of Tennessee
1 Cameron Hill Circle, Suite 0038
Chattanooga, TN 37402-0038
bcbst.com

Change Application Individual Coverage

Use Black Ink Only

Plan Use Only
Rec:_____

IHCC

— Confidential —

Group Number | Identification Number | Subscriber Last Name | Subscriber First Name | MI | Date of Birth *(mm/dd/yyyy)* | Height *(ft/in)* / | Weight *(lbs)*

Section 1 — I Wish To *(Mark all that apply)*:

❑ **Change My Name To:** Last Name | First Name | MI | Reason for Name Change

❑ **Change My Address To:** Street | Daytime Phone
- ❑ **Residence**
- ❑ **Mailing**
- ❑ **Billing**

City | State | Zip | E-mail Address

❑ **Cancel My Policy Effective** *(mm/dd/yyyy)*: 20 **Reason:** ❑ **Keep Dental/Vision**

Section 2 — If Changing Products *(Mark all that apply)*:

❑ **Requested Date of Change** *(mm/dd/yyyy)*: 20

❑ **Change Benefit Options To:**
- — *Indicate the letter and two character benefit plan.*
- — *Indicate your choice of Network* ***P or S*** *in the single box.*

❑ **Maternity:** ❑ **Add** ❑ **Delete:**
- — *Maternity may only be added to Medical within 31 days of the qualifying event of marriage, or spouse's loss of group coverage.*

❑ **Vision:** ❑ **Add** ❑ **Delete:**
- ❑ **Exam Only**
- ❑ **Exam with Materials**

❑ **Dental:** ❑ **Add** ❑ **Delete:**
- — *When adding dental or vision coverage, the applicant, spouse and all dependents will be enrolled.*

❑ **USAble Life Product** ❑ Add Spouse ❑ Delete
- — *Life is a product offered independently by USAble Life.*
- — *This is not a BlueCross BlueShield of Tennessee product.*
- — ***Term Life insurance may be purchased for a spouse if the Primary applicant already has USAble Life Coverage and the spouse is applying for health insurance coverage on this application.***

❑ **Change Benefit Options To Non-Tobacco Use Policy**
I certify that the following covered members have NOT used tobacco products within the past 12 months (Check One):
❑ Subscriber Only ❑ Spouse Only ❑ Neither Use Tobacco Products
— *All requests for change to a non-tobacco use policy* ***must include a current urine continine test showing a negative result****. Any request received without a urine continine test will be declined.*

❑ **Activate Policy Due to Return from Active Duty:** **Date of Discharge** *(mm/dd/yyyy)*: **Previous ID #:**

❑ **Add/Delete/Transfer a Policy Member.** ***Complete Section 3*****.**

❑ **Term the Subscriber. Issue new ID for Spouse/Dependents due to Subscriber's:**
❑ Medicare Eligibility ❑ Death ❑ Enrolled in Group Coverage *(DO NOT Complete Section 3.)* ❑ Other:

Section 3 — Spouse/Dependent Information:

— If adding spouse/dependent(s) or increasing medical coverage, please complete the Health Questionnaire in Section 6 for all family members.
—Check "Delete" to remove spouse/dependent(s) from existing policy.
—Check "Transfer" to move spouse/dependent(s) to a new policy/product.

Legal Spouse: Legal Spouse Last Name | First Name | MI | Date of Birth *(mm/dd/yyyy)* | Social Security Number | Male ❑ | Female ❑
- ❑ **Add**
- ❑ **Delete**
- ❑ **Transfer**

Reason for Change: ❑ Marriage ❑ Divorce ❑ Death ❑ Enrolled in Group Coverage

Event Date 20 | Height *(feet/inches)* | Weight *(pounds)*

1) Dependent: Dependent Last Name | First Name | MI | Date of Birth *(mm/dd/yyyy)* | Social Security Number | Male ❑ | Female ❑
- ❑ **Add**
- ❑ **Delete**
- ❑ **Transfer**

❑ Natural Child/Stepchild ❑ Adopted/Legal Guardian ❑ Other (Specify):

Reason for Change: ❑ Marriage ❑ Divorce ❑ Death ❑ Enrolled in Group Coverage ❑ Dependent Age Off ❑ Birth ❑ Adoption/Legal Guardian ❑ Other:

