



of Tennessee

1 Cameron Hill Circle
Chattanooga, Tennessee 37402-0001

bcbst.com

-- Confidential --

HIPAA / Group Conversion /
Inter-Plan Transfer
Application For Coverage
For Individuals

Please Print Clearly

Form with fields for Last Name, First Name, Middle Initial, Street Address, City, County, State, ZIP Code, Applicant's Social Security No., Applicant's Birthdate, Applicant's Occupation, Daytime Phone No., E-mail Address, and PLAN USE ONLY section with I.D. Number, Group, Class, Plan I.D., Effective Date, Date, Init, and 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).

- 1) Do you or any person for whom you are applying have creditable coverage as outlined in HIPAA?
2) Are you or any member for whom you are applying eligible for COBRA or any state continuation coverage plan?
3) Are you or any member for whom you are applying enrolled in COBRA, Medicaid, TennCare, an Employer Group Plan, a State or Federal Continuation Coverage plan or Medicare A or B?
4) Are you applying through the Inter-Plan Transfer Program?

Option Code of Benefit Plan you wish to purchase:
Do you wish to purchase MATERNITY coverage?
Do you wish to purchase DENTAL coverage?
Do you wish to purchase VISION coverage?
Applicant Response Only: Indicate dependent tobacco use in the "Dependent Information" section below.
I wish to pay my first month's premium:
Effective Date

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

Table with columns: First Name, MI, Last Name (If Different), Relationship, Sex, Tobacco Use?, Birthdate (Mo., Day, Year), Social Security 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:

*In the event a policy is issued, by providing your email address you are agreeing to receive all communications (presently available or that become available during the term of your policy) related to this policy, the benefits contemplated under this policy, your relationship with BlueCross BlueShield of Tennessee, etc., in electronic form from BlueCross BlueShield of Tennessee. You may opt out of this service by changing your preferences through BlueAccess once your policy is issued.

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