

# APPLICATION FOR PERSONAL TRUE BLUE<sup>SM</sup> (Chamber) APPLICATION FOR PERSONAL BLUEPLAN<sup>SM</sup> HDHP



South Carolina

BlueCross BlueShield of South Carolina  
is an independent licensee of the  
Blue Cross and Blue Shield Association

1. Complete the application and sign PART THREE.
2. Please include a check for your first month's premium — you'll have 30 days to review coverage with no obligation.

P.O. Box 61153, Columbia, SC 29260-1153  
www.SouthCarolinaBlues.com

## PART ONE (Please PRINT IN INK)

### SECTION A – APPLICANT INFORMATION

Requested Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ As of the requested effective date, will you and every person listed on the application be a resident of South Carolina?  Yes  No  
(Effective dates must be either the 1<sup>st</sup> or the 15<sup>th</sup> of the month.) (Only South Carolina residents are eligible for coverage.)

Are you and every person listed on the application a United States Citizen?  Yes  No  
If no, provide copies of your Green Card.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Telephone Number: Home/Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Social Security Number: --

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Billing Address for Premium Notices. (Complete only if different from above.)  
Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Occupation: \_\_\_\_\_

### SECTION B – COVERAGE INFORMATION

#### Personal True Blue

<b>Single Coverage:</b> Coinsurance: 80%/60%				<b>Family Coverage:</b> Coinsurance: 80%/60%			
Deductible: (In/Out)	Out-of-Pocket Maximum: In-Network	Out-of Network	Specialist Copayment:	Deductible: (In/Out)	Out-of-Pocket Maximum: In-Network	Out-of Network	Specialist Copayment:
<input type="checkbox"/> \$2,000/\$4,000	\$5,000	\$10,000	Yes	<input type="checkbox"/> \$4,000/\$8,000	\$15,000	\$30,000	Yes
<input type="checkbox"/> \$2,000/\$4,000	\$5,000	\$10,000	No	<input type="checkbox"/> \$4,000/\$8,000	\$15,000	\$30,000	No
Coinsurance: 60%/40% – Limited Benefits Health Insurance Coverage				Coinsurance: 60%/40% – Limited Benefits Health Insurance Coverage			
<input type="checkbox"/> \$3,500/\$7,000	\$5,000	\$10,000	Yes	<input type="checkbox"/> \$7,000/\$14,000	\$15,000	\$30,000	Yes
<input type="checkbox"/> \$3,500/\$7,000	\$5,000	\$10,000	No	<input type="checkbox"/> \$7,000/\$14,000	\$15,000	\$30,000	No
<b>Prescription Drug Coverage: (Choose One):</b>				<b>Choose Optional Benefit(s):</b>			
<input type="checkbox"/> Drug Card	<input type="checkbox"/> Secure Card			<input type="checkbox"/> Dental/Vision			
<input type="checkbox"/> Basic Card	<input type="checkbox"/> Blue Rx <sup>SM</sup>			<input type="checkbox"/> Maternity			
<input type="checkbox"/> Generic Card				<input type="checkbox"/> Supplemental Accident			

#### Personal BluePlan High Deductible

Select your Benefit Period:  
 Begins on date coverage goes into effect and lasts 365 days except for leap year.  Calendar Year (January 1 – December 31)

Select your plan:

<b>Single Coverage:</b>				<b>Family Coverage:</b>			
Deductible:	Coinsurance:	Out-of-pocket Maximum: In-network	Out-of-Network	Deductible:	Coinsurance:	Out-of-Pocket Maximum: In-network	Out-of-network
<input type="checkbox"/> \$1,500	100%/60%	\$1,500	\$3,000	<input type="checkbox"/> \$3,000	100%/60%	\$3,000	\$6,000
<input type="checkbox"/> \$2,600		\$2,600	\$5,200	<input type="checkbox"/> \$5,200		\$5,200	\$10,400
<input type="checkbox"/> \$3,500		\$3,500	\$5,500	<input type="checkbox"/> \$7,000		\$7,000	\$11,000
<input type="checkbox"/> \$5,000		\$5,000	\$10,000	<input type="checkbox"/> \$10,000		\$10,000	\$20,000
<input type="checkbox"/> \$1,500	80%/60%	\$3,000	\$4,500	<input type="checkbox"/> \$3,000	80%/60%	\$6,000	\$9,000
<input type="checkbox"/> \$2,600		\$5,200	\$7,800	<input type="checkbox"/> \$5,200		\$10,400	\$15,600
<input type="checkbox"/> \$3,500		\$5,500	\$7,500	<input type="checkbox"/> \$7,000		\$11,000	\$15,000
<b>Limited Benefits Health Insurance Coverage</b>				<b>Limited Benefits Health Insurance Coverage</b>			
<input type="checkbox"/> \$1,500	70%/50%	\$3,000	\$4,500	<input type="checkbox"/> \$3,000	70%/50%	\$6,000	\$9,000
<input type="checkbox"/> \$2,600		\$5,200	\$7,800	<input type="checkbox"/> \$5,200		\$10,400	\$15,600
<input type="checkbox"/> \$3,500		\$5,500	\$7,500	<input type="checkbox"/> \$7,000		\$11,000	\$15,000

