NOTICE OF EXCLUSIONS AND OTHER LIMITATIONS

All individuals accepted for coverage by the Individual Blue health plan are subject to an exclusion period of 365 consecutive days, after the effective date of coverage, for pre-existing conditions. A “pre-existing condition” includes any condition, no matter how caused, for which you or your dependent received medical advice, a diagnosis, care or for which treatment was recommended or received during the two-year period prior to the effective date of coverage. In addition to the exclusion for pre-existing conditions, the Individual Blue health plan does not provide any coverage for the first 365 days of coverage by the plan for maternity benefits, the removal of tonsils and/or adenoids, the placement of tubes in the ears, the replacement of any joint, such as a knee, a hysterectomy (or any related surgery, such as the removal of ovaries), or the treatment of a birth defect. Prior creditable coverage will not reduce the 365 day exclusion period. Maternity benefits are never available to any dependent other than your spouse. The plan also contains other exclusions for specific conditions, procedures or treatments that apply for the entire time that you are covered by this plan, as described in the plan booklet.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

The Women's Health and Cancer Rights Act of 1998 requires health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. A participant or dependent who is receiving benefits in connection with a mastectomy will also receive coverage for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications of the mastectomy, including lymphedema.

ALABAMA HEALTH INSURANCE PLAN (AHIP) NOTICE

If you recently had group coverage, including COBRA, you may be eligible for coverage under the Alabama Health Insurance Plan (AHIP). If you qualify for this state sponsored plan, you would not be subject to pre-existing or other waiting periods. You can reach AHIP by calling the State Employees’ Insurance Board in Montgomery, Alabama at 1 877 619-2447. Qualifying individuals have a 63 day window within which to enroll in AHIP. It may take us longer than 63 days to determine whether you satisfy our health underwriting guidelines. If you become covered by Individual Blue, you would no longer qualify for AHIP.

BINDING ARBITRATION NOTICE

THE CONTRACT YOU'RE APPLYING FOR INCLUDES FINAL AND BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT WILL BE SETTLED BY ARBITRATION—NOT A COURT. THE ARBITRATOR'S DECISION IS BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THE DECISION OF THE ARBITRATOR CAN'T BE REVIEWED BY A COURT, EXCEPT IN CERTAIN CIRCUMSTANCES AS DESCRIBED IN THE CONTRACT. THE ARBITRATOR ACTS AS THE JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE - AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE CONTRACT. I UNDERSTAND THAT I AM VOLUNTARILY SURRENDERING MY RIGHT TO HAVE ANY DISAGREEMENT BETWEEN US RESOLVED IN COURT. THIS MEANS THAT I AM WAIVING MY RIGHT TO TRIAL BY JURY.
I UNDERSTAND THAT I HAVE THE RIGHT TO RETURN THE CONTRACT TO YOU DURING THE FIRST THIRTY DAYS OF COVERAGE IF I AM NOT SATISFIED. IF I DO THIS, YOU WILL REFUND ANY FEES THAT I HAVE PAID AND RETROACTIVELY REVOKE ANY BENEFIT PAYMENTS THAT YOU HAVE MADE.

CONDITIONS OF ENROLLMENT

I apply for coverage with Blue Cross and Blue Shield of Alabama (Blue Cross) for myself, and family members listed. I wish to be enrolled under your Individual Blue health contract with such terms and conditions as Blue Cross now issues. This application (if accepted), the plan booklet, and changes to the plan, along with any supplemental applications will be the entire contract between Blue Cross and me. The contract can only be changed by my submission of another application, which Blue Cross accepts, or by Blue Cross’s amendment, rider or other written change to the health contract signed by one of its officers.

I certify that the persons named are in good health except for the conditions listed in the Health Statement portion of this application. I understand and agree that all statements and answers on this application are complete and true and all coverage under this contract is void if found false or incomplete. Discovery of any misrepresented or material information omitted on this application will result in the recision of this contract retroactively to the beginning of coverage. I understand that any misrepresentation is fraud and will be pursued to the fullest extent of the law including all compensatory and punitive damages as well as costs and attorney’s fees. I understand that each person applying for coverage must complete and return the Authorization for Health Information. If a signed authorization for each person applying for coverage is not returned with this application, coverage by the Individual Blue health plan will be denied. I understand and agree that coverage does not begin until this application is accepted by Blue Cross and an effective date of coverage is assigned.

If Blue Cross accepts this application, Blue Cross will send me the plan booklet for which I am eligible along with an identification card showing the date my coverage begins.

If my application is not accepted for any reason, I understand I will receive a letter of rejection. If approved, I understand I must pay according to the effective/due date of my contract. If the application is accepted but is not paid, the policy will be cancelled as null and void.

