



801 Pine Street
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bcbst.com

CHANGE APPLICATION INDIVIDUAL HEALTH COVERAGE

Use Black Ink Only

Plan Use Only

Rec: _____

IHCC

- CONFIDENTIAL -

Section 1 - Select Type of Change - Please mark all that apply. Complete corresponding in Section 2.

Group Number	Identification Number	Subscriber Last Name	Subscriber First Name	MI	Date of Birth (mmddyyyy)
<input type="checkbox"/> Change Name	<input type="checkbox"/> Add Dental Coverage	<input type="checkbox"/> Remove Tobacco Usage	<input type="checkbox"/> Cancel Policy		
<input type="checkbox"/> Change Address	<input type="checkbox"/> Delete Maternity Coverage	<input type="checkbox"/> Add Dependent(s)**	<input type="checkbox"/> Reactivate Policy due to return from Active Military Duty		
<input type="checkbox"/> Change Medical Option (within same product)	(may add with qualifying event)	<input type="checkbox"/> Delete Dependent(s)**	<input type="checkbox"/> Term Subscriber, Issue ID for Spouse/Dependents**	Event Date**	
<input type="checkbox"/> Add Maternity Coverage**	(not eligible to re-add)	<input type="checkbox"/> Change to Subscriber Only**	<input type="checkbox"/> Product to Product Transfer**	2 0	
		<input type="checkbox"/> Transfer Spouse/Dependent(s) to Separate Policy**		** Requires An Event Date	

Section 2 - Currently Enrolled subscriber - You only need to fill in the sections you want changed.

Change Name To: Last _____ First _____ MI _____ Reason for Name Change _____

Change Address To: Street _____
 Residence _____
 Mailing _____
 Billing _____ City _____ State _____ Zip _____ Daytime Phone _____
 EMAIL Address _____

Change Medical Option To: _____ (Complete Health Questionnaire)* Height (ft/in) _____ Weight (lbs) _____ Have You Used Any Tobacco Products In The Past 12 Months: Yes No

Change Tobacco Usage: *I certify that the following covered members have NOT used tobacco within the past 12 months (Check One):*
 Subscriber Only Spouse Only Neither Use Tobacco Products
All requests to change to a non-tobacco use policy must include a current urine cotinine test showing a negative result. Requests received without these test results will be declined by the Underwriting Department.

Add/Delete Dependent(s) Reason: Marriage Divorce Birth/Adoption Death Other _____
 (Complete Section 3 if adding or deleting dependents. If adding, complete Health Questionnaire.) Complete Event Date in Section 1.

Cancel My Policy Effective (mmddyyyy): | | | | 2 | 0 | Reason _____

Reactivate Past Policy Due to Return from Active Duty: Date of Discharge: | | | | 2 | 0 | Previous ID #: _____

Add/Delete Dependent(s) Reason: Divorce (Complete Section 3 by listing spouse/dependents to be deleted from original policy.)

Term Subscriber, Issue ID for Spouse/Dependents Due to Subscriber's: Medicare Eligibility Death Enrolled in Group Coverage (Do NOT complete Section 3.)

Section 3 - Spouse/Dependent Information - If adding spouse/dependents, or increasing medical coverage for currently covered spouse/dependents, please complete Health Questionnaire

Legal Spouse Legal Spouse Last Name _____ First _____ MI _____ Male Female Date of Birth (mmddyyyy) _____ Social Security Number _____
 Add Delete

Has Spouse Used Any Tobacco Products In The Past 12 Months: Yes No Height (ft/in) _____ Weight (lbs) _____

Dependent Dependent Last Name _____ First _____ MI _____ Male Female Date of Birth (mmddyyyy) _____ Social Security Number _____
 Add Delete

Natural Child/Stepchild Adopted/Legal Guardian Other _____ Height (ft/in) _____ Weight (lbs) _____

*Note: A Health Statement will be necessary to evaluate requests to increase your medical coverage.

Identification Number _____ Subscriber Last Name _____ Subscriber First Name _____ MI _____

Section 3 - Spouse/Dependent Information Continued

To Include Additional Dependents - Please record information for additional dependents on a separate sheet of paper and attach it to this application.

Dependent Dependent Last Name _____ First _____ MI _____ Male Female Date of Birth (mmddyyyy) _____ Social Security Number _____

Add Delete

Natural Child/Stepchild Adopted/Legal Guardian Other _____

Height (ft/in) _____ Weight (lbs) _____

Dependent Dependent Last Name _____ First _____ MI _____ Male Female Date of Birth (mmddyyyy) _____ Social Security Number _____

Add Delete

Natural Child/Stepchild Adopted/Legal Guardian Other _____

Height (ft/in) _____ Weight (lbs) _____

Section 4 - Explanation of Pre-existing Condition Waiting Period and Health Insurance Portability and Accountability Act of 1996 (HIPAA). Complete if adding spouse and/or dependent.

