Blue Care Network of Michigan

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

Application for Individual Coverage

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.

Product: ☐ Smart Select℠ ☐ OneBlue℠

Requested effective date: Month _____ ☐ 1st ☐ 15th

Your application must be received by Blue Care Network 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.

Type of application:
☐ New enrollment
☐ Add spouse to current contract number _____
☐ Add dependent children to current contract number _____
Note: If adding spouse or children please complete entire application with the spouse and/or children(s) information. You may add a dependent during a special enrollment event as defined in your certificate or during the annual open enrollment period (June 1 through June 30 for Sept. 1 effective date). Documentation to support the enrollment may be required.

Applicant information

Applicant last name	Applicant first name	M.I.	Social Security number	Date of birth	Height	Weight	Gender	Marital status
					____ft ____in		☐ Male ☐ Female	☐ Married ☐ Single

Street address (cannot be a P.O. Box)	City	State	ZIP code	County	Email address

Daytime phone number	Evening phone number	Driver's license or state ID number	Issue state	Expiration date

You may be contacted for a telephone interview with an underwriter. What is the best time between 8 a.m. and 4 p.m. EST to reach you?	**Phone number for interview:**

Primary care physician last name	PCP first name	Physician code (10 digit NPI number)	Physician's city	Has PCP been seen in last 12 months?
				☐ Yes ☐ No

Dependent information

Find a physician, look up a provider code, check location and more at MiBCN.com/find or call 1-800-662-6667

	Last Name	First name	M.I.	Gender	Rel. Code*	PCP last name	PCP first name	Physician code (10 digit NPI number)	Physician's city	Seen in last 12 months?
Spouse				☐ M ☐ F						☐ Yes ☐ No
Dependent				☐ M ☐ F						☐ Yes ☐ No
Dependent				☐ M ☐ F						☐ Yes ☐ No
Dependent				☐ M ☐ F						☐ Yes ☐ 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)

Eligibility information

Note: 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 or for an employer-sponsored group health plan.

1. Are all individuals applying for coverage permanent residents of Michigan who reside in Michigan at least nine months each calendar year? ☐ Yes ☐ No

2. Are any individuals applying for coverage:

   Eligible for an employer-sponsored health plan through your employer, a parent's employer, or spouse's employer health plan? ☐ Yes ☐ No

   If yes, provide name of eligible individual(s) and employer name: _____

   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 individuals 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, middle initial, last)	**Gender**	**Relationship**	**Date of birth**	**Height***	**Weight***	**Social Security number (required for all applicants age one or older)**	**Driver's license or state ID number** (age 18 or older)
	☐M ☐F	Spouse		_____ ft _____ in			
	☐M ☐F	Dependent		_____ ft _____ in			
	☐M ☐F	Dependent		_____ ft _____ in			
	☐M ☐F	Dependent		_____ ft _____ in			
	☐M ☐F	Dependent		_____ ft _____ in			

* Height and weight are not required for dependents age 18 and under for the **OneBlue product**

Current health coverage information

Type of current health 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

For Smart Select only, 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

Billing information

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

☐ Bill Me ☐ Automatic withdrawal/Electronic Funds Transfer (If you select EFT, please complete the last page of this application)

Health information

Answer "Yes" or "No" to every question or we may return or reject the application. **For every "yes," write details in the space after the question.**

