BenefitsManager.net

Application Instructions For Blue Cross Blue Shield Texas

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to BenefitsManager.net for review along with the completed application. If you do not have access to a fax machine, send the completed application to BenefitsManager.net along with the $30 non refundable application fee.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- ❏ Indicate your requested effective date.
- ❏ Select your preferred billing method.
- ❏ Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Blue Cross Blue Shield Texas** if you are not paying by credit card.

Mail completed application and check to:

BenefitsManager.net
Attn: New Enrollment
1235 W. Stone Creek Lane
Layton, UT 84041

BenefitsManager.net will review your application for completeness and accuracy before we submit it to Blue Cross Blue Shield Texas for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at (888)310-9623 or e-mail us at mikeoliphant@benefitsmanager.net.

BenefitsManager.net

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:

BenefitsManager.net

FAX# (801)444-7389

Dear BenefitsManager.net,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name ____

E-mail ____

Date ____

Time ____

☐ Please contact me at this phone number ______________________after you have reviewed my application for completeness and accuracy.

☐ I will contact BenefitsManager.net at (888)310-9623 to verify receipt of my application.

**I understand that BenefitsManager.net will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend

I understand that the original signed application must still be mailed to BenefitsManager.net. I will mail the original signed application to :

BenefitsManager.net
Attn: New Enrollment
1235 W. Stone Creek Lane
Layton, UT 84041

I will send the original application as soon as I have been contacted by BenefitsManager.net with confirmation that my application has been received by fax and reviewed for completeness.

Signature: ___________________________________ Date: ________________

BlueCross BlueShield of Texas

P. O. Box 833940
Richardson, TX 75083-3940
(972) 766-8755 or 1-800-554-6303

PPO Select Choice

Application for Medical Expense Insurance

Print all information in blue or black ink.

List all persons to be covered (First name, MI, Last name) Dependent unmarried children must be less than 25 years of age to be eligible for health and dental coverage.		Sex	Age	Birth Date	State of Birth	Height	Weight	Social Security No.
Applicant A								
Spouse B								
☐ Son ☐ Daughter C								
☐ Son ☐ Daughter D								
☐ Son ☐ Daughter E								

Is any Dependent coverage required by court order? ☐ Yes ☐ No If "Yes," was it effective within the last 30 days? ☐ Yes ☐ No
If "Yes," to apply for court-mandated coverage for Dependent children, contact Blue Cross and Blue Shield of Texas for the appropriate form.

Home Address (P. O. Box is not acceptable)

Street______________________________

City/Town______________ State______ ZIP Code__________

Phone No. (________) ______________________

Billing Address (if other than home address shown)

Street or P. O. Box______________________________

City/Town______________ State______ ZIP Code__________

Phone No. (________) ______________________

Employment

Applicant: Name of Employer______________________

Street______________________________

City/Town______________ State______ ZIP Code__________

Occupation______________ Phone No. (____) __________
(if self-employed, provide details of occupation)

Spouse's Occupation______________ Phone No. (____) __________

Payor or Premium

Name (If different from Applicant)______________________

Street______________________________

City/Town______________ State______ ZIP Code__________

Date of Birth______________ Social Security No.______________

Applicant's Relationship to Payor______________________

HEALTH INSURANCE COVERAGE

Smoker/Tobacco User (any family member applying for coverage): ☐ Yes ☐ No

I (We) hereby apply for:

Options	Health Deductibles		Copayment	Coinsurance Amounts		PDP			
	Network Individual/Family	*Out-of-Network Individual/Family*	*Physician Office Visit Copayment*	*Network*	*Out-of-Network*	*Generic*	***Preferred Brand Name***	*Non Preferred Brand Name*	*Deductible*
Plan I ☐ Plan II ☐	$250/$750 $500/$1,500	$500/$1,500 $1,000/$3,000	$25	$3,000/$6,000	$5,000/$10,000	$15	$25	$40	$100
Plan III ☐ Plan IV ☐	$1,000/$3,000 $1,500/$4,500	$2,000/$6,000 $3,000/$9,000	$25	$3,000/$6,000	$5,000/$10,000	$15	$25	$40	$200
Plan V ☐ Plan VI ☐	$2,500/$7,500 $5,000/$15,000	$5,000/$15,000 $10,000/30,000	$25	$3,000/$6,000	$5,000/$10,000	$15	$25	$40	$300

