

Print in black or blue ink or type your information. **All fields are required to be completed except where otherwise noted.** Review your application for completeness and accuracy, and sign and date the application where requested. The information provided will be used and disclosed only as permitted by our Notice of Privacy Practices. You can find a copy of our Notice of Privacy Practices on our website (bcbsm.com).

Requested Effective Date (must be a future date and either the 1st or 15th of the month): _____
Final effective date will be determined by BCBSM.

Part 1: Applicant Information

Primary Applicant

| | | | | | | |
|-------------------------------------|---|--|--|----------------------------------|--|-----------------------|
| Last Name | | First Name | | M.I. | Suffix <input type="checkbox"/> Sr. <input type="checkbox"/> Jr. <input type="checkbox"/> Other _____ | |
| Street Address | | City | | State | Zip | County |
| Daytime Phone Number () () () | | Evening Phone Number () () () | | Cell Phone Number () () () | | |
| Date of Birth(MM/DD/YY) | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | | Height ____ Feet ____ Inches | | Weight ____ Pounds |
| Social Security Number | | | Applicant's Drivers License or State ID: Issue state: _____ Number: _____ | | | |
| E-mail Address | | | Spouse's Drivers License or State ID: (if applying for coverage) Issue state: _____ Number: _____ | | | |

Spouse and Dependent Children

List your spouse and dependent children you wish to cover. **Dependent children must be unmarried and age 25 or under and a Michigan resident to be eligible for coverage.**

| Spouse Name | Date of Birth(MM/DD/YY) | Gender | Height | Weight | Social Security Number |
|-------------|-------------------------|---|--------|--------|------------------------|
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| Child Name | Date of Birth(MM/DD/YY) | Gender | Height | Weight | Social Security Number |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| Child Name | Date of Birth(MM/DD/YY) | Gender | Height | Weight | Social Security Number |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| Child Name | Date of Birth(MM/DD/YY) | Gender | Height | Weight | Social Security Number |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| Child Name | Date of Birth(MM/DD/YY) | Gender | Height | Weight | Social Security Number |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |
| Child Name | Date of Birth(MM/DD/YY) | Gender | Height | Weight | Social Security Number |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | | | |

If you have additional dependents you wish to cover, please provide information on a separate sheet of paper and attach to application.

Has anyone applying for coverage used tobacco products in the past 12 months? Yes No
 If yes, who? _____

Are you or any family members applying for coverage eligible for Medicare? Yes No

Note: height, weight, gender and smoking status will not be used in determining plan eligibility or premium.

Part 2: Choose Your Coverage

Select a Health Plan

I'd like to enroll in the following health care plan (check the box that applies):

Blue Traditional Option A **Blue Tradition Option C**

Eligibility Information

1. Do you live in Michigan six months or more each year ? Yes No
2. Have you or any family members applying for coverage had health coverage in the past six months? Yes No
 If yes, please complete:
 Name of insurance company: _____

Type of coverage: Group Individual COBRA Medicare/Medicare Advantage Medicaid
 Other _____

Contract/ID number: _____ Effective date of coverage: _____ / _____ / _____

Expected termination date of coverage _____ / _____ / _____

Are benefits provided through a Sole Proprietorship? Yes No

3. Have you or any family members applying for coverage been covered under a Blue Cross Blue Shield of Michigan health plan within the past 60 days? Yes No If yes, please complete: Group name: _____

Contract number: _____ Group number: _____ Termination date: _____ / _____ / _____

4. Are you applying for group conversion coverage? Yes No

Note: If you qualify for a group conversion plan, we will align your effective date with the termination date of your group coverage, to ensure continuous coverage.

5. Are you currently employed? Yes No If yes, name of employer: _____
 If no, please skip to question # 9.

6. Does your employer offer a group health plan? Yes No If yes, are you eligible for it or currently enrolled?

Eligible: Yes No Enrolled: Yes No

If currently enrolled, when will your coverage terminate? _____ / _____ / _____

If currently enrolled, why will your coverage terminate?

