Zip
Custodial Parent's Signature	X	Date Signed

Comments:	OFFICE USE ONLY
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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. Until that time, make sure you pay any statement you receive.

Complete the information below.

Required only for Essential Blue Freedom

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield and/or the BANK indicated below, to debit my Arkansas Blue Cross 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 coverage, UNLESS Arkansas Blue Cross 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.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

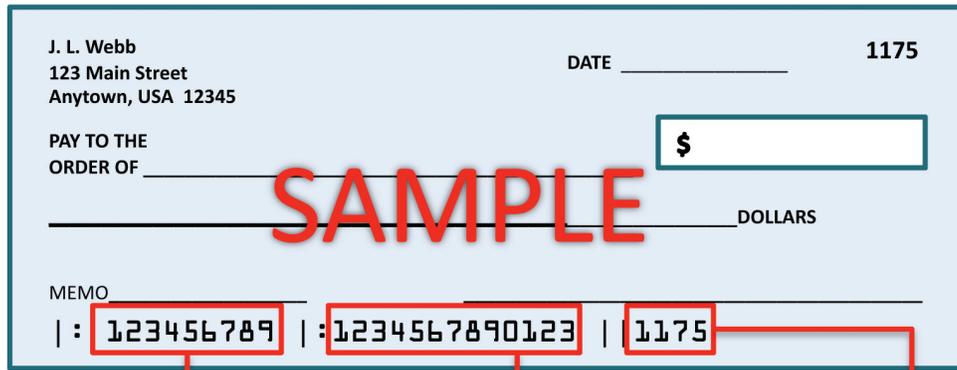
PROPOSED INSURED'S INFORMATION

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



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!

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

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 DATES FOR ESSENTIAL BLUE FREEDOM

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

POLICY EFFECTIVE DATES FOR SHORT-TERM BLUE

Your Short-Term Blue policy will take effect on the later of: (1) the requested effective date; or (2) the day after the postmark date affixed by the U.S. Postal Service,* but only if the following conditions are satisfied:

- Your application and the appropriate premium payment are received at Arkansas Blue Cross in Little Rock within 15 days of your signing;
- Your application is properly completed and unaltered;
- If you answered Eligibility Question 1 Yes, you are applying for Individual coverage;
- You answered Questions 2, 3 and 4 No;
- You are between the ages of six months and 65 and **not** on Medicare or any other health insurance.

* If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (1) the date you requested; or (2) the date received by Arkansas Blue Cross.



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

Application for Essential Blue Freedom OR Short-Term Blue

You must apply for only one product — Essential Blue Freedom or Short-Term Blue.

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION. APPLICATION MUST BE COMPLETED IN ITS ENTIRETY 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.
- 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 primary applicant, 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.

SECTIONS 3, 4 AND 5 – ADDRESS INFORMATION

- You are required to provide address information when submitting this application. Please note there are three separate listings for this information. Complete all that apply.
 - **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 11 – TYPE OF COVERAGE (For Essential Blue Freedom only)

- 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.

SECTION 12 – U.S. CITIZENSHIP STATUS (For Essential Blue Freedom only)

- 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 and must have a primary care physician in the U.S. 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.



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

***For Essential Blue Freedom Only:**

IMPORTANT:

We cannot process your Essential Blue Freedom 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, pharmacy benefits manager, 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. I understand that information re-disclosed may no longer be protected by federal privacy regulations. 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, PO Box 2181, Little Rock, AR 72203-2181. 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).

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

Print Name(s)

Signature

Date

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

Applicants age 18 and older

List applicants under age 18 (Print Name).

Applicants under age 18

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 Essential Blue Freedom OR Short Term Blue

For Arkansas Blue Cross Use Only

This application was received by:

- C NW NE WC
 SC SW SE Customer Service
 Retail Store

Date Stamp _____

You must apply for only one product — Essential Blue Freedom or Short-Term Blue.

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)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> Stepfather

3 MARITAL STATUS

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

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

Street _____ City _____ State _____ Zip _____
AR

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

Street or P.O. Box _____ City _____ State _____ Zip _____

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

Street or P.O. Box _____ City _____ State _____ Zip _____

7 CONTACT INFORMATION

Primary Phone Number ()	Alternate Phone Number ()	E-mail Address	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> Phone
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8 HOUSEHOLD INFORMATION

- Yes No a. Do all applicants under the age of 19 reside in the same household?
 If "no," please provide reason and his/her name and address:
 Name: _____ Address: _____
 Reason: _____
- Yes No b. Are all applicants permanent, legal residents of Arkansas?
 If "no," please 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
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Application for Short-Term Blue

Short-Term Blue is a short-term, limited-duration health insurance policy that provides health insurance coverage for 30 to 182 days.

To apply for Short-Term Blue, please complete and return pages 1, 2 and 8.

9 SHORT-TERM COVERAGE INFORMATION

Deductible: \$500 \$1,000

Type of Coverage:

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

Requested Effective Date: ___/___/___

The effective date cannot be more than 30 days from the sign date on the application.

Number of Days: _____ (30 minimum / 182 maximum) X Daily Rate _____ = \$ _____

*See rate calculation page in Short-Term Blue brochure.

Enclose a check made payable to Arkansas Blue Cross and Blue Shield in the amount of the premium for the entire term of the policy.

10 SHORT-TERM ELIGIBILITY QUESTIONS

The following questions must be answered in relation to each person applying for coverage.

1. Is any male applying for coverage an expectant parent? Yes No
If you answer "Yes", you and any other family members who are not pregnant may apply for "Individual" coverage; however, you must complete separate applications.

If question 2, 3 or 4 is answered "Yes", you are not eligible for Short-Term Blue and no policy will be issued.

2. Is any female applying for coverage pregnant? Yes No

3. Will there be any other health insurance in force on the effective date of this coverage? Yes No

4. Within the last five (5) years, have you or anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for **any of the following**: liver disorders, kidney disorders, chronic obstructive pulmonary disease (COPD), emphysema, diabetes, cancer (other than skin cancer), heart or circulatory system disorders, alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection? Yes No

13 CURRENT/PREVIOUS INSURANCE INFORMATION (continued)

- Yes No e. Are any applicants covered by Medicaid (including AR Kids First)? If "yes," please provide name(s) below:
Applicant Name: _____
Applicant Name: _____
- Yes No f. Are any applicants covered by Medicare? If "yes," please provide name(s) below:
Applicant Name: _____
Applicant Name: _____

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

Name: _____ Employer: _____
Job duties: _____

Name: _____ Employer: _____
Job duties: _____

15 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): _____

16 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: _____

17 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: _____

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 an 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 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 printout 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				