DENTAL INSURANCE COVERAGE

I (We) hereby apply for Dental coverage and understand that all Applicants and Dependents approved for health coverage will be covered under the Dental coverage. If any covered health individual is cancelled from the health coverage or if health coverage is cancelled in its entirety, then the same action will be applied to Dental coverage. ☐ Yes ☐ No

Method of Payment: ☐ Direct Monthly ☐ Direct Quarterly ☐ Bank Draft Monthly (include Bank Draft Form and a blank check marked "void")
☐ List Bill Monthly (available for two or more Applicants billed at the same address)

Billing Cycle: First of Month

All coverage applied for will be effective on the first day of the month following medical approval and payment in full of the first month's premium. Special effective dates are subject to approval by Blue Cross and Blue Shield of Texas. A $30.00 NONREFUNDABLE Application Fee must be submitted with completed application. Please make check payable to Blue Cross and Blue Shield of Texas.

$30.00 Nonrefundable Application Fee Enclosed

Home Office Use Only	Grp-Sec	Pkg	Eff Date	BCF #	R/D/T	RSE #	Broker #

Please Complete Pages 2 through 5.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Applicant Name: ____ Social Security No. ______________________________

Please Complete the Following Health Questions

For this insurance to be in force, you must answer the following health questions fully and truthfully and provide all of the health information asked for, including routine physical examinations, and Blue Cross and Blue Shield of Texas must approve this application. No one may change this requirement for you in any way. If you commit fraud or intentionally misrepresent any information required on any enrollment form, your coverage may later be rescinded. Rescission voids your coverage from the effective date, and any premiums already paid (less any benefits paid) will be refunded. **Please do not mark over or strike out any signature, date or health question information. Important! Do not cancel any existing health or life coverage until notified of your acceptance.**

HEALTH STATEMENT

Please provide information regarding the last doctor's visit and/or physical examination for ALL family members you wish to cover in No.15 on page 3. If needed and/or requested, all applicants must be able to provide medical records from a licensed U. S. Physician, including but not limited to, a health evaluation conducted within the past 2 years.

Yes No

1) Has any person applying for coverage smoked and/or used tobacco products during the 12 months immediately preceding the date this application is signed? If "Yes," please explain in No. 13 on page 3. . . . . ☐ ☐
2) Is each person applying for coverage a legal U.S. citizen? If non-U.S. citizen, how long in U.S.?_______________ . . . . ☐ ☐
3) Is each person applying for coverage a permanent resident of Texas, except for court-ordered Dependents? . . . . ☐ ☐
4) If any person applying for coverage is not approved, do you want coverage issued on those who are approved? . . . . ☐ ☐
5) Is any person applying or residing in the household currently pregnant? If "Yes," please explain in No. 14 on page 3. . . . . ☐ ☐
6) Does any person applying for coverage currently take any prescription medication, or has any person done so in the last two years? If "Yes," please explain in No. 14 on page 3. . . . . ☐ ☐
7) Has any person applying for coverage been treated for any abnormal test results, laboratory, x-ray and/or recurring medical condition? If "Yes," please explain in No. 13 on page 3. . . . . ☐ ☐
8) Does your employer deduct the entire premium from your paycheck? If "No," or "Not Applicable," please explain in detail: . . . . ☐ ☐
____
9) Has anyone applying for coverage ever been diagnosed as having or told by a medical doctor that you have AIDS, HIV, or ARC disorders? . . . . ☐ ☐
10) Have you or any person applying for coverage ever been tested positive for antibodies for the AIDS virus? . . . . ☐ ☐
11) Has any person applying been diagnosed by a member of the medical profession as having AIDS and/or has any proposed insured received treatment from a member of the medical profession for AIDS? . . . . ☐ ☐
12) To the best of your knowledge, has any person applying for coverage **EVER HAD** or is any such person now having symptoms, treatment, surgery or a diagnosis of any of the following conditions in A-P below? **Check either "YES" or "NO" to each part.** If "Yes," circle the specific ailment(s) in the section below and enter the detailed information in No. 13 on page 3. Any person applying for coverage may be asked to provide the results of a recent physical exam.