I understand that if my application is accepted and a contract is issued I have the right to return the contract to Blue Cross during the first 30 days of coverage if I am not satisfied for any reason. If I do this, Blue Cross will refund any fees that I have paid and retroactively revoke any benefit payments.

I understand that if my application is accepted, then my premiums are due on the first day of each month. If I fail to pay premiums during the month they are due, my contract will be cancelled. If my contract is cancelled, I may reapply and if my application is accepted, I will once again be required to serve a 365-day pre-existing exclusion period.

I understand that the premium amount is based on my age (applicant) and county of residence. I understand that my premium amount may change if my age category and/or county of residence changes. By giving 30 days written notice to me, Blue Cross may change the premiums or specified provisions of the contract. Please consult your contract. If I pay any premium after notice to me of the change in the premiums or the contract, I accept the new premiums or changes in the contract.

I understand that my application requires normal processing time (4-6 weeks) and may require additional time if medical correspondence is necessary.

I certify that I have read and personally completed the requested information on this form. (If not, I have attached a letter of explanation.)

individualBlue℠

APPLICATION FOR HEALTH COVERAGE

Be sure to read the important disclosures listed on the back before completing this application.
If you or any of your dependents are eligible for benefits under Medicaid, you may not need this policy.
Please use black ink, print clearly and complete each section.

Failure to provide requested information may delay processing of your application.

Keep the white copy for your records. Mail the blue and yellow copies in the return envelope which is included in your packet, or send to:

Blue Cross and Blue Shield of Alabama
Attention: Payment Processing Department
P.O. Box 11551
Birmingham, Alabama 35282-9722
Customer Service: 1 888 215-1832

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

INDIVIDUAL BLUE APPLICATION FOR HEALTH COVERAGE

Please complete all items on this application and the Authorization for Health Information. A signed Authorization for Health Information for each person applying for health coverage must accompany this application.

CONTRACT TYPE: Select the type of coverage needed: ☐ Individual ☐ Family

Complete the following only if you are applying for a family contract:
☐ I will accept a contract if I, or a family member, do not meet the underwriting requirements.
☐ I will accept individual contracts for children if an adult is not extended coverage.
☐ I will not accept a contract that excludes myself, or a family member.

APPLICANT'S LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐
HOME MAILING ADDRESS			BIRTHDATE: (MM/DD/YYYY) ☐☐/☐☐/☐☐☐☐
CITY	COUNTY	STATE / ZIP	SEX: F / M; HEIGHT; WEIGHT
HOME TELEPHONE NUMBER ( )	ALTERNATE TELEPHONE NUMBER ( )		MARITAL STATUS: ☐ SINGLE ☐ MARRIED

Please complete the following information for all additional family members applying for coverage.

LAST NAME	FIRST NAME	MI	SOCIAL SECURITY NUMBER	SEX (Circle)	BIRTHDATE MM/DD/YYYY	HEIGHT	WEIGHT
SPOUSE				F / M			
CHILD				F / M			
CHILD				F / M			
CHILD				F / M			

Dependent children are eligible until age 19; unmarried college students are eligible until age 25 with proof of full-time student status.
STUDENT EXTENSION: List name of unmarried dependent children (age 19–25) applying for extension.
Name of Child:_____ Name of College:_____

ELIGIBILITY CONFIRMATION: To be eligible for this coverage, the applicant must be a resident of the state of Alabama and not eligible for Medicare.

1. For coordination of benefits purposes, is any person to be insured covered under another health benefit plan or policy? ☐Yes ☐No
   If yes, give name of person: _____ Name of other health benefit plan: _____
2. Is any person to be insured eligible for or entitled to Medicare? ☐Yes ☐No If yes, give name of person: _____

HEALTH STATEMENT: All persons applying for coverage are subject to health underwriting. Please answer the questions below as to whether you currently have ***(or have ever had)*** any of the conditions listed. Complete an Authorization for Health Information for each person applying for coverage. **A separate Authorization for Health Information is required for each person.**
Each condition must be checked (X) YES OR (X) NO, or this application may be returned for completion.