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.)**

<p>A. BRAIN OR NERVOUS SYSTEM DISORDERS</p> <p><input type="checkbox"/> Alzheimer's disease or senile dementia</p> <p><input type="checkbox"/> Amyotrophic lateral sclerosis (Lou Gehrig's disease)</p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Concussion or brain injury</p> <p><input type="checkbox"/> Convulsions, epilepsy or seizures</p> <p><input type="checkbox"/> Headaches or migraines</p> <p><input type="checkbox"/> Meningitis</p> <p><input type="checkbox"/> Multiple sclerosis, muscular dystrophy or myasthenia gravis</p> <p><input type="checkbox"/> Neuritis</p> <p><input type="checkbox"/> Paralysis or palsy</p> <p><input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> Polyneuritis</p> <p><input type="checkbox"/> Vertigo, fainting or dizziness</p> <p><input type="checkbox"/> Any other disorder of the brain or nervous system</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>	<p>D. KIDNEY, URINARY, REPRODUCTIVE</p> <p><input type="checkbox"/> Abnormal pap smear</p> <p><input type="checkbox"/> Bladder or renal stones</p> <p><input type="checkbox"/> Cesarean section or miscarriage</p> <p><input type="checkbox"/> Dialysis</p> <p><input type="checkbox"/> Nephritis</p> <p><input type="checkbox"/> Nephrotic syndrome, renal disease or failure</p> <p><input type="checkbox"/> Sexually transmitted disease</p> <p><input type="checkbox"/> Sugar, blood or protein in urine</p> <p><input type="checkbox"/> Any other disorder of the kidneys or urinary tract</p> <p><input type="checkbox"/> Any other disorder of the male reproductive organs, including prostate</p> <p><input type="checkbox"/> Any other disorder of the female reproductive organs, including ovaries or breasts</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>	<p>MUSCULOSKELETAL (cont.)</p> <p><input type="checkbox"/> Fracture(s) or broken bone(s) Exposed bone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Lupus, systemic</p> <p><input type="checkbox"/> Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder</p> <p><input type="checkbox"/> Any other disorder of the muscles, bones or joints to include chiropractic care</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>
<p>B. CIRCULATORY</p> <p><input type="checkbox"/> Abnormal cholesterol/lipids</p> <p><input type="checkbox"/> Angina, heart attack, myocardial infarction</p> <p><input type="checkbox"/> Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty</p> <p><input type="checkbox"/> Cerebrovascular accident (stroke), including transient ischemic attack (TIA)</p> <p><input type="checkbox"/> Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever</p> <p><input type="checkbox"/> Heart bypass surgery, pacemaker implant</p> <p><input type="checkbox"/> Heart or vein/artery surgery</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Hemophilia</p> <p><input type="checkbox"/> Valve repair/replacement</p> <p><input type="checkbox"/> Any other disorder of the heart, blood, blood vessels or circulatory system</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>	<p>E. RESPIRATORY</p> <p><input type="checkbox"/> Allergies, asthma or bronchitis</p> <p><input type="checkbox"/> Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV)</p> <p><input type="checkbox"/> Obstructive or reactive airway disorder</p> <p><input type="checkbox"/> Sleep apnea, cpap, bipap or vpap</p> <p><input type="checkbox"/> Any other disorder of the lungs, bronchial tubes or respiratory system</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>	<p>I. EARS/EYES/NOSE/THROAT</p> <p><input type="checkbox"/> Cataracts or glaucoma</p> <p><input type="checkbox"/> Meniere's disease</p> <p><input type="checkbox"/> Nasal septal defect</p> <p><input type="checkbox"/> Sinusitis, tonsillitis or otitis media</p> <p><input type="checkbox"/> Any other disorder of the eyes, ears, nose, throat or esophagus</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>
<p>C. DIGESTIVE</p> <p><input type="checkbox"/> Cirrhosis</p> <p><input type="checkbox"/> Crohn's disease or ulcerative colitis</p> <p><input type="checkbox"/> Gastric bypass surgery or other weight loss procedure</p> <p><input type="checkbox"/> Gastric or duodenal ulcer</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hernia, hemorrhoids</p> <p><input type="checkbox"/> Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)</p> <p><input type="checkbox"/> Pancreatitis</p> <p><input type="checkbox"/> Pyloric stenosis</p> <p><input type="checkbox"/> Any other disorder of stomach, intestines, liver, gallbladder or rectum</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>	<p>F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Cancer, leukemia or malignancy of any kind</p> <p><input type="checkbox"/> Hodgkin's or Non-Hodgkin's disease</p> <p><input type="checkbox"/> Melanoma, neoplasm or tumor</p> <p><input type="checkbox"/> Any other disorder of the lymphatic system</p> <p><input type="checkbox"/> Any other disorder of the skin</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>	<p>J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE</p> <p><input type="checkbox"/> Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder</p> <p><input type="checkbox"/> Attempted suicide</p> <p><input type="checkbox"/> Counseling or psychiatric treatment (in-patient or out-patient)</p> <p><input type="checkbox"/> Bipolar disorder, obsessive compulsive disorder or developmental disorder</p> <p><input type="checkbox"/> Eating disorder</p> <p><input type="checkbox"/> Any other mental, emotional disorder or situation, including ADD/ADHD</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>
	<p>G. GLANDULAR DISORDERS</p> <p><input type="checkbox"/> Adrenal disorders</p> <p><input type="checkbox"/> Diabetes, abnormal glucose</p> <p><input type="checkbox"/> Goiter or thyroid disease</p> <p><input type="checkbox"/> Any disorder of the pancreas</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>	<p>K. OTHER</p> <p><input type="checkbox"/> Current patient in a hospital or nursing home</p> <p><input type="checkbox"/> Pending Surgery Surgery Date: __/__/__</p> <p><input type="checkbox"/> Sarcoidosis</p> <p><input type="checkbox"/> Breast implants <input type="checkbox"/> Saline <input type="checkbox"/> Silicone Surgery Date: __/__/__</p> <p><input type="checkbox"/> Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)</p> <p><input type="checkbox"/> Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV</p> <p><input type="checkbox"/> Transplant recipient</p> <p><input type="checkbox"/> Any injury, deformity, incapacitation, disease or condition not listed elsewhere</p> <p><input type="checkbox"/> None of the above apply to any applicant(s)</p>
	<p>H. MUSCULOSKELETAL</p> <p><input type="checkbox"/> Arthritis, osteoarthritis, degenerative joint or disc disease</p> <p><input type="checkbox"/> Back pain and/or neck pain</p> <p><input type="checkbox"/> Chronic fatigue</p> <p><input type="checkbox"/> Connective tissue disorder</p> <p><input type="checkbox"/> Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other</p> <p><input type="checkbox"/> Fibromyalgia, bursitis or tendonitis</p>	

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 8 if more room is needed for details.

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) 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.

In signing, 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) 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.