- No longer employed by employer
- Costs too much
- No longer eligible for coverage
- Employer cancelled plan or no longer offers plan
- Other reason: _____

7. If you are eligible for the group health plan:

Does the employer pay for or reimburse eligible employees for any portion of their health coverage?

Yes No I don't know

If known, what amount does the employer contribute towards the employee premium (percentage or dollar amount)?

Does the employer pay for or reimburse eligible dependents for any portion of their health coverage?

Yes No I don't know

If known, what amount does the employer contribute towards the employee premium (percentage or dollar amount)?

8. Under this individual health policy for which you are applying, will your employer pay any portion of the premium?
 Yes No If yes, will the premium be paid through a qualified HRA (Health Reimbursement Account) or Section 125 (Flexible Spending Account)? Yes No

If yes, are you the business owner? Yes No

9. Who will be paying the premium for this individual health policy? Please check all that apply:

- Self
- Other family member
- Legal guardian
- My employer
- Other: _____

Eligibility Information (continued)

10. Are you or any family members applying for coverage enrolled in an individual (non-group sponsored) health plan?
 Yes No If yes, when will policy terminate (mm/dd/yyyy)? _____/_____/_____

11. Are you applying for this individual coverage because you are HIPAA eligible? Yes No I don't know
Do you believe you are eligible for waiver of pre-existing under HIPAA guidelines? Yes No I don't know

Please refer to the Terms and Conditions page of this application under "Pre-Existing Conditions" for information on HIPAA Eligibility.

12. Has any person applying for coverage been rejected for coverage within the past 6 months by another insurance carrier? (optional) Yes No

If yes, please indicate which person(s): _____

Name of carrier: _____

What was the reason?

- | | |
|--|--|
| <input type="checkbox"/> Ongoing medical condition(s) | <input type="checkbox"/> Residence outside of the carrier's service area |
| <input type="checkbox"/> Past medical history | <input type="checkbox"/> Eligible for or covered under a group health plan |
| <input type="checkbox"/> Current pregnancy or in the process of adoption | <input type="checkbox"/> Eligible for or enrolled in Medicare |
| <input type="checkbox"/> Primary residence outside the U.S. | <input type="checkbox"/> Employer paying premium for Individual plan |
| <input type="checkbox"/> Not a U.S. citizen or a citizen for less than one year | <input type="checkbox"/> Ineligible occupation |
| <input type="checkbox"/> Residence outside of Michigan more than 6 months a year | <input type="checkbox"/> Other _____ |

13. Background: (optional)

- | | |
|---|---|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> American Indian | <input type="checkbox"/> Mixed (no single dominant race/ethnic group) |
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Pan Asian |
| <input type="checkbox"/> Caucasian | |

14. Education (optional):

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> High school | <input type="checkbox"/> Grad school |
| <input type="checkbox"/> College | <input type="checkbox"/> Vocational/technical school |

15. Home ownership (optional):

- | | |
|-------------------------------|------------------------------|
| <input type="checkbox"/> Rent | <input type="checkbox"/> Own |
|-------------------------------|------------------------------|

16. Household Income (optional):

- | | | |
|---|--|---|
| <input type="checkbox"/> \$15,000 or less | <input type="checkbox"/> \$16,000 to \$35,000 | <input type="checkbox"/> \$36,000 to \$50,000 |
| <input type="checkbox"/> \$51,000 to \$75,000 | <input type="checkbox"/> \$76,000 to \$100,000 | <input type="checkbox"/> \$100,000 + |

General Health Information

1. In order for us to help you manage your chronic health condition(s) through one of our Care Management Programs, please provide us with the following medical information. The answers you provide will not be used in determining plan eligibility or your premium. If you qualify and meet eligibility guidelines, you may be eligible for member discounts in the future.

Have you or any family members applying for coverage been diagnosed or treated within the past 5 years for any of the following conditions? Please check all that apply, list the specific condition or description of the illness if applicable and the family member with the condition.

