

Please Print Clearly

Last Name		First Name		Middle Initial		PLAN USE ONLY									
Street Address (P.O. Box is NOT acceptable -- please provide street address)												I.D. Number:			
City			County			State		ZIP Code			Group		Class		
Applicant's Social Security No.				Applicant's Birthdate			<input type="checkbox"/> Male		<input type="checkbox"/> Single			Plan I.D.:			
				Mo. Day Year			<input type="checkbox"/> Female		<input type="checkbox"/> Married						
Applicant's Occupation				Daytime Phone No.			E-mail Address					Effective Date			
				()								Date		Init	
												Action:			

HIPAA Guaranteed Issue Rights

If you or any member for whom you are applying has had at least 18 consecutive months of group, COBRA, federal government, association or church coverage AND it has been no more than 63 days since that coverage terminated, you may be eligible for waivers of our normal pre-existing condition waiting periods. These rights are available through the Health Insurance Portability and Accountability Act (HIPAA) of 1996. To exercise your rights under HIPAA, you must attach a copy of certification(s) of creditable coverage issued to you by previous insurance carrier(s).

- Do you or any person for whom you are applying have creditable coverage as outlined in HIPAA? Yes No
 If "Yes," please attach a copy of the certificate(s) to this application.
- Are you or any member for whom you are applying eligible for COBRA or any state continuation coverage plan? Yes No
 If "Yes," please specify who is eligible for such coverage:
- Are you or any member for whom you are applying enrolled in COBRA, Medicaid, TennCareSM, an Employer Group Plan, a State or Federal Continuation Coverage plan or Medicare A or B? Yes No
 If "Yes," please specify who is enrolled for such coverage:
- Are you applying through the Inter-Plan Transfer Program? Yes No

Option Code of Benefit Plan you wish to purchase: _____	Applicant Response Only:	I wish to pay my first month's premium:
Do you wish to purchase MATERNITY coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (Not available for all option codes)	Indicate dependent tobacco use in the "Dependent Information" section below.	<input type="checkbox"/> Bill Me
Do you wish to purchase DENTAL coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	I have used tobacco products in the last year: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> eCheck: Bank Routing No.: _____
		Bank Account No.: _____

Effective Date

If your application is received **before** your existing coverage ends, the effective date of your guaranteed issue coverage will be the day after your current coverage terminates.

If your application is received **after** your prior coverage terminates, the effective date of your guaranteed issue coverage will be the day after we receive your application.

Notice: If the date your application is received results in a lapse of coverage of more than 63 days, you may forfeit your right to guaranteed issue coverage.

Dependent Information (Required only if applying for dependent coverage):

First Name	MI	Last Name (If Different)	Relationship	Sex	Tobacco Use?	Birthdate			Social Security No.				
						Mo.	Day	Year					
Spouse			Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No								

My Current BlueCross BlueShield Plan Number is:

Group No.: _____ ID No.: _____
 City & State: _____

My Spouse, Parent or Dependent belongs to BlueCross BlueShield Plan:

Group No.: _____ ID No.: _____
 City & State: _____

Please Read Carefully and Sign Below

I understand and agree:

- that BlueCross BlueShield of Tennessee is entitled to rely solely on the statements made on this application, which are complete and correct to the best of my knowledge.
- that any contract which may be issued to me shall be binding only if each statement included in this application is complete and true.
- that any contract which may be issued to me will be subject to all the terms and conditions of the contract issued to me.
- that my signature on this application will authorize any doctor, hospital, or other provider of treatment to furnish to BlueCross BlueShield of Tennessee any and all medical records pertaining to

- any person who is to be covered by the contract, and I am responsible for any fee for these records.
- that any contract issued to me is directly between BlueCross BlueShield of Tennessee and me and affirm that no third party is involved. My premiums will be billed to me by BlueCross BlueShield of Tennessee and my premium payments will be sent directly to BlueCross BlueShield of Tennessee.
- that BlueCross BlueShield of Tennessee's acceptance of my initial premium payment is an estimate of the first month's premium. I also understand that the premium payment does not constitute a contract between BlueCross BlueShield of Tennessee and myself. I further understand that my application must be approved and a final determination of the monthly premium must be made before a policy is issued.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Date: _____ Sign: X _____ Relationship to Applicant: _____
 Application not acceptable unless completely filled out and signed by the applicant (parent or guardian, if the applicant is a minor).
 If relationship is guardian, please provide copy of legal guardianship papers, finalized by court / agency.

I certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Licensed Agent's Name: _____ (Print Clearly)
 Agent's Signature: _____ Date: _____
 Agent's I.D. Number: _____ Arrangement Code: _____

A scanned, imaged or photocopied version of this completely executed application will have the same force and effect as the original document.