A **Heart/Cardiovascular:** high or low blood pressure, chest pain, congestive heart problems, heart attack, heart surgery (including angioplasty/bypass, valve or any other heart/vessel surgery), mitral valve prolapse, irregular heart beat, pacemaker, congenital heart disorders, murmur, rheumatic fever, elevated cholesterol . . . . Yes ☐ No ☐

B **Circulatory:** varicose veins, phlebitis, carotid artery disorder, blood clot, stroke, peripheral vascular disease, enlarged lymph nodes or any circulatory disorder . . . . Yes ☐ No ☐

C **Digestive:** colon/intestinal disorder (polyps, colitis, chronic diarrhea), esophagus, stomach, ulcers, hernia, gallbladder, pancreatitis or any testing/evaluation for any digestive disorder . . . . Yes ☐ No ☐

D **Liver Disease/Disorder:** hepatitis (give type, date and treatment), cirrhosis, blood transfusion, abnormal liver studies . . . . Yes ☐ No ☐

E **Mental/Emotional/Behavioral:** alcohol/drug abuse or addiction, depression/anxiety, chemical imbalance, bipolar, hyperactivity/ADD, mental deficiency/retardation, anorexia, bulimia, counseling/therapy or support groups . . . . Yes ☐ No ☐

F **Brain/Nervous System:** epilepsy, convulsions, tremors, fainting, headaches, dizziness, paralysis, neuropathy, concussion, any loss of consciousness or other disease/dysfunction of the brain/nervous system . . . . Yes ☐ No ☐

G **Endocrine/Metabolic:** diabetes, lupus, abnormal glucose level, thyroid, pituitary, adrenal or growth disorder, anemia or any other blood disorder (type/treatment/date), persistent/ chronic fatigue, night sweats, 15 lbs or more weight loss in last 12 months . . . . Yes ☐ No ☐

H **Lungs/Respiratory:** asthma, bronchitis, pneumonia, emphysema, obstructive respiratory disorders, tuberculosis (history of or exposure to), chemical or asbestos exposure, shortness of breath, apnea/sleep disorder, use of any respiratory equipment or oxygen to assist with breathing . . . . Yes ☐ No ☐

I **Cancer:** Cancer, leukemia, Hodgkin's disease, Kaposi's sarcoma, melanoma . . . . Yes ☐ No ☐

J **Tumors:** Tumor, cyst or growth (benign/malignant) . Yes ☐ No ☐

K **Breast Disease/Disorder:** any changes, lump(s), aspiration(s), biopsies or breast implants (provide type/ complications) . . . . Yes ☐ No ☐

L **Male/Female Disease/Disorder:** kidney/bladder, uterus/tubes/ ovaries, prostate, stones, incontinence, infertility, endometriosis, genital warts, herpes or any other sexually transmitted disease . . . . Yes ☐ No ☐

M **Musculoskeletal System:** arthritis (type/joints affected), gout, polio, congenital disorder, back/neck/spine disorder, muscular disease/disorder, bone/joint, injury, fracture, hardware present, amputation or any surgical procedures. Provide Left_______Right_______if applicable . . . . . Yes ☐ No ☐

N **Eye/Ear Disease/Disorder:** any impairment of sight, hearing or speech or any surgical procedures . . . . Yes ☐ No ☐

O **Any Other Disease, Disorder or Surgical Procedure?** . . . . Yes ☐ No ☐

P Has any **PERSON** been advised of future treatment, surgery, therapy, hospitalization, testing or evaluation? . . . . . Yes ☐ No ☐

Applicant Name: ____ Social Security No. _____________________________

13) DETAILS OF MEDICAL HISTORY

QUESTION NO.	FAMILY MEMBER	CONDITIONS/ TREATMENT/ MEDICATIONS PRESCRIBED	DATE OF ONSET	DATE HOSPITALIZED	SURGERY	RECOVERY DATE	NAME, PHONE NO. OF PHYSICIAN OR HOSPITAL ADDRESS/CITY/STATE/ZIP CODE
Example 9a	John Smith	Hypertension/ Corgard	5/99	N/A	N/A	N/A	John Jones, MD (888) 555-1234 12345 Main Street City Town, Texas 77777

14) DETAILS OF MEDICATIONS: List all Medications taken currently or within the last 24 months by any family member listed on this Application. Use additional sheet if necessary.