Details or Description of Illness

Family Member

| | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV/ARC | | |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis/ALS (Lou Gehrig's Disease) | | |
| <input type="checkbox"/> Asthma | | |
| <input type="checkbox"/> Brain Surgery | | |
| <input type="checkbox"/> Cancer | | |
| <input type="checkbox"/> Coronary Artery Disease (including Heart Attack, Bypass, Angioplasty) | | |
| <input type="checkbox"/> Cerebral Palsy | | |
| <input type="checkbox"/> Cerebral Vascular Disease (including Stroke and TIA) | | |
| <input type="checkbox"/> Congestive Heart Failure | | |
| <input type="checkbox"/> COPD (Emphysema, Chronic Bronchitis) | | |
| <input type="checkbox"/> Cirrhosis of Liver | | |
| <input type="checkbox"/> Crohn's Disease | | |
| <input type="checkbox"/> Cystic Fibrosis | | |
| <input type="checkbox"/> Diabetes | | |
| <input type="checkbox"/> Epilepsy/Seizures | | |
| <input type="checkbox"/> Guillan-Barre Syndrome | | |
| <input type="checkbox"/> Hemophilia or other bleeding disorder | | |
| <input type="checkbox"/> Hepatitis C, D or G | | |
| <input type="checkbox"/> Hodgkin's Disease | | |
| <input type="checkbox"/> Huntington's Disease | | |
| <input type="checkbox"/> Hydrocephalus | | |
| <input type="checkbox"/> Infertility | | |
| <input type="checkbox"/> Leukemia | | |
| <input type="checkbox"/> Lupus | | |
| <input type="checkbox"/> Muscular Dystrophy | | |
| <input type="checkbox"/> Myasthenia Gravis | | |
| <input type="checkbox"/> Paraplegia or Quadriplegia | | |
| <input type="checkbox"/> Parkinson's Disease | | |
| <input type="checkbox"/> Polycystic Kidney Disease | | |
| <input type="checkbox"/> Renal Failure | | |
| <input type="checkbox"/> Rheumatoid Arthritis | | |
| <input type="checkbox"/> Scleroderma | | |
| <input type="checkbox"/> Sclerosis (Multiple, Disseminated or Postero-Lateral) | | |
| <input type="checkbox"/> Sickle Cell Anemia | | |
| <input type="checkbox"/> Transplant (Heart, Kidney, Liver or Lung) | | |
| <input type="checkbox"/> Wilson's Disease | | |
| <input type="checkbox"/> Major Psychiatric Disorders (Alzheimer's, Dementia, Paranoia, Schizophrenia, Major Depression, Bipolar Disorder) | | |
| <input type="checkbox"/> None of the above | | |
| <input type="checkbox"/> Applicant declines to answer health information | | |

Part 3: Payment

Payment Options

How do you want to pay your initial premium?

Bill me Credit card (please complete on page 8 of this application)

Please select a billing frequency for future payments:

Monthly (must be automatic payment) Quarterly Annual
 Bi-monthly (must be automatic payment) Semi-annual

Automatic Payment (must be selected for monthly or bi-monthly billing frequency)

This option automatically deducts monthly premium payments from an account you designate.

I'd like to use the automatic payment option Yes No **If yes, please provide the following information:**

| | | | | |
|------------------------------------|-------|-----|---|--|
| Full Name (first, middle and last) | | | Social Security # | |
| Street Address | | | E-mail address | |
| City | State | Zip | Daytime Phone Number | |
| Name of Financial Institution | | | Type of account <input type="checkbox"/> Checking <input type="checkbox"/> Savings | |
| Bank Account Number | | | ABA/Routing Number (9 digits) | |

Note: Include a blank, voided check or a deposit slip from your designated account for verification. Allow three to four weeks for processing your application. Continue to mail your payment as usual until you see "Automatic Payment – Do Not Pay" on your bill.

Automatic payment cannot be processed without your signature. I authorize Blue Cross Blue Shield of Michigan to deduct payments from the checking or savings account listed above. I understand that I control my payments and if at any time I decide to discontinue the payment, I will notify Blue Cross Blue Shield of Michigan. I also understand that all information provided will remain confidential.