SHORT-TERM BLUE: I UNDERSTAND that this application may be rejected. If persons proposed for coverage are eligible and coverage is offered, I understand: (1) The coverage shall not become effective until the date shown on my identification card and the premium is paid in full. (2) Once the policy is in effect and payment received, premiums will not be refunded for any reason. (3) Pre-existing conditions will not be covered. (4) No changes can be made to the policy after coverage is in effect. (5) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (6) Arkansas Blue Cross and Blue Shield may phone or e-mail me for additional information that may help with the timely processing of my application. **This application is valid for 30 days only when completed and signed.**

ESSENTIAL BLUE FREEDOM: 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, my application may be approved with no changes, approved but charged a higher premium and/or approved with non-medical exclusions, 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 364 days.** (2) 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. (3) Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY) may phone me for additional information that may help with the timely processing of my application. (4) The Health 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. **This application is valid for 90 days only when completed and signed.**

In signing, I: (a) 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; (b) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (c) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (d) agree that this application shall be valid without time limit.

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.

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

SIGNATURE SECTION (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian (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 primary applicant or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name (please print)	X	Telephone No.
Custodial Parent's Address	Street or PO Box	City State Zip
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)	X	Sales Representative's Name (Please Print)	Telephone No.
Agency Federal Tax ID No. (If applicable)	X	Sales Representative's Signature	Date Signed

Comments:	OFFICE USE ONLY
------------------	------------------------

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. Until that time, make sure you pay any statement you receive.

Complete the information below.

Required only for Essential Blue Freedom

IMPORTANT: PLEASE READ BEFORE SIGNING

I authorize Arkansas Blue Cross and Blue Shield and/or the BANK indicated below, to debit my Arkansas Blue Cross 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 coverage, UNLESS Arkansas Blue Cross 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.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

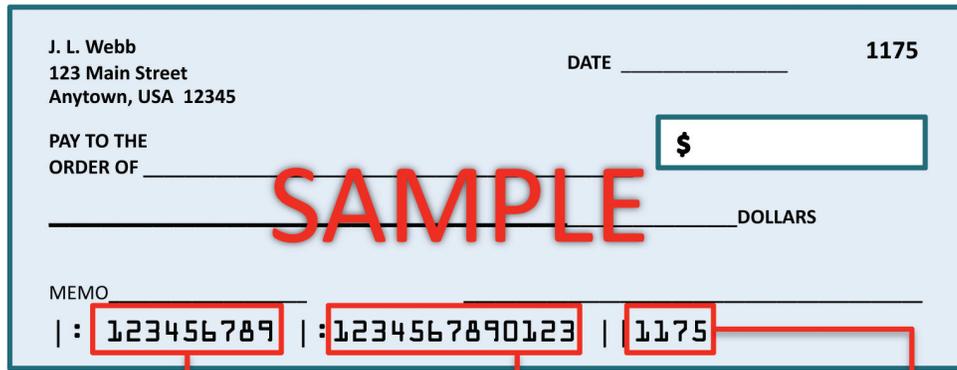
PROPOSED INSURED'S INFORMATION

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



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!

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

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 DATES FOR ESSENTIAL BLUE FREEDOM

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

POLICY EFFECTIVE DATES FOR SHORT-TERM BLUE

Your Short-Term Blue policy will take effect on the later of: (1) the requested effective date; or (2) the day after the postmark date affixed by the U.S. Postal Service,* but only if the following conditions are satisfied:

- Your application and the appropriate premium payment are received at Arkansas Blue Cross in Little Rock within 15 days of your signing;
- Your application is properly completed and unaltered;
- If you answered Eligibility Question 1 Yes, you are applying for Individual coverage;
- You answered Questions 2, 3 and 4 No;
- You are between the ages of six months and 65 and **not** on Medicare or any other health insurance.

* If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (1) the date you requested; or (2) the date received by Arkansas Blue Cross.



Arkansas
BlueCross BlueShield

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



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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 7).
- If any dependents are under age 19 and do NOT reside with the primary applicant, the custodial parent must also sign the application (see *Signature Section* on Page 7).

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 and must have a primary care physician in the U.S. 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
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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, pharmacy benefits manager, 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. I understand that information re-disclosed may no longer be protected by federal privacy regulations. 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, PO Box 2181, Little Rock, AR 72203-2181. 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.

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)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> 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
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8 CONTACT INFORMATION

Primary Phone Number ()	Alternate Phone Number ()	E-mail Address	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> Phone
--------------------------------	----------------------------------	----------------	--

9 HOUSEHOLD INFORMATION

- Yes No a. Do all applicants under the age of 19 reside in the same household?

If "no," please provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

- Yes No b. Are all applicants permanent, legal residents of Arkansas?

If "no," please 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
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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 any applicants recently lost employer-sponsored health coverage? If "yes," please provide:
- Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Yes No c. Have any applicants 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 (including AR Kids First)?
- 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: _____

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

18 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

19 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: ____/____/____

20 INFERTILITY

Has any applicant or spouse of an 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: ____/____/____

21 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: ____/____/____

22 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: _____

23 PRESCRIPTION QUESTIONNAIRE

Yes No Is any 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 printout 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				