FAMILY MEMBER	MEDICATION AND DOSAGE	ILLNESS FOR WHICH PRESCRIBED	DATE PRESCRIBED	DATE DISCONTINUED	NAME, PHONE NO. OF PHYSICIAN OR HOSPITAL ADDRESS/CITY/STATE/ZIP CODE
Example John Smith	Corgard 20 mg	Hypertension	5/99	N/A	John Jones, MD (888) 555-1234 12345 Main Street City Town, Texas 77777

15) Please provide information regarding the last doctor visit and/or physical examination for ALL family members you wish to cover.

FAMILY MEMBER	DATE OF VISIT	RESULTS/ REASON FOR VISIT	EXPLANATION	NAME, PHONE NO. OF PHYSICIAN OR HOSPITAL ADDRESS/CITY/STATE/ZIP CODE
Example Jane Smith	5/99	Physical Exam	Normal	John Jones, MD (888) 555-1234 12345 Main Street City Town, Texas 77777

16) A telephone interview may be conducted with every applicant during business hours 8:00 a.m. to 4:30 p.m.
Do you prefer to be contacted at work?________or at home?_________
Will an interpreter be needed? ☐ Yes ☐ No If so, what Language?____

17) Remarks ____
____

Applicant Name: ____ Social Security No. ______________________________

Previous Coverage Information

In order to receive credit for pre-existing condition waiting periods, you must provide coverage information for the last 18 months for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this application. (If more than one plan was in effect, attach additional pages.)

List names of every individual covered:____

Name of Policyholder	Date of Birth ___/___/___	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Group or Policy Number	ID Number

Employer's Name __________________ ______________________________ Name and address of other insurance company, TPA, HMO	Employment Date ___/___/___ Effective Date ___/___/___ Will coverage be continued? ☐ Yes ☐ No If "No," Expected Cancel Date ___/___/___	Type of Coverage ☐ Health ☐ Dental ☐ Employer-Sponsored OR ☐ Individual Purchase	Type of Policy ☐ Self ☐ Family ☐ Employee/Spouse ☐ Employee/Child

Replacement of Coverage

Will this insurance replace any health insurance currently in force? ☐ Yes ☐ No
If "Yes," read the statement below and complete the following:

List all coverage that will be replaced

Insured	Name of Company	Policy Number	Termination Date

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Blue Cross and Blue Shield of Texas. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

1. Health conditions which you may presently have may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning the medical/health history of any person applying for coverage. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Blue Cross and Blue Shield of Texas.

Applicant Name: ____________________

Social Security Number: ____________________

IMPORTANT

Please complete the proxy card (below) and submit it with your application.

DO NOT DETACH.

Trim

Perf. do not print

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group Number: ____________________ Subscriber Number: ____________________

By: ____________________
Print Signer's Name Here

____
Subscriber's Name

➜ ____________________
Signature

____
Address

____
City/State/ZIP

Dated this__________day of____________________, __________
Month Year

Do Not Write Below This Line

FC849a7/83 Rev. 0203

8705.312-203

IMPORTANT! — Please continue on next page ⟶

Acknowledgements: The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows: 1. This application does not provide coverage of any kind unless approval is provided by Blue Cross and Blue Shield of Texas (the Company); and the application, if not previously approved or declined, will be considered declined on the 45th day after its date. **2.** Medical expense coverage will not be available until the effective date of the health contract and payment, in full, of the first month's premium. **3.** The medical expense benefits applied for and if issued, shall not cover any illness, accident, or physical impairment which existed or occurred prior to the effective date of the Applicant's coverage until the Applicant shall have held coverage under the contract for 12 months. **4.** No agent can accept risks or modify policy or requirement of the Company. **5.** The Company is not bound by any statement not written in this application. **6.** If a spouse is included for medical expense coverage, the premium will be calculated based on the age of each adult. **7.** Fraud or any intentional misrepresentation of a material fact may result in rescission of coverage or denial of a claim under the terms of the policy.