Signature

Date

Part 4: Consent, Terms and Conditions

You are eligible for individual coverage if:

- You are a resident of Michigan and live in the state at least six months of the year, and
- You are not eligible for group coverage through an employer or your spouse's employer, and
- You are not currently covered by another health plan, excluding Medicaid, and
- You do not have Medicare and are not eligible for Medicare supplemental coverage

We will consider you to be eligible for group coverage if your employer or your spouse's employer pays you or BCBSM any part of your premium. You may be eligible for BCBSM group conversion coverage if, in addition to meeting the eligibility requirements for individual coverage as listed above, you have been enrolled in a BCBSM group that contributes to the subsidy required by the State of Michigan.

Note: If you voluntarily terminate your BCBSM coverage as a sole proprietor or one-subscriber group, or your benefits as a member in an association that offers BCBSM coverage to its members, you are not eligible for the Group Conversion programs.

I am applying for BCBSM health coverage and/or BCBSM Personal Blue Dental or Personal Blue Dental Plus subject to the terms and conditions of this application, and I agree that I and my covered dependents will be bound by all provisions in the BCBSM certificate and riders, and/or the BCBSM Personal Blue Dental or Personal Blue Dental Plus benefit requirements. Approval of this application and coverage effective date will be determined by BCBSM and shall be subject to requirements by BCBSM for additional information and payment of bills.

I certify that the requirements of eligibility are met and that all of the information supplied on this application is true, correct, and complete to the best of my knowledge. I understand that the information will be used in reviewing my application and administering coverage and that any misrepresentation and/or false or misleading information regarding eligibility may result in termination of coverage. This coverage is not an employer group health plan and is not intended in any way to be an employer-sponsored health insurance plan. I certify that my or my spouse's employer will not contribute any part of the premium, nor will I be reimbursed for any part of the premium by the employer now, or in the future.

Authorization for Use and Disclosure of Protected Health Information (PHI)

I understand that BCBSM may collect personal and protected health information (PHI) about me in order to complete my application for coverage. BCBSM will use and disclose this information only in accordance with their Notice of Privacy Practices which is available on bcbsm.com or by calling 313-225-9000.

I authorize:

- Use and disclosure of my PHI, including membership, eligibility and claims data stored on Blue Cross Blue Shield of Michigan and its subsidiaries' computer systems.
- Physicians, health care professionals, hospitals, clinics, laboratories, pharmacies or pharmacy benefit managers, or other health care providers that have provided treatment or services to me or any of my dependents who are also applying for coverage to disclose medical records, prescription history, medications prescribed and other PHI as requested to BCBSM.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or who have knowledge of my medical information or the medical information of any of my dependents who are also applying for coverage to disclose medical records information, prescription history, medications prescribed and other PHI as requested to BCBSM.

My authorizations include disclosure of information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and treatment of mental illness and the use of alcohol, drugs and tobacco, but exclude disclosure of psychotherapy notes.

This PHI is to be disclosed so that BCBSM may: (1) perform case, care and disease management, (2) administer claims and determine or fulfill responsibility for coverage and provision of benefits, and (3) for other legally permissible purposes, including but not limited to, healthcare operations. If BCBSM discloses this information, the recipient must obtain an additional authorization from me before it may re-disclose the information and if I provide this authorization, information may be re-disclosed by the recipient and no longer protected.

I understand that my enrollment with BCBSM is conditioned upon my authorization to release PHI for the purposes stated above and that if I do not provide authorization, I may not be eligible for enrollment. My signature on this form indicates my approval for the release of PHI from BCBSM and its subsidiaries and from any of the parties listed above to BCBSM. A photographic copy of this authorization shall be valid as the original.

This authorization will expire after 30 months or upon rejection of coverage. I understand that I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request on a standard form available online at bcbsm.com or by contacting my agent. I understand that revocation will not affect actions taken before BCBSM or any of the parties identified above receive my request.

Pre-existing Conditions

A pre-existing condition is any medical condition for which medical advice, diagnosis, care, or treatment was recommended or received in the 6 months prior to the date your application was received by BCBSM.