**Choose Optional Benefit(s):**  Maternity

**SECTION C – BILLING INFORMATION**

- Monthly Bank Draft - *Voided Check (not deposit slip) and Authorization Form required*
- Monthly Direct Bill
- List Bill: (through your employer): List Bill Account Number: \_\_\_\_\_
- Credit Card – Monthly                       Credit Card – First Payment Only

**FOR USE BY BLUECROSS ONLY**

Bank Number

Account Number

**SECTION D – FAMILY INFORMATION**

Coverage is available for unmarried Dependent children through age **18**, or through age **22** if a full-time student.

List dependents to be insured

**For Office Use Only**

Last Name	First Name	M.I.	Social Security Number	Sex	Birthdate	Rider
Spouse:			<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		/ /	
Child:			<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		/ /	
Child:			<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		/ /	
Child:			<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		/ /	

Check here if others are to be insured. List all pertinent information on another sheet.

**PART TWO**

**SECTION A - HEALTH HISTORY**

Applicant's Height:		Applicant's Weight:		Spouse's Height:		Spouse's Weight:	
How Long At Same Weight?				How Long At Same Weight?			
Recent Weight Change?	Lbs. Gained:	Lbs. Lost:		Recent Weight Change?	Lbs. Gained:	Lbs. Lost:	
Reason:				Reason:			

**SECTION B - DETAILS TO HEALTH HISTORY**

In the last 10 years, have you or any person listed on the application had a diagnosis of, advice for, testing for, indication of, symptoms related to, treatment or surgery for, or any injury related to any of the following?

- |  |  |   |  |
|--|--|---|--|
| <p>A. Heart or circulatory system, including high blood pressure, heart attack, chest pain, stroke, heart murmur, irregular heartbeat, varicose veins, phlebitis, poor circulation or high cholesterol or triglycerides.</p> <p>B. Lung or respiratory system, including shortness of breath, sleep apnea, asthma, hay fever or other allergies, sinusitis (<b>indicate below the number of occurrences in the last 12 months</b>), chronic cough, tuberculosis, emphysema, pneumonia or cystic fibrosis.</p> <p>C. Genital or urinary system, including kidney stones, (indicate number of times), prostate, urinary tract infection, blood in urine, breast implants, sexual/reproductive organs, sexually transmitted disease, complications of pregnancy, breast condition, endometriosis, fibroids, abnormal Pap smear or menstrual disorder.</p> <p>D. Digestive system, including gallbladder, pancreas, liver, spleen, colon, reflux, gastritis, intestinal problems, colitis, gastrointestinal bleeding, rectal bleeding, hemorrhoids, hernia or ulcer (indicate type).</p> <p>E. Muscular or skeletal system, including fibromyalgia, connective tissue, lupus, polio, back, joints, bones, muscles, gout, arthritis, amputation or fracture (indicate location, joint involved and location of any screws, pins or plates).</p> | <p>YES    NO</p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> | <p>F. The nervous system, including frequent headaches, migraines, seizures (indicate type), convulsions, fainting, dizziness, multiple sclerosis, cerebral palsy, paralysis, insomnia, stress, anxiety, depression, panic disorder, obsessive compulsive disorder, attention deficit/hyperactivity disorder or any other mental or emotional conditions.</p> <p>G. Eye, ear, nose, throat or mouth (indicate number of occurrences in the last 12 months).</p> <p>H. Any type of cancer, tumor, cyst, polyp, skin problem, thyroid, goiter, endocrine disorder, spleen, anemia, hemophilia, bone marrow, leukemia or any other blood condition.    <input type="checkbox"/> Benign    <input type="checkbox"/> Malignant</p> <p>I. Diabetes, elevated blood sugar, gestational diabetes or presence of any protein, albumin or sugar, in the urine</p> <p>J. Alcohol or drug dependency, abuse or any use of any illegal drugs (includes counseling by any organization or counselor).</p> <p>K. Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex or ever tested positive for the HIV virus.</p> <p>L. Sudden or surgical weight loss, night sweats, persistent fever, fatigue, persistent infection or lymph node enlargement.</p> <p>M. Any other abnormality, deformity, developmental defect or delay, anomaly, acquired or congenital disorder, or any abnormal test results.</p> | <p>YES    NO</p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> <p><input type="checkbox"/>    <input type="checkbox"/></p> |
|--|--|---|--|