In the last five years, has any person* 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.	☐ Yes	☐ No	Diabetes? If yes, type 1 or 2? _____
2.	☐ Yes	☐ No	Chronic obstructive pulmonary disease (COPD) or chronic airway disease?
3.	☐ Yes	☐ No	Chronic kidney disease?
4.	☐ Yes	☐ No	Congestive heart failure (CHF)?
5.	☐ Yes	☐ No	Cancer, tumor, growth, cyst, polyp, enlarged lymph nodes, leukemia? If yes indicate diagnosis and location: _____
6.	☐ Yes	☐ No	Chest pain, arrhythmia or palpitations, heart murmur, mitral valve prolapse, heart attack, bypass or angioplasty or stent, stroke or transient ischemic attack (TIA), 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.	☐ Yes	☐ No	Elevated cholesterol or lipids, varicose veins, varicosities, anemia, blood clot, any other blood disorder?
8.	☐ Yes	☐ No	Any disease or disorder of the gallbladder, pancreas or liver, elevated liver function tests, cirrhosis, hepatitis? If yes to hepatitis, indicate type: _____
9.	☐ Yes	☐ No	Acne, keratosis, psoriasis, basal cell carcinoma, skin lesions, eczema or any other skin disorder?
10.	☐ Yes	☐ No	Kidney stones, kidney reflux, urinary incontinence, any infection or disorder of the urinary tract, bladder or kidney?
11.	☐ Yes	☐ No	Breast cyst or nodule, gynecomastia, fibrocystic breast disease, breast implants, any other disease or disorder of the breast?
12.	☐ Yes	☐ No	Arthritis (osteo, rheumatoid or psoriatic), bursitis, herniated, bulging or slipped disk, gout, temporomandibular joint disorder (TMJ), 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.	☐ Yes	☐ No	Hernia, colitis, chronic diarrhea or intestinal problems, hemorrhoids or rectal disorder, gastroesophageal reflux disease (GERD), any disorder of the esophagus, ulcer of the stomach, diverticular disease or any other digestive disorder or condition?
14.	☐ Yes	☐ No	Cataracts, glaucoma, hearing loss, deviated nasal septum, any other eye, ear, nose or throat disorder?
15.	☐ Yes	☐ No	Asthma, allergies, sinusitis, bronchitis, pneumonia, respiratory syncytial virus (RSV), tuberculosis, sleep apnea, any breathing difficulty, lung or respiratory disease, disorder or condition?
16.	☐ Yes	☐ No	**Males**: Prostate disorder, elevated prostate specific antigen (PSA), sexually transmitted disease, genital warts, herpes, impotence, infertility, any other disease or disorder of the genital or reproductive system?
17.	☐ Yes	☐ No	**Females:** Fibroid or uterine tumor, ovarian cyst, polycystic ovary syndrome (PCOS), 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.	☐ Yes	☐ No	Migraines, headaches, seizure disorder, epilepsy, multiple sclerosis, paralysis, restless leg syndrome, any neurological disorder, or any disorder of the central nervous system?
19.	☐ Yes	☐ No	Memory loss, dementia, narcolepsy, Alzheimer's disease?
20.	☐ Yes	☐ 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.	☐ Yes	☐ No	Thyroid disorder, goiter, Graves disease, lupus, pituitary or adrenal disorder?
22.	☐ Yes	☐ No	AIDS, AIDS-related complex (ARC) or HIV positive, any other immune disorder?
23.	☐ Yes	☐ No	Alcohol use or abuse, alcoholism, substance abuse, drug addiction?
24.	☐ Yes	☐ No	Is any person applying for coverage now pregnant or an expectant parent?
25.	☐ Yes	☐ 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.	☐ Yes	☐ 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 below.

27.	☐ Yes	☐ 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? If yes, please provide details: _____
28.	☐ Yes	☐ 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?
29.	☐ Yes	☐ No	Has anyone applying for coverage used tobacco products in the past 12 months? If yes, who? _____ Date tobacco was last used _____

*Answers provided for enrollees under age 19 will not be used to determine if they are eligible for the plan.

Details of "yes" answers in section above (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
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		
					☐ Yes ☐ No		

In the last five years has any person listed on this application 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	Name of prescribing physician

Please provide information about the last physical exam of each family member (attach additional sheet if necessary). **To be considered for coverage, each family member age 26 and older applying for coverage must have had an age-appropriate physical exam including routine lab work within the last three to five years.**

Family member	Date of last physical exam	Test(s) done (including blood work, x-rays and other)	Name and address of provider that performed the exam

Consent, terms and conditions

I understand that this individual product is medically underwritten and that 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. Health information for each family member will be used to determine eligibility and applicable rates; enrollees under age 19 cannot be declined based on health information.

I understand there is an annual open enrollment period (June 1 through June 30 for a Sept. 1 effective date) during which dependents may be added to my contract. If adding a dependent outside of the open enrollment period, there must be a qualifying event as defined in the certificate.

I understand this product is age rated, and that the rates will be adjusted at the beginning of the month following each covered family member's birthday (age 26 and older). I understand that BCN does not issue child-only policies.

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 that 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.

I understand that the benefits my enrolled family members and I will be eligible for are described in the applicable certificate and that BCN' 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 (HIV) 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.

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.

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.

Signature of Applicant	Date
Signature of Spouse	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

Mail your completed application to:

Individual Business Underwriting – MC X513
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

Or fax to 877-464-3950

Blue Care Network of Michigan

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.

Product: ☐ OneBlue ☐ Smart Select

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	Bank address	
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