Blue Cross Blue Shield of Michigan

Application for Individual Coverage

MyBlue℠ My Life, My Health Plan

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 Blue Cross Blue Shield of Michigan.

Part 1: Applicant Information

Applicant

Last Name	First Name	M.I.	Suffix ☐ Sr. ☐ Jr. ☐ Other: _____	
Street Address (cannot be a P.O. Box)	City	State	Zip Code	County
Mailing Address (if different)	City	State	Zip Code	County
Daytime Phone Number ( )	Evening Phone Number ( )	Cell Phone Number ( )		
Date of Birth (MM/DD/YY)	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Height ____ Feet ____ Inches	Weight _____Pounds
Social Security Number	Applicant's Driver's License or State ID (required): Issue state: _____ Number: _____			
Applicant's E-mail Address				

Spouse and Dependent Children

List your spouse and dependent children you wish to cover. **Dependent children must be 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	Driver's License or State ID for all dependents age 19 or older.
		☐ M ☐ F				Issue State: _____ Number: _____
Child Name	**Date of Birth (MM/DD/YY)**	**Gender**	**Height**	**Weight**	**Social Security Number**	**Driver's License or State ID for all dependents age 19 or older.**
Child 1		☐ M ☐ F				Issue State: _____ Number: _____
Child 2		☐ M ☐ F				Issue State: _____ Number: _____
Child 3		☐ M ☐ F				Issue State: _____ Number: _____
Child 4		☐ M ☐ F				Issue State: _____ Number: _____

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 eligible for Medicare? ☐ Yes ☐ No If yes, who? _____
Note: height, weight, gender and smoking status will not be used in determining plan eligibility or premium.

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.

Have you or any family members 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 _____/_____/_____

Part 2: Choose Your Coverage

Select Individual or Group Conversion

☐ **Individual Coverage**

A 180 day pre-existing conditions waiting period applies to Individual coverage unless you are a child under age 19 or you meet the requirements outlined in the Terms and Conditions of this application.

Select one of the following health plans which are **ONLY** available for Individual coverage:

☐ **Keep Fit**
- ☐ $1,500 deductible
- ☐ $2,500 deductible
- ☐ $5,000 deductible
- ☐ $7,500 deductible
- ☐ $10,000 deductible

☐ **Individual Care Blue Plus**
- ☐ Optional Flexible Blue Dental Plus

☐ **Flexible Blue II**
- ☐ $1,500 deductible
  - ☐ Optional Maternity
  - ☐ Optional Flexible Blue Dental Plus
- ☐ $2,500 deductible
  - ☐ Optional Maternity
  - ☐ Optional Flexible Blue Dental Plus
- ☐ $5,000 deductible
  - ☐ Optional Flexible Blue Dental Plus

☐ **Group Conversion Coverage**

A 180 day pre-existing conditions waiting period does not apply to Group Conversion (GC) coverage, however you must meet certain criteria to be eligible for this coverage:
- Your previous BCBSM group plan coverage had at least 2 subscribers covered.
- Your group contributes to the subsidy required by the State of Michigan.
- You had coverage for at least 3 months.
- You applied for this GC plan within 60 days of the termination date of group coverage.
- Termination of coverage was based upon a qualifying event.

NOTE: Final determination of GC eligibility will be made by Underwriting.

Select one of the following health plans which are **ONLY** available for Group Conversion coverage:

☐ **Flexible Blue II**
- ☐ $2,500 deductible
  - ☐ Optional Maternity
  - ☐ Optional Flexible Blue Dental Plus
- ☐ $5,000 deductible
  - ☐ Optional Flexible Blue Dental Plus

Part 3: Eligibility

Eligibility Information

1. Are you a permanent resident of Michigan and reside here 6 months of the year? ☐ Yes ☐ No

2. Have you or any family members applying for coverage had health coverage in the past six months?
   If yes, please complete:
   Name of insurance company: _____

   Type of coverage: ☐ COBRA ☐ Group ☐ Individual
   ☐ Other: _____

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

   Expected termination date of coverage: _____/_____/_____

   Are benefits provided through a Sole Proprietorship? ☐ Yes ☐ No

3. Are you or your spouse currently employed? ☐ Yes ☐ No If yes, question #6 must also be answered.
   If yes, name of employer: _____

