



Application for Individual Coverage

Smart SelectSM

Please complete all fields. 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 obtain a copy of our *Notice of Privacy Practices* at **MiBCN.com** or by calling 313-225-9000.

To be eligible for this coverage, you must be a permanent resident of Michigan, reside in the state of Michigan at least nine months each calendar year, be under age 65 and not be eligible for Medicare.

Requested effective date: Month _____ 1st 15th

Your application must be received by Blue Care Network of Michigan within 30 days of the signature date. Your effective date of coverage will be determined by Blue Care Network and will be the 1st or 15th of the month following the underwriting approval date. The effective date may not be more than 60 days after the signature date. Dependent children must be age 25 or younger to be eligible for coverage.

Type of application:

- New enrollment
- Add spouse to current contract number _____
- Add dependent(s) to current contract number _____

Note: If adding spouse or dependent(s) please complete entire application with the spouse and/or dependent(s) information

Part I : Applicant information

Applicant last name	Applicant first name	M.I.	Social Security number	Evening phone number ()	Daytime phone number ()	
Street address (cannot be a P.O. Box)			City	State	ZIP code	County
Applicant's driver's license or state ID number	Issue state	Expiration date	Spouse's driver's license or state ID number	Issue state	Expiration date	

You will be contacted for a phone interview. What time is best for us to reach you for an interview? Time (between 8 a.m. and 4 p.m. EST):	Phone number for interview:
--	-----------------------------

List all persons you wish to cover (attach additional sheet if necessary)						Primary care physician information				Seen in last 12 months?
Last name	First name	M.I.	Gender	Rel. Code*	Last name	First name	Physician code (10 digit NPI number)	Physician's city		
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent			<input type="checkbox"/> M <input type="checkbox"/> F						<input type="checkbox"/> Yes <input type="checkbox"/> No	

Relationship codes:			
N – Child (by birth or adoption) S – Stepchild (attach legal documentation)	P – Principal support (attach documentation) L – Legal guardianship (attach court order)	A – Child adoption in progress (attach court order)	D – Disabled child (MCL 500.2264a) (attach physician statement) C – Court ordered coverage (QMCSO) (attach court order)

Part II : Eligibility

1. Are all individuals applying for coverage permanent residents of Michigan and reside in Michigan at least nine months each calendar year? Yes No
2. Are any individuals applying for coverage:
- a. *Eligible for* an employer-sponsored health plan through the applicant's employer or their spouse's employer? Yes No
 If yes, provide name of eligible individual(s) and employer name: _____
- b. *Enrolled in* an employer-sponsored health plan through the applicant's or spouse's employer? Yes No
 If yes, provide the following information: Contract holder name: _____ Employer name: _____
 Name of carrier: _____ Contract number: _____ Effective date: _____ Date coverage will end: _____
 Reason coverage has ended or is ending: _____
3. Are any individual listed above eligible for Medicare? Yes No If yes, who? _____
4. Under this individual health plan for which you are applying, will your employer or your spouse's employer pay for or reimburse you for any portion of the premium? Yes No
 Will any portion of the premium be paid through a Flexible Spending Account or through a Health Spending Account to which the employer has provided any funds? Yes No
 Are you the business owner? Yes No

Please list all persons to be covered (attach additional sheet if necessary). Dependent children must be age 25 or younger to be eligible for coverage.

Name (first, M.I., last)	Gender	Relationship	Date of birth	Height*	Weight*	Social Security number (required for all applicants age one or older)
	<input type="checkbox"/> M <input type="checkbox"/> F	Applicant	/ /	_____ ft _____ in		
	<input type="checkbox"/> M <input type="checkbox"/> F	Spouse	/ /	_____ ft _____ in		
	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	/ /	_____ ft _____ in		
	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	/ /	_____ ft _____ in		
	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	/ /	_____ ft _____ in		
	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	/ /	_____ ft _____ in		

* Height and weight are not required for dependents age 18 and under.