180 day pre-existing condition waiting period

BCBSM provides no coverage for treatment of a pre-existing condition for 180 days following your effective date of coverage.

You will be subject to the 180 day pre-existing condition waiting period:

- If you have no prior coverage or your previous coverage was an individual policy. If your previous individual coverage was with BCBSM, you may receive credit toward the waiting period for the number of days you were covered under the previous certificate, provided there is no lapse in coverage.
- If you were covered under COBRA but have not exhausted your COBRA benefit.

You *will not be subject* to the 180 day pre-existing condition waiting period if all the following conditions are met **(HIPAA Eligibility)**:

- Prior to your application for this coverage, you were continuously covered under one or more health plans for a total of at least 18 months, with no more than a 62-day break. Coverage may include group health plans, individual health insurance, Medicare, Medicaid, public health plans, military or federal benefit programs, Indian Health Services, freestanding prescription drug coverage or other health plans. Freestanding dental and vision coverage cannot be counted as prior health coverage.
- Your most recent health coverage must have been through a group health plan (Please note that if health coverage was provided through an association or other organization, it is considered to be "individual" health insurance if it is not provided through an employer sponsored group health plan. Also, a business owner and spouse are usually not considered employees of a business if no other employees take part in the health plan. If this is the case, the health plan cannot be defined as a "group" health plan but is instead an individual plan. If, however, the spouse of the business owner is a bona fide employee of the business, the plan may be a group health plan).
- You have elected and exhausted any COBRA coverage for which you and/or your dependents were eligible
- You are no longer eligible for group coverage and you are not eligible for Medicare or Medicaid
- Your prior coverage was not terminated due to premium nonpayment or fraud

Part 5: Signature

Please review your application for completeness and accuracy. Sign and date your application. If you are enrolling through an independent agent, submit your application directly to your agent so that he or she can process the application for you. If you are enrolling directly with BCBSM, please mail your completed application to:

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Mail Code BP202
Detroit, MI 48226-2998

| | |
|---|-------------|
| Signature of Applicant | Date |
| Signature of Spouse | Date |
| Signature of Dependent (age 18 and over) | Date |
| Signature of Dependent (age 18 and over) | Date |

Have questions? Visit bcbsm.com/myblue for information, or call 877-4MY-BLUE (877-469-2583) or your Authorized Independent Agent for Blue Cross Blue Shield of Michigan.

Area below for Agent Use Only

| | | | |
|----------------------|------------|-----------------|------------------------|
| Agent Code | MA/GA Code | Agent Signature | Date Signed (mm/dd/yy) |
| Assoc. /Chamber Code | | | |

Area below for BCBSM Use Only

| | | | |
|--------------------------------|--------------|----------------------|-----|
| Group # | Service Code | Eff. Date (mm/dd/yy) | U/W |
| Pre-existing Date (mm/dd/yyyy) | | DEID | |

Credit Card Payment (for initial premium payment only)

Note: If you are submitting your application through an agent or by U.S. Mail and do not want your first premium payment paid by credit card, please remove this page before submitting the application.

This option offers the convenience of making your first premium payment by credit card. Your coverage is assigned an effective date upon Underwriting approval, but it is not active until payment is received by BCBSM. Using a credit card to pay your premium will activate your coverage more quickly. Your Identification Card is issued immediately, but coverage will not be activated until payment is received. Credit card payment can be used for your initial premium payment only.

Credit Card Type

 VISA MasterCard

How do you want to make ongoing payments?

 Bill me Automatic payment from my bank account **(To enroll, complete the automatic payment section on page 5.)**

Cardholder's Name (exactly as it appears on the card)

Social Security Number

Credit Card Number

Card Expiration Date

Card Verification Code

Cardholder Billing Address

Street Address

City

State

Zip Code

Daytime Phone Number

Credit card payment cannot be processed without your signature. I authorize Blue Cross Blue Shield of Michigan to charge my credit card for my first health care premium payment amount. If at any time I decide to cancel this transaction, I will notify Blue Cross Blue Shield of Michigan. I also understand that all information provided will remain confidential.

Signature

Date