4. Does your employer or your spouse's employer offer a group health plan? ☐ Yes ☐ No
   If no, please skip to #7.
   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:

5. If you are eligible for the group health plan:
   Does the employer pay for or reimburse eligible employees for any portion of their coverage? ☐ Yes ☐ No
   If known, what amount does the employer contribute towards the employee premium (percentage or amount)? _____
   Does the employer pay for or reimburse towards eligible dependents for any portion of their coverage? ☐ Yes ☐ No
   If known, what amount does the employer contribute towards the dependents premium (percentage or amount)? _____

6. 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

Eligibility Information (cont.)

7. 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: _____

8. Are you applying for this individual coverage because you are HIPAA eligible? ☐ Yes ☐ No

Do you believe you are eligible for waiver of pre-existing under HIPAA guidelines? ☐ Yes ☐ No

Please refer to the Terms and Conditions page of this application under "pre-Existing Conditions" for information on HIPAA Eligibility. If you answered "Yes", you must sign and submit the *Application for Waiver of Pre-Existing Waiting Period*. The application can be found at: **http://www.bcbsm.com/pdf/application_waiver_pre-existing_waiting_period.pdf**

9. Have you been rejected for coverage in the past six months by another insurance carrier? ☐ Yes ☐ No

Name of carrier: _____

What was the reason?

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

10. Background: (optional)

☐ American Indian
☐ Asian
☐ African American
☐ Pacific Islander
☐ Caucasian
☐ Hispanic
☐ Mixed (no single dominant race/ethnic group)
☐ Pan Asian
☐ Arabic

11. Education (optional):

☐ High school ☐ College ☐ Grad school ☐ Vocational/technical school

12. Home ownership (optional): ☐ Own ☐ Rent

13. Household income (optional): ☐ $15,000 or less ☐ $16,000 to $35,000 ☐ $36,000 to $50,000 ☐ $51,000 or $75,000 ☐ $76,000 to $100,000 ☐ $100,000 +

Part 4: Health Information

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 and description of the illness if applicable and the family member with the condition.

	Details or Description of Illness	Family Member
☐ AIDS/HIV/ARC		
☐ Amyotrophic Lateral Sclerosis/ALS (Lou Gehrig's Disease)		
☐ Asthma		
☐ Brain Surgery		
☐ Cancer		
☐ Coronary Artery Disease (including Heart Attack, Bypass, Angioplasty)		

☐ Cerebral Palsy		
☐ Cerebral Vascular Disease (including Stroke and TIA)		
☐ Congestive Heart Failure		
☐ COPD (Emphysema, Chronic Bronchitis)		
General Health Information (cont.)		
☐ Cirrhosis of Liver		
☐ Crohn's Disease		
☐ Cystic Fibrosis		
☐ Diabetes		
☐ Epilepsy/Seizures		
☐ Guillian-Barre Syndrome		
☐ Hemophilia or other bleeding disorder		
☐ Hepatitis C, D or G		
☐ Hodgkin's Disease		
☐ Huntington's Disease		
☐ Hydrocephalus		
☐ Infertility		
☐ Leukemia		
☐ Lupus		
☐ Muscular Dystrophy		
☐ Myasthenia Gravis		
☐ Paraplegia or Quadriplegia		
☐ Parkinson's Disease		
☐ Polycystic Kidney Disease		
☐ Renal Failure		
☐ Rheumatoid Arthritis		
☐ Scleroderma		
☐ Sclerosis (Multiple, Disseminated or Postero-Lateral)		
☐ Sickle Cell Anemia		
☐ Transplant (Heart, Kidney, Liver or Lung)		
☐ Wilson's Disease		
☐ Major Psychiatric Disorders (Alzheimer's, Dementia, Paranoia, Schizophrenia, Major Depression, Bipolar Disorder)		
☐ **None of the Above**		
☐ Applicant declines to answer health information		

Part 5: Billing Information

How would you like to pay your initial premium?