Part II: Eligibility (continued)

Type of current coverage: Individual Group COBRA None

Current carrier: BCN BCBSM Other: _____

Have any family members applying for coverage been covered under a Blue Cross Blue Shield of Michigan health plan? Yes No or a Blue Care Network health plan? Yes No

If yes: Effective date of coverage: _____ Termination date of coverage: _____ Contract holder's name: _____

Contract number: _____ List all covered family members: _____

Please provide coverage history for the past **18 months** for each family member applying for coverage (use as many lines as necessary):

Family member	Carrier name	Group or individual	Effective date	Termination date

Part III: Choose your coverage

- \$1,500 deductible per member / \$3,000 deductible per family per calendar year
- \$2,500 deductible per member / \$5,000 deductible per family per calendar year
- \$5,000 deductible per member / \$10,000 deductible per family per calendar year

Part IV: Billing information

Please select a billing method for your initial and ongoing (monthly) premium payments:

- Bill me
- Automatic withdrawal/EFT (If you select EFT, please complete the last page of this application)

Part V: Health information

All questions must be answered "Yes" or "No" or the application may be returned or rejected. **Please provide details to any 'yes' answers below.** In the last five years, has any person age 19 or older* listed on this application been advised, counseled, tested, diagnosed, treated, hospitalized, taken any medication for, or had treatment recommended for any of the following conditions?

1.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes? If yes, type I or II? _____
2.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic obstructive pulmonary disease or chronic airway disease?
3.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic kidney disease?
4.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Congestive heart failure?
5.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer, tumor, growth, cyst, polyp, enlarged lymph nodes, leukemia? If yes indicate diagnosis and location: _____
6.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest pain, arrhythmia or palpitations, heart murmur, mitral valve prolapse, heart attack, bypass or angioplasty or stent, stroke or transient ischemic attack, any other heart or circulatory disorder or condition, hypertension or high blood pressure? If 'yes' to high blood pressure give last three readings and dates: _____
7.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Elevated cholesterol or lipids, varicose veins, varicosities, anemia, blood clot, any other blood disorder?
8.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any disease or disorder of the gallbladder, pancreas or liver, elevated liver function tests, cirrhosis, hepatitis? If 'yes' to hepatitis, indicate type: _____
9.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Acne, keratosis, psoriasis, basal cell carcinoma, skin lesions, eczema or any other skin disorder?
10.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney stones, kidney reflux, urinary incontinence, any infection or disorder of the urinary tract, bladder or kidney?
11.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breast cyst or nodule, gynecomastia, fibrocystic breast disease, breast implants, any other disease or disorder of the breast?
12.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis (osteo, rheumatoid or psoriatic), bursitis, herniated, bulging or slipped disk, gout, temporomandibular joint disorder, any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles or joints, bunions, carpal tunnel syndrome, joint replacement, manipulation or subluxation therapy, spinal fusion?
13.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia, colitis, chronic diarrhea or intestinal problems, hemorrhoids or rectal disorder, gastroesophageal reflux disease, any disorder of the esophagus, ulcer of the stomach, diverticular disease or any other digestive disorder or condition?
14.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cataracts, glaucoma, hearing loss, deviated nasal septum, any other eye, ear, nose or throat disorder?
15.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma, allergies, sinusitis, bronchitis, pneumonia, respiratory syncytial virus, tuberculosis, sleep apnea, any breathing difficulty, lung or respiratory disease, disorder or condition?
16.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Males: Prostate disorder, elevated prostate specific antigen, sexually transmitted disease, genital warts, herpes, impotence, infertility, any other disease or disorder of the genital or reproductive system?
17.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Females: Fibroid or uterine tumor, ovarian cyst, polycystic ovary syndrome, endometriosis, cystocele/rectocele, infertility, sexually transmitted disease, genital warts, herpes, abnormal pap smear, any other disease or disorder of the genital or reproductive system, previous cesarean section? If 'yes' to C-section why was it done? _____
18.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines, headaches, seizure disorder, epilepsy, multiple sclerosis, paralysis, restless leg syndrome, any neurological disorder, or any disorder of the central nervous system?
19.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Memory loss, dementia, narcolepsy, Alzheimer's disease?
20.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attention deficit disorder; anxiety; depression or chemical imbalance; any emotional, behavioral or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy, marital or any other form of counseling or therapy?
21.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid disorder, goiter, Graves disease, lupus, pituitary or adrenal disorder?
22.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS, AIDS-related complex or HIV positive, any other immune disorder?
23.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol use or abuse, alcoholism, substance abuse, drug addiction?
24.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is any person applying for coverage now pregnant or an expectant parent?