24 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.)**

<p>A. BRAIN OR NERVOUS SYSTEM DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alzheimer's disease or senile dementia <input type="checkbox"/> Amyotrophic lateral sclerosis (Lou Gehrig's disease) <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Concussion or brain injury <input type="checkbox"/> Convulsions, epilepsy or seizures <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Meningitis <input type="checkbox"/> Multiple sclerosis, muscular dystrophy or myasthenia gravis <input type="checkbox"/> Neuritis <input type="checkbox"/> Paralysis or palsy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Polyneuritis <input type="checkbox"/> Vertigo, fainting or dizziness <input type="checkbox"/> Any other disorder of the brain or nervous system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>D. KIDNEY, URINARY, REPRODUCTIVE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bladder or renal stones <input type="checkbox"/> Cesarean section or miscarriage <input type="checkbox"/> Dialysis <input type="checkbox"/> Nephritis <input type="checkbox"/> Nephrotic syndrome, renal disease or failure <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Sugar, blood or protein in urine <input type="checkbox"/> Any other disorder of the kidneys or urinary tract <input type="checkbox"/> Any other disorder of the male reproductive organs, including prostate <input type="checkbox"/> Any other disorder of the female reproductive organs, including ovaries or breasts <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>MUSCULOSKELETAL (cont.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fracture(s) or broken bone(s) Exposed bone <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Gout <input type="checkbox"/> Lupus, systemic <input type="checkbox"/> Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder <input type="checkbox"/> Any other disorder of the muscles, bones or joints to include chiropractic care <input type="checkbox"/> None of the above apply to any applicant(s)
<p>B. CIRCULATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal cholesterol/lipids <input type="checkbox"/> Angina, heart attack, myocardial infarction <input type="checkbox"/> Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty <input type="checkbox"/> Cerebrovascular accident (stroke), including transient ischemic attack (TIA) <input type="checkbox"/> Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever <input type="checkbox"/> Heart bypass surgery, pacemaker implant <input type="checkbox"/> Heart or vein/artery surgery <input type="checkbox"/> High blood pressure <input type="checkbox"/> Hemophilia <input type="checkbox"/> Valve repair/replacement <input type="checkbox"/> Any other disorder of the heart, blood, blood vessels or circulatory system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>E. RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies, asthma or bronchitis <input type="checkbox"/> Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV) <input type="checkbox"/> Obstructive or reactive airway disorder <input type="checkbox"/> Sleep apnea, cpap, bipap or vpap <input type="checkbox"/> Any other disorder of the lungs, bronchial tubes or respiratory system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>I. EARS/EYES/NOSE/THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cataracts or glaucoma <input type="checkbox"/> Meniere's disease <input type="checkbox"/> Nasal septal defect <input type="checkbox"/> Sinusitis, tonsillitis or otitis media <input type="checkbox"/> Any other disorder of the eyes, ears, nose, throat or esophagus <input type="checkbox"/> None of the above apply to any applicant(s)
<p>C. DIGESTIVE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Crohn's disease or ulcerative colitis <input type="checkbox"/> Gastric bypass surgery or other weight loss procedure <input type="checkbox"/> Gastric or duodenal ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia, hemorrhoids <input type="checkbox"/> Irritable bowel syndrome or gastric esophageal reflux disorder (GERD) <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Pyloric stenosis <input type="checkbox"/> Any other disorder of stomach, intestines, liver, gallbladder or rectum <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer, leukemia or malignancy of any kind <input type="checkbox"/> Hodgkin's or Non-Hodgkin's disease <input type="checkbox"/> Melanoma, neoplasm or tumor <input type="checkbox"/> Any other disorder of the lymphatic system <input type="checkbox"/> Any other disorder of the skin <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Counseling or psychiatric treatment (in-patient or out-patient) <input type="checkbox"/> Bipolar disorder, obsessive compulsive disorder or developmental disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Any other mental, emotional disorder or situation, including ADD/ADHD <input type="checkbox"/> None of the above apply to any applicant(s)
<p>G. GLANDULAR DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adrenal disorders <input type="checkbox"/> Diabetes, abnormal glucose <input type="checkbox"/> Goiter or thyroid disease <input type="checkbox"/> Any disorder of the pancreas <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>H. MUSCULOSKELETAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis, osteoarthritis, degenerative joint or disc disease <input type="checkbox"/> Back pain and/or neck pain <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Connective tissue disorder <input type="checkbox"/> Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other <input type="checkbox"/> Fibromyalgia, bursitis or tendonitis 	<p>K. OTHER</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current patient in a hospital or nursing home <input type="checkbox"/> Pending Surgery Surgery Date: __/__/__ <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Breast implants <input type="checkbox"/> Saline <input type="checkbox"/> Silicone Surgery Date: __/__/__ <input type="checkbox"/> Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) <input type="checkbox"/> Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV <input type="checkbox"/> Transplant recipient <input type="checkbox"/> Any injury, deformity, incapacitation, disease or condition not listed elsewhere <input type="checkbox"/> None of the above apply to any applicant(s)

24 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					

25 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 7 if more room is needed for details.

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, and/or approved with non-medical exclusions, 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 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.

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.

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

SIGNATURE SECTION (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian (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 primary applicant or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name (please print)	X	Telephone No.
Custodial Parent's Address	Street or PO Box	City State Zip
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)	X	Sales Representative's Name (Please Print)	Telephone No.
Agency Federal Tax ID No. (If applicable)	X	Sales Representative's Signature	Date Signed

Comments:	OFFICE USE ONLY
------------------	------------------------

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

Reminders

To ensure your application is processed as quickly as possible, make sure:

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

Have you enclosed your Pre-authorized Monthly Bank Draft form?

- Did you provide all the requested information?
- Is it signed by the account holder?

Important Note: Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

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.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

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

J. L. Webb
123 Main Street
Anytown, USA 12345

DATE _____ 1175

PAY TO THE ORDER OF _____ \$ [redacted] DOLLARS

MEMO
| : 123456789 | : 1234567890123 | 1175

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!

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

An Independent Licensee of the Blue Cross and Blue Shield Association

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

1st - 10th

11th - 25th

26th - last day of the month

Effective Date

1st of the following month

15th of the following month

1st of the month after next

Examples

Approved Jan. 2; effective Feb. 1

Approved Jan. 12; effective Feb. 15

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 7).
- If any dependents are under age 19 and do NOT reside with the primary applicant, the custodial parent must also sign the application (see *Signature Section* on Page 7).

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 and must have a primary care physician in the U.S. 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
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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, pharmacy benefits manager, 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. I understand that information re-disclosed may no longer be protected by federal privacy regulations. 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, PO Box 2181, Little Rock, AR 72203-2181. 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	



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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.

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)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> 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 ()	E-mail Address	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> Phone
-------------------------------	---------------------------------	----------------	--

9 HOUSEHOLD INFORMATION

Yes No a. Do all applicants under the age of 19 reside in the same household?

If "no," please provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

Yes No b. Are all applicants permanent, legal residents of Arkansas?

If "no," please 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
----------	-----------	----------------

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 any applicants recently lost employer-sponsored health coverage? If "yes," please provide:
- Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Yes No c. Have any applicants 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 (including AR Kids First)?
- 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: _____

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

18 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

19 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: ____/____/____

20 INFERTILITY

Has any applicant or spouse of an 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: ____/____/____

21 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: ____/____/____

22 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: _____

23 PRESCRIPTION QUESTIONNAIRE

Yes No Is any 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 printout 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				

