



of Tennessee

1 Cameron Hill Circle
Chattanooga, Tennessee 37402-0001

bcbst.com

-- Confidential --

Please Print Clearly

HIPAA/Group Conversion/ Inter-Plan Transfer Coverage for Individuals Application for Change

Subscriber Name	BCBST ID No.		
Street Address	City	State	Zip

Plan Use Only	
I.D. Number:	
Group:	Class:
Plan I.D.:	
Effective Date: / /	
Rider Codes:	
Person	No.
1) _____	_____
2) _____	_____
3) _____	_____
Exclusion:	
Person	
1) _____	
2) _____	
Date	H/U
Action:	

A. I Wish To:

- Change my individual plan to a family plan. (Complete Section B below.)
- Add new dependents to my family plan. (Complete Section B below.)
- Change from a family plan to an individual plan to cover my spouse only, because I am eligible for BlueCross65.
- Change from a family plan to an individual plan to cover myself only.
- Move the dependents listed below to their own individual plans. (Complete Section B below.)
- Change my benefits. (Complete Section C below.)
- Delete the dependents listed in Section B below.
 - Reactivate my past policy since my return from active military duty.
Date of Discharge: ____ / ____ / ____ Previous I.D. #: _____
- Change my address to: _____
Street Address or Rural Route No. (P.O. Box is NOT acceptable. Please provide address of residence.)
City _____ State _____ Zip Code _____
- Cancel my policy effective on: ____ / ____ / ____ Reason: _____
- Change my name to: _____
- Change my e-mail address to: _____

The effective date of your change will be the first of the month following BCBST's receipt of this form, or the date of the qualifying event.

HIPAA Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you or anyone for whom you are applying may be eligible for waivers of underwriting and our normal pre-existing waiting periods. The eligible individual must have had an aggregate of at least 18 months of creditable coverage without a significant break (63 days or more) in coverage. The most recent coverage must be from a group health plan (including COBRA), governmental plan or a church plan. It must also be no more than 63 days since that coverage terminated. COBRA and/or state continuation coverage must be exhausted to exercise your rights under HIPAA.

- 1) 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.
- 2) 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:
- 3) 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:

B. List Dependent Name(s) Below:

First Name	MI	Last Name (If Different)	Relationship	Sex M/F	Birthdate			Social Security Number				Used Tobacco Products in Last 12 Months	
					Mo.	Day	Year						
Spouse													<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent													<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent													<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent													<input type="checkbox"/> Yes <input type="checkbox"/> No

- C. I wish to change the benefits of my policy to Option Code _____
- I wish to purchase: Maternity Coverage (not available for all options) Dental Coverage
- For Maternity Coverage:** Date of Marriage: ____ / ____ / ____ OR
Date of Loss of Other Coverage: ____ / ____ / ____
- Yes No Vision Exam Only Exam with Materials
- I wish to drop: Maternity Coverage Dental Coverage Vision

- Change Tobacco Usage:**
I certify the following members have used tobacco in the past 12 months:
- Subscriber & Spouse Subscriber Only Use
 Spouse Only Use Neither Use

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 both sides of 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 a broker or agent may receive a portion of my premium as commission. For more information I will contact my broker or agent.

- 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
- by submitting this Application, I agree that BlueCross BlueShield of Tennessee's Grievance process will govern any dispute with the Application or any Policy 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 ID No.: _____

Arrangement Code: _____

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