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
1. AIDS / HIV	☐	☐	14. Diabetes	☐	☐	27. Paralysis	☐	☐
2. Amyotrophic Lateral Sclerosis (ALS)	☐	☐	15. Fibromyalgia	☐	☐	28. Parkinson's Disease	☐	☐
3. Aneurysm	☐	☐	16. Heart Disease and/or Heart Attack	☐	☐	29. Pituitary Disorder	☐	☐
4. Anemia	☐	☐	17. Hemophilia	☐	☐	30. Psoriasis	☐	☐
5. Asthma	☐	☐	18. Hodgkin's/Lymphoma/Leukemia	☐	☐	31. Rheumatoid Arthritis	☐	☐
6. Back Disorder	☐	☐	19. Immune Deficiency	☐	☐	32. Seizure DATE OF LAST SEIZURE:_____	☐	☐
7. Bladder Disorder	☐	☐	20. Kidney Disorder and/or Dialysis	☐	☐	33. Sleep Apnea ☐ SURGERY ☐ CPAP	☐	☐
8. Bowel or Stomach Disorder	☐	☐	21. Liver Disease	☐	☐	34. Spina Bifida	☐	☐
9. Brain Disorder	☐	☐	22. Lung Disease	☐	☐	35. Stroke	☐	☐
10. Cancer	☐	☐	23. Lupus	☐	☐	36. Vein / Artery Disease	☐	☐
11. Cerebral Palsy	☐	☐	24. Multiple Sclerosis	☐	☐	**List any condition/surgery not listed above:**		
12. Congenital Defects	☐	☐	25. Muscular Dystrophy	☐	☐	37.		
13. Cystic Fibrosis	☐	☐	26. Pancreatitis	☐	☐	38.		

If any condition on the previous page is checked "Yes", please explain below. Please give us details of injury, ailment, surgery or condition indicating specific location of condition if applicable (example: right knee). Use additional paper if necessary.

PATIENT NAME	CONDITION NUMBER	DIAGNOSIS, TYPE TREATMENT OR SURGERY	DATE OF ONSET	DATE LAST TREATED	SEEN IN HOSPITAL OR ER	PHYSICIAN (FIRST AND LAST NAME AND ADDRESS)*
					☐Yes ☐No	NAME ADDRESS CITY/STATE
					☐Yes ☐No	NAME ADDRESS CITY/STATE
					☐Yes ☐No	NAME ADDRESS CITY/STATE

Please indicate the last time YOU and / or EACH DEPENDENT consulted a physician. Use additional paper if necessary.

PATIENT NAME	DATE OF TREATMENT	PHYSICIAN (NAME AND ADDRESS)*	REASON FOR PHYSICIAN VISIT
		NAME ADDRESS CITY/STATE	
		NAME ADDRESS CITY/STATE	
		NAME ADDRESS CITY/STATE	

If you or any of your dependents take prescribed medication(s) please describe below:

PATIENT NAME	MEDICATIONS	PRESCRIBING PHYSICIAN*	DIAGNOSIS
		NAME ADDRESS CITY/STATE	
		NAME ADDRESS CITY/STATE	

*** Missing physician's name or address may cause a delay in processing your application.**

Has FUTURE surgery, diagnostic testing, or medical treatment been recommended for any person listed on this application?
☐No ☐Yes – Please explain, giving name, date and type of operation, test or treatment recommended:_____

_____

BENEFIT PLAN SELECTION – Please check requested benefit plan. Failure to choose a benefit plan and payment option will delay processing of your application. ☐ 500 plan ☐ 1000 plan ☐ 2500 plan ← **YOU MUST SELECT A PLAN.**

PREMIUM – Please use Premium Calculation Sheet to determine your estimated premium. Actual premium may vary.

PREMIUM PAYMENT – Select **ONE** payment method below. Premiums are payable in advance on a monthly basis. ← **YOU MUST SELECT A PAYMENT METHOD.**

Note: It may take up to 60 days to implement bank draft or payment book; if so, you will receive a bill for your second month's premium.

☐ **Bank Draft –** Application must be submitted with check payable to Blue Cross and Blue Shield of Alabama for first month's premium. Please attach a completed **Authorization Agreement for Bank Draft** with a **blank voided check**.

☐ **Payment Book –** Application must be submitted with check payable to Blue Cross and Blue Shield of Alabama for first month's premium. You will receive a payment book for making future payments after your application is accepted.

☐ **Credit Card –** Application must be submitted with check payable to Blue Cross and Blue Shield of Alabama for first month's premium. Please attach a completed **Credit Card Authorization form**.

I acknowledge by my signature that I have read and understand the front and back of this application and agree to **binding arbitration** as described on the back of this page. If applicant is under age 19, parent or legal guardian must sign on applicant's behalf.

_____ _____

APPLICANT'S SIGNATURE DATE SIGNED

THIS APPLICATION IS NOT COMPLETE UNLESS IT IS SIGNED AND DATED.

YELLOW AND BLUE COPY–BLUE CROSS AND BLUE SHIELD WHITE COPY–APPLICANT