24 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.)**

<p>A. BRAIN OR NERVOUS SYSTEM DISORDERS</p> <input type="checkbox"/> Alzheimer's disease or senile dementia <input type="checkbox"/> Amyotrophic lateral sclerosis (Lou Gehrig's disease) <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Concussion or brain injury <input type="checkbox"/> Convulsions, epilepsy or seizures <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Meningitis <input type="checkbox"/> Multiple sclerosis, muscular dystrophy or myasthenia gravis <input type="checkbox"/> Neuritis <input type="checkbox"/> Paralysis or palsy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Polyneuritis <input type="checkbox"/> Vertigo, fainting or dizziness <input type="checkbox"/> Any other disorder of the brain or nervous system <input type="checkbox"/> None of the above apply to any applicant(s)	<p>D. KIDNEY, URINARY, REPRODUCTIVE</p> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bladder or renal stones <input type="checkbox"/> Cesarean section or miscarriage <input type="checkbox"/> Dialysis <input type="checkbox"/> Nephritis <input type="checkbox"/> Nephrotic syndrome, renal disease or failure <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Sugar, blood or protein in urine <input type="checkbox"/> Any other disorder of the kidneys or urinary tract <input type="checkbox"/> Any other disorder of the male reproductive organs, including prostate <input type="checkbox"/> Any other disorder of the female reproductive organs, including ovaries or breasts <input type="checkbox"/> None of the above apply to any applicant(s)	<p>MUSCULOSKELETAL (cont.)</p> <input type="checkbox"/> Fracture(s) or broken bone(s) Exposed bone <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Gout <input type="checkbox"/> Lupus, systemic <input type="checkbox"/> Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder <input type="checkbox"/> Any other disorder of the muscles, bones or joints to include chiropractic care <input type="checkbox"/> None of the above apply to any applicant(s)
<p>B. CIRCULATORY</p> <input type="checkbox"/> Abnormal cholesterol/lipids <input type="checkbox"/> Angina, heart attack, myocardial infarction <input type="checkbox"/> Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty <input type="checkbox"/> Cerebrovascular accident (stroke), including transient ischemic attack (TIA) <input type="checkbox"/> Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever <input type="checkbox"/> Heart bypass surgery, pacemaker implant <input type="checkbox"/> Heart or vein/artery surgery <input type="checkbox"/> High blood pressure <input type="checkbox"/> Hemophilia <input type="checkbox"/> Valve repair/replacement <input type="checkbox"/> Any other disorder of the heart, blood, blood vessels or circulatory system <input type="checkbox"/> None of the above apply to any applicant(s)	<p>E. RESPIRATORY</p> <input type="checkbox"/> Allergies, asthma or bronchitis <input type="checkbox"/> Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV) <input type="checkbox"/> Obstructive or reactive airway disorder <input type="checkbox"/> Sleep apnea, cpap, bipap or vpap <input type="checkbox"/> Any other disorder of the lungs, bronchial tubes or respiratory system <input type="checkbox"/> None of the above apply to any applicant(s)	<p>I. EARS/EYES/NOSE/THROAT</p> <input type="checkbox"/> Cataracts or glaucoma <input type="checkbox"/> Meniere's disease <input type="checkbox"/> Nasal septal defect <input type="checkbox"/> Sinusitis, tonsillitis or otitis media <input type="checkbox"/> Any other disorder of the eyes, ears, nose, throat or esophagus <input type="checkbox"/> None of the above apply to any applicant(s)
<p>C. DIGESTIVE</p> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Crohn's disease or ulcerative colitis <input type="checkbox"/> Gastric bypass surgery or other weight loss procedure <input type="checkbox"/> Gastric or duodenal ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia, hemorrhoids <input type="checkbox"/> Irritable bowel syndrome or gastric esophageal reflux disorder (GERD) <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Pyloric stenosis <input type="checkbox"/> Any other disorder of stomach, intestines, liver, gallbladder or rectum <input type="checkbox"/> None of the above apply to any applicant(s)	<p>F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer, leukemia or malignancy of any kind <input type="checkbox"/> Hodgkin's or Non-Hodgkin's disease <input type="checkbox"/> Melanoma, neoplasm or tumor <input type="checkbox"/> Any other disorder of the lymphatic system <input type="checkbox"/> Any other disorder of the skin <input type="checkbox"/> None of the above apply to any applicant(s)	<p>J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE</p> <input type="checkbox"/> Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Counseling or psychiatric treatment (in-patient or out-patient) <input type="checkbox"/> Bipolar disorder, obsessive compulsive disorder or developmental disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Any other mental, emotional disorder or situation, including ADD/ADHD <input type="checkbox"/> None of the above apply to any applicant(s)
<p>G. GLANDULAR DISORDERS</p> <input type="checkbox"/> Adrenal disorders <input type="checkbox"/> Diabetes, abnormal glucose <input type="checkbox"/> Goiter or thyroid disease <input type="checkbox"/> Any disorder of the pancreas <input type="checkbox"/> None of the above apply to any applicant(s)	<p>H. MUSCULOSKELETAL</p> <input type="checkbox"/> Arthritis, osteoarthritis, degenerative joint or disc disease <input type="checkbox"/> Back pain and/or neck pain <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Connective tissue disorder <input type="checkbox"/> Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other <input type="checkbox"/> Fibromyalgia, bursitis or tendonitis	<p>K. OTHER</p> <input type="checkbox"/> Current patient in a hospital or nursing home <input type="checkbox"/> Pending Surgery Surgery Date: __/__/__ <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Breast implants <input type="checkbox"/> Saline <input type="checkbox"/> Silicone Surgery Date: __/__/__ <input type="checkbox"/> Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) <input type="checkbox"/> Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV <input type="checkbox"/> Transplant recipient <input type="checkbox"/> Any injury, deformity, incapacitation, disease or condition not listed elsewhere <input type="checkbox"/> None of the above apply to any applicant(s)

24 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					

25 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 7 if more room is needed for details.

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, and/or approved with non-medical exclusions, 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 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.

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.

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

SIGNATURE SECTION (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian (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 primary applicant or the parent/guardian indicated in Section 2, the custodial parent's signature is also required.

Custodial Parent's Name (please print)	X	Telephone No.
Custodial Parent's Address	Street or PO Box	City State Zip
Custodial Parent's Signature	X	Date Signed

Comments:	OFFICE USE ONLY
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THIS APPLICATION IS VALID FOR 90 DAYS ONLY WHEN COMPLETED AND SIGNED.

Reminders

To ensure your application is processed as quickly as possible, make sure:

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

Have you enclosed your Pre-authorized Monthly Bank Draft form?

- Did you provide all the requested information?
- Is it signed by the account holder?

Important Note: Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

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.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

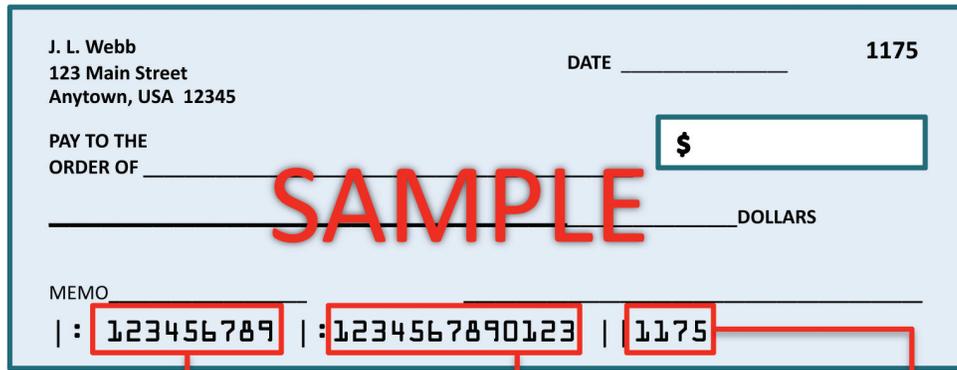
PROPOSED INSURED'S INFORMATION

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



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!

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

ID NO.