Pre-existing Condition Waiting Period – This coverage has a 12-month Pre-Existing Condition Waiting Period. This means that benefits will not be available until the coverage has been in effect for 12 months for any condition (either physical or mental) that was present during the 12-month period prior to the effective date of your coverage. *If you have experienced symptoms of a condition or if medical advice, diagnosis, care or treatment was recommended, received, or should reasonably have been received from a provider of health care services, the condition would be considered pre-existing.* If you are changing coverage from another BlueCross BlueShield of Tennessee individual product, you may be eligible to reduce your Pre-Existing Waiting Period. Information about this can be obtained through your BlueCross BlueShield of Tennessee sales personnel or your insurance representative.

Your Rights Under HIPAA - 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 consecutive creditable coverage AND it has been no more than 63 days since that coverage was terminated. Creditable coverage includes group, COBRA, federal government or church coverage. COBRA or state continuation coverage must be exhausted to exercise HIPAA rights.

1. Do you or any person for whom you are applying have creditable coverage as outlined in HIPAA? YES NO If "NO," initial in box below and go to Section 5.
2. If you do have creditable coverage, check ONE of the following:
 - I (or any person for whom I am applying) have creditable coverage, but I would like to waive my HIPAA rights and apply for an underwritten plan with pre-existing condition waiting periods and medical underwriting. If you select this option, initial in box below and go to Section 5.
 - I (or any person for whom I am applying) have creditable coverage, but do not wish to waive my HIPAA rights. I would like to apply for a guaranteed issue policy with no pre-existing condition waiting period or medical underwriting. If you select this option, stop. See you agent for a different application for guaranteed issue coverage.

Benefit Exclusion Rider – During underwriting review of Your application it may be determined that a Benefit Exclusion Rider is necessary to be placed on Your policy. If a Benefit Exclusion Rider is placed on the Policy provided to You and/or Your dependents then coverage for those specific conditions reflected in the rider will not be available for benefit payment for the lifetime of the Policy. Pre-Existing and HIPAA provisions mentioned above do not apply to conditions excluded by Benefit Exclusion Riders.

I have read the Pre-Existing , HIPAA and Benefit Exclusion Rider sections above and understand these provisions. SUBSCRIBER'S INITIALS: (Required)

SECTION 5 – Disclosure Information

It is understood and agreed as follows:

- I have read the statements and answers recorded on this application. They are true and complete and correctly recorded. They will become part of this application and any policy(ies) issued on it.
- I understand that BlueCross BlueShield of Tennessee is relying on the truthfulness and completion of the statements and answers on this application in making the decision to issue any policies of insurance on health coverage.
- No insurance agent or broker has authority to waive any of BlueCross BlueShield of Tennessee's rights or requirements, or to make or alter any contract or policy. I understand that if my answers on this application are incorrect or untrue, BlueCross BlueShield of Tennessee may have the right to deny benefits or rescind my coverage.
- This insurance coverage is not designed or marketed as employer-provided insurance. I certify that I understand that I am applying for personal health coverage.
- I understand that without my signature and the disclosure authorization, no policy can be issued.
- I understand that I do not have coverage with BlueCross BlueShield of Tennessee until my application has been approved, my initial premium payment has cleared my bank account and BlueCross BlueShield of Tennessee has issued a policy to me.
- I understand that a broker or agent may receive a portion of my premium as commission. For more information I will contact my broker or agent.
- It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Identification Number	Subscriber Last Name	Subscriber First Name	MI

Section 7 - Individual Health Coverage Questionnaire

Have the primary applicant, spouse, or dependents applying for coverage been diagnosed, treated, or had a recommendation for treatment for any of the medical conditions listed below? (Answer ALL questions, even if the answer is NO. Please **CIRCLE** any condition number(s) related to any questions answered YES and complete Section O below. This application will be returned for completion if numbers are not circled or section O is not completed.)