1. In the last 5 years, has any person listed on this application:
  - A. Had any symptoms of or concern with any physical, mental or emotional condition for which a doctor has not been seen, or for which treatment or testing has been advised or discussed but not already disclosed in this application?.....  Yes  No
  - B. Seen a doctor (including physical exams, lab work or testing), been hospitalized, institutionalized or had an accident or injury not already disclosed on this application?.....  Yes  No
2. Is any person applying for coverage expecting a child or in the process of adoption, whether or not the mother is listed on the application?.....  Yes  No
3. In the last 12 months, has any person on this application taken any prescription drugs?.....  Yes  No

NOTE: If you answered, "Yes" to any questions in Part Two, Section B, complete the chart below. For more room, attach a sheet of paper, sign and date it.

Question Letter/ Number	Patient's Name	Condition, Injury, Symptom or diagnosis	Date of Onset	Date of Recovery	Date Last Seen	Treatment, X-ray, Labs, Surgery, Medication & Dosage	Physician's Name, Address & Telephone Number

**SECTION C - OTHER INSURANCE INFORMATION**

1. Do you or does any member of your family to be insured have other health insurance coverage, including Medicare, Medicare Advantage or TRICARE?.....  Yes  No
  - A. If you answered "Yes" to 1, will this policy replace that health insurance?.....  Yes  No
2. Have you or any member of your family to be insured been insured by Blue Cross and Blue Shield of South Carolina or BlueChoice<sup>®</sup> HealthPlan of SC, Inc. formerly known as Companion HealthCare, in the last 12 months? .....  Yes  No  
**If "Yes," who and under what identification number?** \_\_\_\_\_
3. Have you or any member of your family to be insured been turned down for health insurance or had conditions excluded from coverage? .....  Yes  No  
**If "Yes," explain:** \_\_\_\_\_

Remarks \_\_\_\_\_

**PART THREE**

**SECTION A - AUTHORIZATION AND AGREEMENTS – READ CAREFULLY BEFORE SIGNING**

The undersigned authorize(s) release to Blue Cross and Blue Shield of South Carolina (Company) or its representatives of (1) All past and future medical records and other information deemed necessary by the Company to underwrite this application and to process claims and (2) All Medicare Part A and Part B claims information from the effective date of any coverage which may be approved pursuant to this application until the termination of such coverage for the purpose of processing claims.

**It is fully understood and agreed (1) That the Company has the right to accept or reject any person applying for coverage in this application, and (2) If the Company approves coverage, the Company will determine the effective date of such coverage, and (3) That no insurance coverage shall be in force until the Company receives the application, approves coverage, and assigns the date on which coverage shall become effective, and (4) If coverage is approved, the undersigned will receive a policy and identification card(s) from the Company, and (5) That any premium or policy fee submitted herewith may be retained by the Company pending approval of coverage. If any coverage is approved, the Company will retain the premiums thereof and the policy fee. If no coverage is approved, the Company will return any premium or fee paid.**

It is further understood and agreed that the Company may deny claims and may void any coverage (subject to the policy's Time Limit on Certain Defenses provision) if the Company determines that any information was misrepresented on the application. If any coverage is voided, the Company will refund premiums paid minus any claims paid.

The undersigned hereby expressly acknowledges understanding this policy constitutes a policy solely with Blue Cross and Blue Shield of South Carolina, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The "Association" permits Blue Cross and Blue Shield of South Carolina to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and Blue Cross and Blue Shield of South Carolina is not contracting as an agent of the Association. The undersigned further acknowledges and agrees to have not entered into this policy based on representations by any person other than Blue Cross and Blue Shield of South Carolina. No person, entity or organization other than Blue Cross and Blue Shield of South Carolina shall be held accountable or liable to the undersigned for any of Blue Cross and Blue Shield of South Carolina's obligations created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of South Carolina other than those obligations created under other provisions of this agreement.

The undersigned hereby represent(s) that the information on this application and any other information furnished by the undersigned is complete, true and correctly recorded.

**SECTION B - SIGNATURE(S)**

I have read and I fully understand each and every part of this application for insurance.