EFFECTIVE DATE



Arkansas BlueCross BlueShield

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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

1st - 10th

11th - 25th

26th - last day of the month

Effective Date

1st of the following month

15th of the following month

1st of the month after next

Examples

Approved Jan. 2; effective Feb. 1

Approved Jan. 12; effective Feb. 15

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 primary applicant, 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 and must have a primary care physician in the U.S. 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

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, pharmacy benefits manager, 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. I understand that information re-disclosed may no longer be protected by federal privacy regulations. 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, PO Box 2181, Little Rock, AR 72203-2181. 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.

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)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> 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 AR Zip _____

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 ()	E-mail Address	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> Phone
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9 HOUSEHOLD INFORMATION

- Yes No a. Do all applicants under the age of 19 reside in the same household?

If "no," please provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

- Yes No b. Are all applicants permanent, legal residents of Arkansas?

If "no," please 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
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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 any applicants recently lost employer-sponsored health coverage? If "yes," please provide:
- Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Yes No c. Have any applicants 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 (including AR Kids First)?
- 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: _____

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 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: ____/____/____

18 INFERTILITY

Has any applicant or spouse of an 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: ____/____/____

19 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: ____/____/____

20 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: _____

21 PRESCRIPTION QUESTIONNAIRE

Yes No Is any 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 printout 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				

22 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.)**

<p>A. BRAIN OR NERVOUS SYSTEM DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alzheimer's disease or senile dementia <input type="checkbox"/> Amyotrophic lateral sclerosis (Lou Gehrig's disease) <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Concussion or brain injury <input type="checkbox"/> Convulsions, epilepsy or seizures <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Meningitis <input type="checkbox"/> Multiple sclerosis, muscular dystrophy or myasthenia gravis <input type="checkbox"/> Neuritis <input type="checkbox"/> Paralysis or palsy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Polyneuritis <input type="checkbox"/> Vertigo, fainting or dizziness <input type="checkbox"/> Any other disorder of the brain or nervous system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>D. KIDNEY, URINARY, REPRODUCTIVE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bladder or renal stones <input type="checkbox"/> Cesarean section or miscarriage <input type="checkbox"/> Dialysis <input type="checkbox"/> Nephritis <input type="checkbox"/> Nephrotic syndrome, renal disease or failure <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Sugar, blood or protein in urine <input type="checkbox"/> Any other disorder of the kidneys or urinary tract <input type="checkbox"/> Any other disorder of the male reproductive organs, including prostate <input type="checkbox"/> Any other disorder of the female reproductive organs, including ovaries or breasts <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>MUSCULOSKELETAL (cont.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fracture(s) or broken bone(s) Exposed bone <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Gout <input type="checkbox"/> Lupus, systemic <input type="checkbox"/> Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder <input type="checkbox"/> Any other disorder of the muscles, bones or joints to include chiropractic care <input type="checkbox"/> None of the above apply to any applicant(s)
<p>B. CIRCULATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal cholesterol/lipids <input type="checkbox"/> Angina, heart attack, myocardial infarction <input type="checkbox"/> Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty <input type="checkbox"/> Cerebrovascular accident (stroke), including transient ischemic attack (TIA) <input type="checkbox"/> Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever <input type="checkbox"/> Heart bypass surgery, pacemaker implant <input type="checkbox"/> Heart or vein/artery surgery <input type="checkbox"/> High blood pressure <input type="checkbox"/> Hemophilia <input type="checkbox"/> Valve repair/replacement <input type="checkbox"/> Any other disorder of the heart, blood, blood vessels or circulatory system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>E. RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies, asthma or bronchitis <input type="checkbox"/> Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV) <input type="checkbox"/> Obstructive or reactive airway disorder <input type="checkbox"/> Sleep apnea, cpap, bipap or vpap <input type="checkbox"/> Any other disorder of the lungs, bronchial tubes or respiratory system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>I. EARS/EYES/NOSE/THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cataracts or glaucoma <input type="checkbox"/> Meniere's disease <input type="checkbox"/> Nasal septal defect <input type="checkbox"/> Sinusitis, tonsillitis or otitis media <input type="checkbox"/> Any other disorder of the eyes, ears, nose, throat or esophagus <input type="checkbox"/> None of the above apply to any applicant(s)
<p>C. DIGESTIVE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Crohn's disease or ulcerative colitis <input type="checkbox"/> Gastric bypass surgery or other weight loss procedure <input type="checkbox"/> Gastric or duodenal ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia, hemorrhoids <input type="checkbox"/> Irritable bowel syndrome or gastric esophageal reflux disorder (GERD) <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Pyloric stenosis <input type="checkbox"/> Any other disorder of stomach, intestines, liver, gallbladder or rectum <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer, leukemia or malignancy of any kind <input type="checkbox"/> Hodgkin's or Non-Hodgkin's disease <input type="checkbox"/> Melanoma, neoplasm or tumor <input type="checkbox"/> Any other disorder of the lymphatic system <input type="checkbox"/> Any other disorder of the skin <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Counseling or psychiatric treatment (in-patient or out-patient) <input type="checkbox"/> Bipolar disorder, obsessive compulsive disorder or developmental disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Any other mental, emotional disorder or situation, including ADD/ADHD <input type="checkbox"/> None of the above apply to any applicant(s)
<p>G. GLANDULAR DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adrenal disorders <input type="checkbox"/> Diabetes, abnormal glucose <input type="checkbox"/> Goiter or thyroid disease <input type="checkbox"/> Any disorder of the pancreas <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>H. MUSCULOSKELETAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis, osteoarthritis, degenerative joint or disc disease <input type="checkbox"/> Back pain and/or neck pain <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Connective tissue disorder <input type="checkbox"/> Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other <input type="checkbox"/> Fibromyalgia, bursitis or tendonitis 	<p>K. OTHER</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current patient in a hospital or nursing home <input type="checkbox"/> Pending Surgery Surgery Date: __/__/__ <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Breast implants <input type="checkbox"/> Saline <input type="checkbox"/> Silicone Surgery Date: __/__/__ <input type="checkbox"/> Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) <input type="checkbox"/> Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV <input type="checkbox"/> Transplant recipient <input type="checkbox"/> Any injury, deformity, incapacitation, disease or condition not listed elsewhere <input type="checkbox"/> None of the above apply to any applicant(s)

22 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					

23 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.

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, and/or approved with non-medical exclusions, 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 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, 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.

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.

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

SIGNATURE SECTION (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian (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 primary applicant or the parent/guardian indicated in Section 2, the **custodial parent's** signature is also required.

Custodial Parent's Name (please print)	X	Telephone No.
Custodial Parent's Address	Street or PO Box	City State Zip
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)	X	Sales Representative's Name (Please Print)	Telephone No.
Agency Federal Tax ID No. (if applicable)	X	Sales Representative's Signature	Date Signed

Comments:

OFFICE USE ONLY

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

Reminders

To ensure your application is processed as quickly as possible, make sure:

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

Have you enclosed your Pre-authorized Monthly Bank Draft form?

- Did you provide all the requested information?
- Is it signed by the account holder?