- A. YES NO**
BONE / SKELETAL / MUSCLE
 001 Abdominal / Inguinal Hernia
 002 Back Injury or Impairment
 003 Bulging Disc / Herniated Disc
 004 **Fibromyalgia ***
 005 Knee Injury or Impairment
 006 Osteoarthritis
 007 Pituitary Dwarfism / Growth Hormones
 008 **Rheumatoid Arthritis ***
 009 Scoliosis
 010 Spina Bifida *
 011 **Osteoporosis * (include DEXA scan results)**
 012 Other Bone / Skeletal / Muscular Disorder
- B. YES NO**
INTESTINAL / ENDOCRINE
 013 Adult / Juvenile Diabetes (non-gestational)
 014 **Bleeding Ulcer ***
 015 Chronic Pancreatitis
 016 Cirrhosis of the Liver
 017 Crohn's Disease
 018 Diverticulosis / Diverticulitis
 019 Gastroesophageal Reflux Disease (GERD)
 020 Hiatal Hernia
 021 **Hepatitis B ***
 022 Hepatitis C
 023 Irritable Bowel Syndrome (IBS)
 024 Colon Polyps
 025 Ulcerative Colitis / Ulcerative Proctitis
 026 Thyroid Disease
 027 Other Intestinal / Endocrine Disorder
- C. YES NO**
URINARY / KIDNEY
 028 Chronic Prostatitis
 029 Dialysis
 030 **Enlarged Prostate ***
 031 Kidney Stones
 032 Neurogenic Bladder
 033 Polycystic Kidney Disease
 034 Renal Failure
 035 Other Urinary / Kidney Disorder
- D. YES NO**
LUNG / RESPIRATORY
 036 Asthma
 037 Allergies
 038 Cystic Fibrosis
 039 Emphysema
 040 Pneumonia
 041 RSV Shots
 042 Sleep Apnea
 043 **Tuberculosis ***
 044 Chronic Bronchitis
 045 Other Lung or Respiratory Disorder
- E. YES NO**
HEART / CIRCULATORY
 046 Anemia
 047 Aneurysm
 048 Angina
 049 Angioplasty
 050 Bypass Surgery
 051 Congestive Heart Failure
 052 Heart Attack
 053 Heart Murmur
 054 Hemophilia
 055 **High Blood Pressure / Hypertention ***
 056 **High Cholesterol / Lipid Disorders * (include current fasting lipid panel)**
 057 Mitral Valve Prolapse
 058 Stroke
 059 Transient Ischemic Attacks (TIAs)
 060 Other Heart or Circulatory Disorder
- F. YES NO**
BRAIN / NERVOUS
 061 Alzheimer's or Dementia
 062 Cerebral Palsy
 063 **Epilepsy / Seizures ***
 064 Migraine
 065 Multiple Sclerosis
 066 Muscular Dystrophy
 067 Paralysis
 068 Parkinson's Disease
 069 **Developmental Disorders ***
 070 Other Brain / Nervous Disorder
- G. YES NO**
CANCER
 071 Breast Cancer
 072 Chemotherapy / Radiation
 073 Colon Cancer
 074 Hodgkin's / Lymphoma
 075 Leukemia
 076 Liver Cancer
 077 Lung Cancer
 078 Melanoma
 079 Other Cancer
- H. YES NO**
IMMUNE SYSTEM
 080 AIDS / HIV Infection
 081 Connective Tissue Disease
 082 **Discoid (subcutaneous) Lupus ***
 083 Systemic Lupus Erythematosus
 084 Other Immune System Disorder
- I. YES NO**
TRANSPLANTS
 085 Bone Marrow Transplant
 086 Organ Transplant
 087 Discussed Possible Transplant
- J. YES NO**
EYES / EARS / NOSE / THROAT / SKIN
 088 Acoustic Neuroma
 089 Adenoiditis
 090 Cataracts
 091 Chronic Ear Infections / Ear Tubes
 092 Chronic Sinusitis
 093 Chronic Tonsillitis
 094 Cleft Lip / Cleft Palate
 095 Eczema or Psoriasis
 096 Glaucoma
 097 **Retinopathy ***
 098 TMJ Syndrome
 099 Other Eye / Ear / Nose / Throat / Skin
- K. YES NO**
BEHAVIORAL HEALTH / CHEMICAL DEPENDENCY
 100 ADD / ADHD
 101 Alcoholism
 102 Anorexia / Bulimia or Other Eating Disorder
 103 **Anxiety / Depression ***
 104 Bipolar Disorder / Manic Depressive Disorder
 105 **Counseling ***
 106 Drug Abuse or Illegal Drug Use
 107 Other Behavioral Health Disorder
- L. YES NO**
REPRODUCTIVE
 108 Anyone Currently Pregnant/Expectant Parent (including Father)
 109 Born Premature (<37 weeks)
 110 Breast or Other Fluid-Filled Implants
 111 Endometriosis
 112 History of Pregnancy Complications
 113 Polycystic Ovarian Disease
 114 Sexually Transmitted Disease
 115 Uterine Fibroids
 116 Other Reproductive System Disorder
- M. YES NO**
MISCELLANEOUS
 117 **Advised to have Surgery and / or Testing ***
 118 Inpatient or Outpatient Surgery
 119 **Abnormal Lab Results / Abnormal Pap Smear ***
 120 **Physical Exam with Abnormal Results ***
 121 Anyone currently taking or has taken any medications within the last 12 months
 122 Anyone seen any physicians and / or practitioners within the last 12 months
- N. YES NO**
CONSUME ALCOHOL
 123 If "Yes," please indicate the family members' name and number of drinks consumed per day in Section O below.

* Medical Records including office visit notes, must be provided for these conditions. Medical Records may also be required for conditions other than those indicated with an (*).

Section O - Answer all of the specific information below for any condition with a "YES" above

Condition #	Family Member Name	Diagnosis, Treatment including Medications, or Reason for Visit	Date of Onset	Date of Last Treatment	Physician/Provider Name	Was Recovery Complete?

If more room is needed, please record information on a separate sheet of paper and attach it to this application.