**X** \_\_\_\_\_  
 Applicant's Signature Date Signed  
*NOTE: If Applicant is a minor, a parent or legal guardian must sign. If legal guardian is signing, please attach legal documents.*

**X** \_\_\_\_\_  
 Spouse's Signature (Only required if applying for coverage) Date Signed

\_\_\_\_\_  
 Agent's Name (Please Print)

**X** \_\_\_\_\_  
 Agent's Signature Date Signed 6 7 3 - □ □ □  
Agent's Code

Chamber Name \_\_\_\_\_

**FOR USE BY BLUECROSS**

Effective Date	CH	PF	PR	Approved	Rejected
----------------	----	----	----	----------	----------

**For additional applications, or answers to any questions, please call toll free:  
 1-800-868-2500, ext. 46401**

**AUTHORIZATION AGREEMENT FOR BANK DRAFT/CREDIT CARD PAYMENTS**

If you choose Monthly Bank Draft/Credit Card Payments, complete the authorization agreement below and attach a voided check, if applicable.

Company Name: Blue Cross and Blue Shield of South Carolina

Company ID Number: 320396492

I authorize Blue Cross and Blue Shield of South Carolina to initiate debit/charge entries to my checking account/credit card below and the Bank/Company named to debit/charge my account.

Bank Name: \_\_\_\_\_ Bank Routing Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Visa      Master Card      Expiration Date: \_\_\_\_\_

My Account No.: \_\_\_\_\_ Name on Account: \_\_\_\_\_

This authority is to remain in force until the Bank/Company has received written notification from me of its termination in such time and such manner as to afford the Bank/Company a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notifying the Bank/Company prior to charging the account. If Blue Cross and Blue Shield of South Carolina initiates an erroneous debit entry to a customer's account, the customer shall have the right to have the amount of the entry credited to his/her account by the Bank/Company. If, within 15 calendar days following the date on which the Bank/Company sent to the customer a statement of account or written notice pertaining to the entry or 46 days after posting, whichever occurs first, the customer shall have sent to the Bank/Company a written notice identifying the entry, stating that the entry was in error and requesting the Bank/Company to credit the amount to his/her account.

Your Name: \_\_\_\_\_

Signed: X \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FOR UNDERWRITING**

This authorization is only needed if you are applying for a Personal Blue<sup>SM</sup> Policy.

Please complete this form and send it to the following address if you have been seen by a licensed medical provider within the last 10 years:

Group & Individual Privacy Official (AX-E05)  
BlueCross<sup>®</sup> BlueShield<sup>®</sup> of South Carolina  
I-20 at Alpine Road  
Columbia, SC 29219  
Fax: (803) 264-0174

**Section 1: Authorization** – I authorize my past or present treating physicians/hospitals/clinics, licensed medical providers, pharmacies, and/or pharmacy-related service organizations to disclose to BlueCross BlueShield of South Carolina (“BlueCross”), or its designated agent, my protected personal health information concerning symptoms or conditions for which I may have been treated or given advice for, but does not include psychotherapy notes, in the 10 years prior to my signing this authorization. I further authorize BlueChoice<sup>®</sup> HealthPlan of South Carolina (formerly Companion HealthCare) to disclose to BlueCross, my electronic claims history for the same time period, if any. I understand this authorization is voluntary. However, BlueCross reserves the right to deny enrollment or eligibility for benefits if I refuse to sign this form.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

**Section 2: Purpose** – The purpose of this authorization is for BlueCross to obtain copies of documents related to my medical history in order to determine eligibility before enrollment, and the requested use or disclosure does not include psychotherapy notes.

**Section 3: Options for Disclosures** – Disclosure may occur by sending copies of documents concerning my medical history in the 10 years prior to my signing this form by U.S. mail, by fax, hand delivery or by an electronic transmission.

**Section 4: Expiration and Revocation – Expiration:** This authorization will expire: 1) upon the effective date of my enrollment with BlueCross; or 2) upon BlueCross’ denial of coverage; or 3) upon my written revocation, whichever occurs first. **Revocation:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above.

BlueCross will condition my eligibility for insurance based on whether or not I sign this form. I understand that revocation of this authorization will not affect any action BlueCross took in reliance on this authorization before BlueCross received my notice of revocation.

**Section 5: Signature** – I, the undersigned, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction.

Print Applicant’s Name: \_\_\_\_\_

Applicant’s Social Security No.: -- Spouse’s Social Security No.: --

List Dependents to be included in this Authorization to Disclose Protected Health Information for Underwriting:

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse’s Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(If Applying for Coverage)

**Please Note: If this authorization is for a Dependent age 16 or over, that dependent must sign below.**

Dependent’s Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(If Applying for Coverage and Age 16 or Over)

**You are entitled to a copy of this Authorization Form**

Underwriting (Rev. 9/07)

Order # 12216M

BlueChoice HealthPlan is a wholly-owned subsidiary of BlueCross BlueShield of South Carolina. Both are Independent Licensees of the Blue Cross and Blue Shield Association.

<sup>®</sup>Registered marks of the Blue Cross and Blue Shield Association. <sup>SM</sup> Service mark of the Blue Cross and Blue Shield Association.