



**BlueCross BlueShield of Tennessee**

801 Pine Street  
Chattanooga, Tennessee 37402-2555  
[www.bcbst.com](http://www.bcbst.com)

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

Please Print Clearly

|   |  |  |            |             |                |       |          |       |          |       |
|---|--|--|------------|-------------|----------------|-------|----------|-------|----------|-------|
| <p>Subscriber Name _____</p> <p>Street Address _____</p>  | <p>BlueCross BlueShield of TN ID No. _____</p> | <p><b>Plan Use Only</b></p> <p>I.D. Number: _____</p> <p>Group: _____ Class: _____</p> <p>Plan I.D.: _____</p> <p>Effective Date: _____ / _____ / _____</p> <p>Rider Codes:</p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; text-align: center;">Person</td> <td style="width:50%; text-align: center;">No.</td> </tr> <tr> <td>1) _____</td> <td>_____</td> </tr> <tr> <td>2) _____</td> <td>_____</td> </tr> <tr> <td>3) _____</td> <td>_____</td> </tr> </table> <p>Exclusion: Person</p> <p>1) _____</p> <p>2) _____</p> <p>Date _____ H/U _____</p> <p>Action: _____</p> | Person     | No.         | 1) _____       | _____ | 2) _____ | _____ | 3) _____ | _____ |
| Person  | No.  |  |            |             |                |       |          |       |          |       |
| 1) _____  | _____  |  |            |             |                |       |          |       |          |       |
| 2) _____  | _____  |  |            |             |                |       |          |       |          |       |
| 3) _____  | _____  |  |            |             |                |       |          |       |          |       |
| <p><b>A. I Wish To:</b></p> <p><input type="checkbox"/> Change my individual plan to a family plan. <i>(Complete Section B.)</i></p> <p><input type="checkbox"/> Add new dependents to my family plan. <i>(Complete Section B below.)</i></p> <p><input type="checkbox"/> Change from a family plan to an individual plan to cover my spouse only, because I am eligible for BlueCross65.</p> <p><input type="checkbox"/> Change from a family plan to an individual plan to cover myself only.</p> <p><input type="checkbox"/> Move the dependents listed below to their own individual plans. <i>(Complete Section B below.)</i></p> <p><input type="checkbox"/> Change my benefits <i>(Complete Section C below.)</i></p> <p><input type="checkbox"/> Delete the dependents listed in Section B below.</p> <p><input type="checkbox"/> Reactivate my past policy since my return from active military duty.<br/>Date of Discharge: _____ / _____ / _____ Previous I.D. #: _____</p> <p><input type="checkbox"/> Change my address to: _____<br/>Street Address or Rural Route Number <i>(PO Box is not acceptable - please provide address of residence.)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;">City _____</td> <td style="width:20%; border: none;">State _____</td> <td style="width:30%; border: none;">Zip Code _____</td> </tr> </table> <p><input type="checkbox"/> Cancel my policy effective on: _____ / _____ / _____ Reason: _____</p> <p><input type="checkbox"/> Change my name to: _____</p> <p><input type="checkbox"/> Change my e-mail address to: _____</p> |  |  | City _____ | State _____ | Zip Code _____ |       |          |       |          |       |
| City _____  | State _____                                    | Zip Code _____   |            |             |                |       |          |       |          |       |
| <p><b>The effective date of your change will be the first of the month following BlueCross BlueShield of Tennessee's receipt of this form, or the date of the qualifying event.</b></p>   |  |  |            |             |                |       |          |       |          |       |

**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, TennCare<sup>SM</sup>, 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<br>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: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

I wish to drop:  Maternity Coverage  Dental Coverage

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

**I understand and agree**

**Please Read Carefully and Sign Below**

- 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. Date: \_\_\_\_\_

Licensed Agent's Name: \_\_\_\_\_ Agent's I.D. Number: \_\_\_\_\_

Agent's Signature: \_\_\_\_\_ (Print Clearly) Arrangement Code: \_\_\_\_\_

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