Important Note: Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.

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

1st - 10th

11th - last day of the month

Effective Date

1st of the following month

1st of the month after next

Examples

Approved Jan. 2; effective Feb. 1

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 primary applicant, 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 and must have a primary care physician in the U.S. 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**

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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, pharmacy benefits manager, 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. I understand that information re-disclosed may no longer be protected by federal privacy regulations. 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, PO Box 2181, Little Rock, AR 72203-2181. 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.

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)
			<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian <input type="checkbox"/> Father <input type="checkbox"/> 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 ()	E-mail Address	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> Phone

9 HOUSEHOLD INFORMATION

Yes No a. Do all applicants under the age of 19 reside in the same household?

If "no," please provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

Yes No b. Are all applicants permanent, legal residents of Arkansas?

If "no," please 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

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 any applicants recently lost employer-sponsored health coverage? If "yes," please provide:
- Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Yes No c. Have any applicants 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 (including AR Kids First)?
- 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: _____

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 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: ____/____/____

18 INFERTILITY

Has any applicant or spouse of an 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: ____/____/____

19 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: ____/____/____

20 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: _____

21 PRESCRIPTION QUESTIONNAIRE

Yes No Is any 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 printout 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				

22 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.)**

<p>A. BRAIN OR NERVOUS SYSTEM DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Alzheimer's disease or senile dementia <input type="checkbox"/> Amyotrophic lateral sclerosis (Lou Gehrig's disease) <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Concussion or brain injury <input type="checkbox"/> Convulsions, epilepsy or seizures <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Meningitis <input type="checkbox"/> Multiple sclerosis, muscular dystrophy or myasthenia gravis <input type="checkbox"/> Neuritis <input type="checkbox"/> Paralysis or palsy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Polyneuritis <input type="checkbox"/> Vertigo, fainting or dizziness <input type="checkbox"/> Any other disorder of the brain or nervous system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>D. KIDNEY, URINARY, REPRODUCTIVE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal pap smear <input type="checkbox"/> Bladder or renal stones <input type="checkbox"/> Cesarean section or miscarriage <input type="checkbox"/> Dialysis <input type="checkbox"/> Nephritis <input type="checkbox"/> Nephrotic syndrome, renal disease or failure <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Sugar, blood or protein in urine <input type="checkbox"/> Any other disorder of the kidneys or urinary tract <input type="checkbox"/> Any other disorder of the male reproductive organs, including prostate <input type="checkbox"/> Any other disorder of the female reproductive organs, including ovaries or breasts <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>MUSCULOSKELETAL (cont.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fracture(s) or broken bone(s) Exposed bone <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Gout <input type="checkbox"/> Lupus, systemic <input type="checkbox"/> Temporomandibular joint disorder (TMJ/TMD) or craniomandibular disorder <input type="checkbox"/> Any other disorder of the muscles, bones or joints to include chiropractic care <input type="checkbox"/> None of the above apply to any applicant(s)
<p>B. CIRCULATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal cholesterol/lipids <input type="checkbox"/> Angina, heart attack, myocardial infarction <input type="checkbox"/> Arteriosclerosis, atherosclerosis, coronary artery disease, stent placement or angioplasty <input type="checkbox"/> Cerebrovascular accident (stroke), including transient ischemic attack (TIA) <input type="checkbox"/> Chest pain, shortness of breath, heart murmur, palpitation of the heart, ablation, rheumatic fever <input type="checkbox"/> Heart bypass surgery, pacemaker implant <input type="checkbox"/> Heart or vein/artery surgery <input type="checkbox"/> High blood pressure <input type="checkbox"/> Hemophilia <input type="checkbox"/> Valve repair/replacement <input type="checkbox"/> Any other disorder of the heart, blood, blood vessels or circulatory system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>E. RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies, asthma or bronchitis <input type="checkbox"/> Chronic pulmonary disease, emphysema, lung disease or respiratory syncytial virus (RSV) <input type="checkbox"/> Obstructive or reactive airway disorder <input type="checkbox"/> Sleep apnea, cpap, bipap or vpap <input type="checkbox"/> Any other disorder of the lungs, bronchial tubes or respiratory system <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>I. EARS/EYES/NOSE/THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cataracts or glaucoma <input type="checkbox"/> Meniere's disease <input type="checkbox"/> Nasal septal defect <input type="checkbox"/> Sinusitis, tonsillitis or otitis media <input type="checkbox"/> Any other disorder of the eyes, ears, nose, throat or esophagus <input type="checkbox"/> None of the above apply to any applicant(s)
<p>C. DIGESTIVE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Crohn's disease or ulcerative colitis <input type="checkbox"/> Gastric bypass surgery or other weight loss procedure <input type="checkbox"/> Gastric or duodenal ulcer <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia, hemorrhoids <input type="checkbox"/> Irritable bowel syndrome or gastric esophageal reflux disorder (GERD) <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Pyloric stenosis <input type="checkbox"/> Any other disorder of stomach, intestines, liver, gallbladder or rectum <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Cancer, leukemia or malignancy of any kind <input type="checkbox"/> Hodgkin's or Non-Hodgkin's disease <input type="checkbox"/> Melanoma, neoplasm or tumor <input type="checkbox"/> Any other disorder of the lymphatic system <input type="checkbox"/> Any other disorder of the skin <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety, insomnia, sleep disorder, depression, emotional problems or nervous disorder <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Counseling or psychiatric treatment (in-patient or out-patient) <input type="checkbox"/> Bipolar disorder, obsessive compulsive disorder or developmental disorder <input type="checkbox"/> Eating disorder <input type="checkbox"/> Any other mental, emotional disorder or situation, including ADD/ADHD <input type="checkbox"/> None of the above apply to any applicant(s)
	<p>G. GLANDULAR DISORDERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adrenal disorders <input type="checkbox"/> Diabetes, abnormal glucose <input type="checkbox"/> Goiter or thyroid disease <input type="checkbox"/> Any disorder of the pancreas <input type="checkbox"/> None of the above apply to any applicant(s) 	<p>K. OTHER</p> <ul style="list-style-type: none"> <input type="checkbox"/> Current patient in a hospital or nursing home <input type="checkbox"/> Pending Surgery Surgery Date: __/__/__ <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Breast implants <input type="checkbox"/> Saline <input type="checkbox"/> Silicone Surgery Date: __/__/__ <input type="checkbox"/> Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents) <input type="checkbox"/> Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV <input type="checkbox"/> Transplant recipient <input type="checkbox"/> Any injury, deformity, incapacitation, disease or condition not listed elsewhere <input type="checkbox"/> None of the above apply to any applicant(s)
	<p>H. MUSCULOSKELETAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis, osteoarthritis, degenerative joint or disc disease <input type="checkbox"/> Back pain and/or neck pain <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Connective tissue disorder <input type="checkbox"/> Disease or disorder of the joints: knee(s), shoulder(s), elbow(s), wrist(s), other <input type="checkbox"/> Fibromyalgia, bursitis or tendonitis 	

22 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					

23 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.

