

APPLICATION FOR PERSONAL BLUESM

(BLUEPLAN, HDHP, SECURE and BASIC Plans)

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.



South Carolina

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

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

PART ONE (Please PRINT IN INK)

SECTION A - APPLICANT INFORMATION

Requested Effective Date: ____/____/____

(Effective dates must be either the 1st or the 15th of the month.)

As of the requested effective date, will you and every person listed on the application be a resident of South Carolina? Yes No
(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: _____

Personal BluePlanSM

- Plan 1 Plan 2
 Plan 3 – Limited Benefits Health Insurance Coverage Plan 4 – Limited Benefits Health Insurance Coverage

Coinsurance Options: (Select One) 90%/70% 70%/50% – Limited Benefits Health Insurance Coverage
 80%/60% 60%/40% – Limited Benefits Health Insurance Coverage

Deductible Options: (Select One) \$250 \$500 \$1,000 \$1,500 \$2,000 \$3,000 \$5,000 (N/A with Plan 1)

Out-of-Pocket Maximums: (Select One) \$1,500/\$3,000 \$2,500/\$5,000 \$3,000/\$6,000 \$5,000/\$8,000

Prescription Drug Coverage: (Choose One)

Drug Card

Prescription Drug coverage is not available with Plans 3 or 4.

Choose Optional Benefit(s):

- Dental Coverage
 Maternity (N/A with Plans 3 or 4)
 Supplemental Accident

Personal BluePlanSM High Deductible

Select your Benefit Period:

- Begins on date coverage goes into effect and lasts 365 days except for a leap year. Calendar Year (January 1 – December 31)

Select your plan:

Single Coverage:

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"/> \$2,600		\$2,600	\$5,200
<input type="checkbox"/> \$3,500		\$3,500	\$5,500
<input type="checkbox"/> \$5,000		\$5,000	\$10,000
<input type="checkbox"/> \$1,500	80%/60%	\$3,000	\$4,500
<input type="checkbox"/> \$2,600		\$5,200	\$7,800
<input type="checkbox"/> \$3,500		\$5,500	\$7,500

Limited Benefits Health Insurance Coverage

<input type="checkbox"/> \$1,500	70%/50%	\$3,000	\$4,500
<input type="checkbox"/> \$2,600		\$5,200	\$7,800
<input type="checkbox"/> \$3,500		\$5,500	\$7,500

Choose Optional Benefit(s): Maternity

Family Coverage:

Deductible:	Coinsurance:	Out-of-Pocket Maximum:	
		In-network	Out-of-network
<input type="checkbox"/> \$3,000	100%/60%	\$3,000	\$6,000
<input type="checkbox"/> \$5,200		\$5,200	\$10,400
<input type="checkbox"/> \$7,000		\$7,000	\$11,000
<input type="checkbox"/> \$10,000		\$10,000	\$20,000
<input type="checkbox"/> \$3,000	80%/60%	\$6,000	\$9,000
<input type="checkbox"/> \$5,200		\$10,400	\$15,600
<input type="checkbox"/> \$7,000		\$11,000	\$15,000

Limited Benefits Health Insurance Coverage

<input type="checkbox"/> \$3,000	70%/50%	\$6,000	\$9,000
<input type="checkbox"/> \$5,200		\$10,400	\$15,600
<input type="checkbox"/> \$7,000		\$11,000	\$15,000

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 (indicate below the number of occurrences in the last 12 months), 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 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 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[®] HealthPlan of South Carolina, 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 -
 Agent's Code

AUTHORIZATION AGREEMENT FOR BANK DRAFT 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: _____

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 TO DISCLOSE PROTECTED HEALTH INFORMATION FOR UNDERWRITING

This authorization is only needed if you are applying for a Personal BlueSM 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[®] BlueShield[®] 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[®] 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 mandatory. If I refuse to sign this authorization, BlueCross will deny my enrollment in the Personal Blue policy selected.

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 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