Part V: Health information (continued)

25.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage ever had an implant, internal fixation (pins, screws or plates), prosthesis, pacemaker, valve replacement, shunt or monitoring device?
26.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage had a physical examination (including check ups), diagnostic tests, consulted a physician, chiropractor or therapist? For each person applying for coverage, please provide details of their last physical in below.
27.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy or surgery which has not yet been performed?
28.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage ever been hospitalized or treated in the emergency room, or had any physical impairment, deformity, congenital anomaly, sickness, operation or injury other than those listed above?

* Answers provided for dependents under age 19 will not be used to determine if the dependent is eligible for the plan.

In the last five years has any person age 19 years or older* applying for coverage been prescribed any medications? Yes No If yes, please provide details below:

Family member	Medication and dosage	Illness for which medication is prescribed	Date prescribed	Date discontinued

If you answered yes to any of the medical questions on pages 4 and 5, please complete (attach additional sheet if necessary):

Question #	Family member	Illness or condition	Date illness began	Date of recovery (if applicable)	Complete recovery?	Type of treatment	Name, address and phone of doctors and hospital
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		
					<input type="checkbox"/> Yes <input type="checkbox"/> No		

Part V: Health information (continued)

Please provide details of the last physical exam of each family member age 19 or older*:

Family member	Date of last physical exam	Test(s) done (including blood work, x-rays, other tests)	Test results

Has anyone applying for coverage (age 19 or older*) used tobacco products in the past 12 months? Yes No

If yes, who? _____ Date last used tobacco: _____

Note: You may be asked to complete and have your primary care physician sign a *BCN Smoking Status Form*, which will be mailed to you. If you answered no, a nicotine screening may be required.

* Answers provided for dependents under age 19 will not be used to determine if the dependent is eligible for the plan.

Part VI : Consent, terms and conditions

I understand that this individual product is medically underwritten and that if I am age 19 and over, I must provide evidence of good health in order to be eligible for this product. If I have received treatment for certain medical conditions within the last five years, including taking prescription drugs, I may not be eligible for this product.

I understand that this is a managed care product that includes case/care management programs through Blue Care Network of Michigan. I understand that if I have a condition that would benefit from a care management program, I will be contacted by the program and will be provided guidance for my care through the program. I also understand that I may initiate contact with the case/care management program.

I understand that approval of this application and coverage effective date will be determined by Blue Care Network of Michigan and shall be subject to requirements by BCN for additional information and payment of bills. I am applying for myself and eligible members of my family for health coverage in the individual health plan offered by BCN. The coverage shall not exceed those benefits and services contained on the certificates and riders.

I may enroll my legal spouse and eligible dependents who reside in BCN's service area. Eligible dependents are defined as children of mine or my spouse, by birth, legal adoption, foster parenthood or legal guardianship. Eligible dependents must be 25 years of age or younger to enroll. I may not enroll myself, my spouse or any dependents who are eligible for, beneficiaries of or recipients of Medicare or who are eligible for any employer sponsored-health benefit plan.

I understand that coverage for my dependent children will end on the last day of the year in which they reach age 26. These dependent children may apply for their own individual coverage.

On behalf of myself and my enrolled family members, I agree that all our medical services must be performed, prescribed, directed or authorized by our designated BCN primary care physician(s) except in the case of an immediate and unforeseen medical emergency as those terms are defined in the coverage documents. I request that payment of insurance company or HMO benefits be made payable to BCN on my behalf for any services furnished to me by BCN.