☐ Bill Me ☐ Automatic withdrawal (EFT) ☐ Credit Card (please complete the last page of this application)

Please select a billing frequency for ongoing payments:

☐ Monthly (must be automatic payment) ☐ Quarterly

Automatic Payment (must be selected for monthly billing frequency)

This option automatically deducts 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, last)		Social Security Number	
Street Address		E-mail Address	
City	State	Zip Code	Daytime Phone Number
Name of Financial Institution	Type of Account ☐ Checking ☐ 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 bank 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 6: Consent, Terms and Conditions

You are eligible for individual coverage if:

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

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

I am applying for Blue Cross Blue Shield of Michigan coverage subject to the terms and conditions of this application and I agree that I will be bound by all provisions in the Blue Cross Blue Shield of Michigan certificate and riders. Approval of this application and coverage effective date will be determined by Blue Cross Blue Shield of Michigan and shall be subject to requirements by Blue Cross Blue Shield of Michigan for additional information and payment of bills.

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 regarding my 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 Blue Cross Blue Shield of Michigan may collect personal and protected health information (PHI) about me in order to complete my application for coverage. Blue Cross Blue Shield of Michigan will use and disclose this information only in accordance with their Notice of privacy Practices which is available in **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 information, prescription history, medications prescribed and other PHI as requested to Blue Cross Blue Shield of Michigan.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or 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 by Blue Cross Blue Shield of Michigan.

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 treatments or services where I have requested a restriction and/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 Blue Cross Blue Shield of Michigan may: (1) perform case, care and disease management, (2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits, and (3) for other legally permissible purposes, including but not limited to, health care operations. If Blue Cross Blue Shield of Michigan 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 re-disclosed by the recipient and no longer protected.

I understand that my enrollment with Blue Cross Blue Shield of Michigan 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 the PHI from Blue Cross Blue Shield of Michigan and its subsidiaries and from any parties listed above to Blue Cross Blue Shield of Michigan. 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 Blue Cross Blue Shield of Michigan 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 Blue Cross Blue Shield of Michigan.

<u>180-day pre-existing condition waiting period</u>

Blue Cross Blue Shield of Michigan provides no coverage for treatment of a pre-existing condition for individuals 19 years of age or older 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 most recent coverage was an individual policy. If your previous individual coverage was Blue Cross Blue Shield of Michigan, 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 all COBRA benefits available to you.

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 cannot be counted as prior health coverage.
- Your most recent health coverage must have been through an employer-sponsored group health plan; a group health plan is defined as a group with at least two subscribers enrolled. If there were not at least two subscribers enrolled at the time your coverage was terminated, it may be considered a group health plan if the plan at one time had two or more subscribers enrolled. Note: the certificate may state "group health plan" but there must be an employer sponsored plan with at least two contracts enrolled when the plan was enrolled with the insurance carrier.
- 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 non-payment or fraud.
- You did not voluntarily terminate your previous health coverage

Part 7: 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 Blue Cross Blue Shield of Michigan, please mail your completed application to:

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Mail Code 609B
Detroit, MI 48226-2998

I understand that a Summary of Benefits and Coverage (SBC) related to the coverage for which I am applying is available on the web at: www.bcbsm.com/SBC. I understand the SBC is not a contract and that it provides only a general overview of coverage information; and, if there is any difference or discrepancy between the SBC and any applicable plan document (including certificates and riders), the plan document will control. I consent to delivery of the SBC electronically via the website. I understand a paper copy is also available, free of charge, by calling 1-888-288-2738 (a toll-free number).

Signature of Applicant	**Date**
Signature of Spouse	**Date**
Signature of Dependent age 18 or older	**Date**
Signature of Dependent age 18 or older	**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	Agent's E-mail Address		
Area below for BCBSM Use Only			
Group #	Service Code	Eff. Date (mm/dd/yy)	U/W
Pre-existing Date (mm/dd/yy)			DEID

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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 Blue Cross Blue Shield of Michigan. 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

☐ VISA ☐ Mastercard

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 health care premium payment amount. I understand that all information provided will remain confidential.

_____ _____

Signature **Date**