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, and/or approved with non-medical exclusions, 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 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, 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.

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.

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

SIGNATURE SECTION (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian (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 primary applicant or the parent/guardian indicated in Section 2, the **custodial parent's** signature is also required.

Custodial Parent's Name (please print)	X	Telephone No.
Custodial Parent's Address	Street or PO Box	City State Zip
Custodial Parent's Signature	X	Date Signed

Comments:

OFFICE USE ONLY

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

Reminders

To ensure your application is processed as quickly as possible, make sure:

- All questions are answered.
- All the pages are returned.
- All appropriate signatures and signature dates are provided.

Have you enclosed your Pre-authorized Monthly Bank Draft form?

- Did you provide all the requested information?
- Is it signed by the account holder?

Important Note: Depending on the date your application is approved, we may not be able to draft your first premium payment. To ensure coverage, please promptly pay any invoice you receive.

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

1st - 10th

11th - last day of the month

Effective Date

1st of the following month

1st of the month after next

Examples

Approved Jan. 2; effective Feb. 1

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

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.healthcare.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 and must have a primary care physician in the U.S. 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 available for **all** of our individual policies.
- **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 or fax to 501-378-3752

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 () ()	E-mail Address	How do you prefer we communicate with you? <input type="checkbox"/> E-mail <input type="checkbox"/> 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 and provide date of qualifying life event.

<input type="checkbox"/> 1-Annual Open Enrollment Period			
<input type="checkbox"/> 2-Birth	Date	<input type="checkbox"/> 7-New Guardianship/Legal custody/court order to add child	Date
<input type="checkbox"/> 3-Adoption	_____	<input type="checkbox"/> 8-Loss of employer-sponsored health coverage	_____
<input type="checkbox"/> 4-Death	_____	<input type="checkbox"/> 9-Involuntary loss of other health coverage	_____
<input type="checkbox"/> 5-Marriage	_____		
<input type="checkbox"/> 6-Divorce or Legal Separation	_____	<input type="checkbox"/> 10-Military Leave	Date
		<input type="checkbox"/> 11-Military Reinstatement	_____
		<input type="checkbox"/> 12-Other (Give specific details & date)	_____

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 on the instruction sheet 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 on the instruction sheet 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.

7 ADD MATERNITY

- | | | |
|---|---|---|
| <p>AccessBlue PPO (Not an option)</p> <p><input type="checkbox"/> BlueCare PPO</p> <p><input type="checkbox"/> BlueCare PPO Plus</p> <p><input type="checkbox"/> Blue Choice</p> <p><input type="checkbox"/> Blue Select</p> <p style="padding-left: 20px;"><input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000</p> <p><input type="checkbox"/> Blue Solution PPO</p> <p><input type="checkbox"/> Comprehensive Blue PPO (Grandfathered only*)</p> <p><input type="checkbox"/> Comprehensive Blue PPO II (Grandfathered only*)</p> | <p>Basic Blue PPO (Not an option)
Conversion (Not applicable)</p> | <p>Comprehensive Blue PPO III (Not an option)</p> <p><input type="checkbox"/> HSA Blue PPO</p> <p><input type="checkbox"/> HSA Blue PPO Plus</p> <p><input type="checkbox"/> HSA Blue PPO II (Grandfathered only*)</p> <p><input type="checkbox"/> UniqueCare</p> <p><input type="checkbox"/> UniqueCare Blue</p> <p style="padding-left: 20px;"><input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000</p> <p><input type="checkbox"/> UniqueCare Blue Preferred</p> <p><input type="checkbox"/> Farm Bureau FlexPlan</p> <p><input type="checkbox"/> Farm Bureau FlexPlan Preferred</p> |
|---|---|---|

*Refer to Section 8 Benefit Changes below to determine if your policy is grandfathered.

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: \$1,000 \$2,000

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: \$1,000

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:

- \$1,250 Individual/\$2,500 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
- \$3,250 Individual/\$6,450 Family Deductible, 80/20% Coinsurance, \$10,000 Individual/\$20,000 Family Coinsurance Maximum
- \$3,250 Individual/\$6,450 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

Uniqecare Group # 610100-611000, 620100-621000 or 650100-651000, 660100-661000 - Grandfathered

Uniqecare Blue Group # 600100-600114, 600200-600214 or 600300-600311, 600400-600410 - Grandfathered

Uniqecare Blue Preferred Group # 622001-622016, 633001-633016 - Grandfathered

Farm Bureau Flexplan Group # 809031-809046 - 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 Plan 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.

9 HOUSEHOLD INFORMATION

- Yes No a. Do all applicants under the age of 19 reside in the same household?
If "no," please provide reason and his/her name and address:
Name: _____ Address: _____
Reason: _____
- Yes No b. Are all applicants permanent, legal residents of Arkansas?
If "no," please provide reason and his/her name and address:
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 any applicants recently lost employer-sponsored health coverage? If "yes," please provide:
Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
Name: _____ Carrier Name: _____ Termination Date: ___/___/___.
- Yes No c. Have any applicants 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 (including AR Kids First)?
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: _____

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 an 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 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 printout 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				

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 syncytial 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)**

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.

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 age 19 or older 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.

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.

I certify that I signed this change form in the state of Arkansas.

SIGNATURE SECTION (Please sign appropriate line only)

Current Policyholder (required if policyholder is age 19 or older) OR Parent/Guardian (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 policyholder indicated in Section 1, the **custodial parent's** signature is also required.

Custodial Parent's Name (please print)	X	Telephone No.
Custodial Parent's Address	Street or PO Box	City State Zip
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

	OFFICE USE ONLY
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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, pharmacy benefits manager, 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. I understand that information re-disclosed may no longer be protected by federal privacy regulations. 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, PO Box 2181, Little Rock, AR 72203-2181. 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).

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

Applicants age 18 and older	Print Name(s)	Signature	Date
	_____	_____	____/____/____
	_____	_____	____/____/____
	_____	_____	____/____/____
	_____	_____	____/____/____
	_____	_____	____/____/____
	_____	_____	____/____/____

List applicants under age 18 (Print Name).

Applicants under age 18	_____		

	_____	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

SERFF Tracking #:

ARBB-128812895

State Tracking #:**Company Tracking #:**

EBF/STB DR (01/13)

State:

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005C Individual - Other

Product Name:

Individual Applications

Project Name/Number:

Applications/EBF/STB DR (01/13),EBF/STB AG (01/13),

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	12/17/2012
Bypass Reason:	Not required.		
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	12/17/2012
Bypass Reason:	Applications already attached.		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	12/17/2012
Bypass Reason:	Not required.		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	12/17/2012
Bypass Reason:	Not required.		
		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	12/17/2012
Bypass Reason:	Not PPACA related.		