With regard to costs of hospital and medical services delivered by or paid for by BCN, I agree to assign to BCN, my entire right to recovery of those costs against any person or organization as a result of accident or disease including injuries or disease claimed under workers compensation laws or acts whether by redemption award or voluntary payment or otherwise.

Part VI : Consent, terms and conditions (continued)

I understand that the benefits my enrolled family members and I will be eligible for are described in the applicable certificate and that BCN's marketing materials are only a summary. I understand that I may protest a proposed amendment in this contract or rate changed within 30 days of receipt of notice, and that my continued payment, while an appeal is in progress, shall not be deemed to constitute acceptance of the proposed amendment or rate change.

I certify that the requirements of eligibility are met and that 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 may result in termination of coverage.

Pre-existing conditions

I understand that during the six month period following the effective date of coverage, neither I nor my enrolled family members age 19 or older will be covered for any and all conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months before my enrollment. The term "conditions" includes, but is not limited to, maternity care, obstetrical care and termination of pregnancy. I understand that my enrollment date begins on the effective date of coverage as determined by BCN.

Authorization for use and disclosure of Protected Health Information

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

I authorize:

- Use and disclosure of my PHI, including membership, eligibility and claims data stored on Blue Care Network, Blue Cross Blue Shield of Michigan and its subsidiaries' or affiliates' computer systems.
- Physician, 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 BCN.
- 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, medication prescribed and other PHI as requested to BCN.

My authorization includes disclosure of information on the diagnosis and treatment of Human Immunodeficiency Virus and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes disclosure of psychotherapy notes.

This authorization includes and applies to any and all protected health information related to treatment or services where I have requested a restriction, or for any health care item or service for which the health care provider has been paid out of pocket in full.

This PHI is to be disclosed so that BCN 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, health care operations. If PHI is disclosed under your authorization to persons or organizations that are not subject to federal privacy laws, it may be redisclosed and no longer protected.

I understand that my enrollment with BCN 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 BCN and from any of the parties listed above to BCN. A photographic copy of this authorization shall be valid as the original.

This authorization will expire after 30 months from the signature date. 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 **MiBCN.com** or by contracting my agent. I understand that revocation will not affect actions taken before BCN or any of the parties identified above receive my request.

Part VII : Signatures

Please review your application for completeness and accuracy, then sign and date below. A dated signature is required for each applicant over the age of 18. Submit your completed application to:

Blue Cross Blue Shield of Michigan
Individual Business Smart Select
600 E. Lafayette Blvd. Mail Code 1124
Detroit, MI 48226
Fax: 1-313-983-2286

Signature of applicant	Date
Signature of spouse	Date
Signature of dependent (age 18 or older)	Date
Signature of dependent (age 18 or older)	Date

Agent name (please print)	Agent number
Agent signature	Date
Managing agent or general agent name	Managing agent or general agent number



A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Authorization Agreement for Automatic Payments

This form may be used for your first payment and for ongoing payments.

Requested effective date: Month _____ 1st 15th

Applicant name		Applicant address	
City	State	ZIP code	Applicant telephone number

Authorization for automatic payments

I hereby authorize Blue Care Network, hereinafter called BCN, to withdraw from my checking or savings account the amounts necessary to pay the premium owed by me under my BCN contract. This authority will remain in effect until I notify you, or the bank listed below, in writing to cancel it in such time as to afford the bank a reasonable opportunity to act on the cancellation.

Bank name		Branch location	
City	State	ZIP code	

Please deduct my monthly BCN premium from my (check one):

- Checking account (Include a voided check when you return this form)
 Savings account (include a voided deposit slip when you return this form)

If you bank online, please write in your checking or savings account number and bank routing number:

Account number: _____ Bank routing number: _____

Signature	Date
-----------	------

Blue Care Network use only

Member's contract number	Process date	Effective date	Processor
--------------------------	--------------	----------------	-----------