Agreement: I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that the Company will provide no coverage until the first day of the month following medical approval of my application and payment, in full, of the first month's premium unless a special effective date was requested in the application and approved by the Company. The undersigned Applicant and agent acknowledge that the Applicant has read the completed application and that he/she realizes that any false statement material to the risk or misrepresentations therein may result in loss of coverage under the policy.

Health Authorization: I authorize any hospital, physician, provider, clinic or medical related facility, governmental agency, insurance carrier, group health plan or other entity to give Blue Cross and Blue Shield of Texas (BCBSTX) the Company or its authorized representative, upon request, any information concerning the health condition of any person listed on this application whenever such information is considered necessary by the Company for the proper disposition of this application.

I understand that this authorization is voluntary and that my signature is required for the Company to consider this application and to make a determination on whether to accept and issue the coverage applied for herein and that without my signed authorization no action will be taken on this application. I also understand that I may revoke this authorization at any time in writing and that such revocation will have no effect on any actions taken by the Company prior to receipt of the revocation. I further understand the potential that any information disclosed pursuant to this authorization may be redisclosed and is no longer protected by the Federal privacy laws. A photographic copy of this authorization shall be as valid as the original. **Please Initial ______ ☐ Yes ☐ No**

I hereby give authorization to my Agent to inquire and discuss information contained in this application as well as the final disposition of my application ☐ Yes ☐ No Please Initial ______ (If left blank or not initialed, "No" is considered the answer)

Policy(ies) should be mailed to ☐ Agent ☐ Applicant
(**Note:** the policy will not be mailed to the Agent if the preceding authorization is checked "No" or is left blank)

Signatures: I acknowledge receipt of the Required Outline of Coverage and I certify that:
1. Premiums are being paid by me as a personal expense. **2.** My employer is not contributing to any part of the premium, either directly or through reimbursement. **3.** Since my employer does not sponsor an employee health plan, neither my employer nor I deduct any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code.

The Patient Protection Act Disclosure Statement will be provided upon request.

Signatures: ______________________________ ______________________________
Applicant Date Spouse (if to be insured) Date

If Applicant is a minor, parent/guardian's signature is required below:

____
Signature of Parent/Guardian Date

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the Required Outline of Coverage, and if requested, Patient Protection Act Disclosure Statement. **Do you have any knowledge or reason to believe that replacement of any existing health insurance may be involved? ☐ Yes ☐ No If "Yes," explain in No. 17 on Page 3.**

PAY COMMISSION TO:

☐ Agent ☐ Agency # 14687 (BCBSTX Assigned Agent #) ______ % (percent of commission)

Please PRINT Name: Michael Oliphant

Address: 1235 W. Stone Creek Lane, Layton, UT 84041

City, State, Zip: Layton, UT 84041

Phone#: (888) 310-9623 Fax #: (801) 444-7389

Signature ______________________ Date ________

PAY COMMISSION TO:

☐ Agent ☐ Agency # ________ (BCBSTX Assigned Agent #) ______ % (percent of commission)

Please PRINT Name ______________________

Address ______________________

City, State, Zip ______________________

Phone# (____) ____________ Fax # (____) ____________

Signature ______________________ Date ________

Do Not Write in Spaces Below

Approved Preferred . . . . ☐
Approved Standard . . . . ☐
Approved Preferred w/Rider . . . . . ☐
Approved Standard w/Rider . . . . . ☐
Declined . . . . ☐
Incomplete . . . . ☐

Underwriter ______________________
Decision Date ______________________
Effective Date ______________________
Condition/Waiver ______________________

Smoker/Tobacco User: . . . . ☐
Non-Smoker/Tobacco User: . . . . . ☐

The following named Applicant(s) shall not be included for coverage under this Contract:

____
____
____
____