Event Date 20

(Additional Dependents Continued on Next Page)

Identification Number | Subscriber Last Name | Subscriber First Name | MI

Section 3 *(Continued)* — Spouse/Dependent Information:

2) Dependent: Dependent Last Name | First Name | MI | Date of Birth *(mm/dd/yyyy)* | Social Security Number | Male ❑ | Female ❑

❑ **Add** ❑ **Delete** ❑ **Transfer**

❑ Natural Child/Stepchild ❑ Adopted/Legal Guardian ❑ Other (Specify):

Reason for Change: ❑ Marriage ❑ Divorce ❑ Death ❑ Enrolled in Group Coverage ❑ Dependent Age Off ❑ Birth ❑ Adoption/Legal Guardian ❑ Other:

Event Date 2 0

3) Dependent: Dependent Last Name | First Name | MI | Date of Birth *(mm/dd/yyyy)* | Social Security Number | Male ❑ | Female ❑

❑ **Add** ❑ **Delete** ❑ **Transfer**

❑ Natural Child/Stepchild ❑ Adopted/Legal Guardian ❑ Other (Specify):

Reason for Change: ❑ Marriage ❑ Divorce ❑ Death ❑ Enrolled in Group Coverage ❑ Dependent Age Off ❑ Birth ❑ Adoption/Legal Guardian ❑ Other:

Event Date 2 0

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 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 "NO," 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, 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 periods or medical underwriting. ***If you select this option, STOP. See your agent for a different application for guaranteed issue coverage.***

Section 5 — AUTHORIZATION/Consent for Release of Personal and Health Information:

This form is to authorize the disclosure and use of protected health information to determine eligibility for enrollment in a health plan. ***If you do not sign and date this authorization, you will not be enrolled.***

My dependents and I authorize any doctor, hospital, clinic, provider of health care, pharmacy or pharmacy benefit manager, health plan, insurance *(or reinsuring)* company, consumer reporting agency, my insurance agents, employers or any other person or firm having:

1) information as to cause, treatment, diagnosis, prognosis or advice of my physical or mental condition; or
2) any other information needed to determine my eligibility for insurance; to give BlueCross BlueShield of Tennessee, its affiliates, its employees and agents, my broker, or any consumer reporting agency, all such information. This may include *(but is not limited to)* medical records, prescription history, medications prescribed, information about driving records, mental illness and use of alcohol and drugs.

I (WE) UNDERSTAND:

— The information obtained with this authorization will be used by BlueCross BlueShield of Tennessee to determine eligibility for insurance. A copy of the authorization is as valid as the original. I (We) or my (our) authorized representative may request a copy of this authorization. This authorization will be in force for two years and six months from the date shown below.
— That I *(we)* may revoke this authorization at any time by writing BlueCross BlueShield of Tennessee. If I *(we)* revoke this authorization, any action taken by BlueCross BlueShield of Tennessee in reliance on this authorization prior to my *(our)* revocation will not be affected.
— My *(our)* signature*(s)* and date*(s)* 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 this contract. I *(we)* may be responsible for any fees for these records.
— If this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, this information may be re-disclosed by the recipient and no longer protected by federal privacy regulation.

Primary Applicant's Signature X _____ **Date (mm/dd/yyyy):** 2 0

Relationship: _____
(If signed by parent or guardian and primary applicant is under age 18)

Legal Spouse's Signature X _____ **Date (mm/dd/yyyy):** 2 0

Dependent's Signature (Age 18 and Over) X _____ **Date (mm/dd/yyyy):** 2 0

Dependent's Signature (Age 18 and Over) X _____ **Date (mm/dd/yyyy):** 2 0

Dependent's Signature (Age 18 and Over) X _____ **Date (mm/dd/yyyy):** 2 0

Identification Number | Subscriber Last Name | Subscriber First Name | MI

SECTION 6 – Individual Health Coverage Questionnaire

Please accurately and truthfully answer all of the following questions for all person(s) applying for coverage. All persons applying who are age 18 and older must review these questions and answer appropriately. For persons under age 18, a parent or legal guardian may answer on their behalf. The questions are organized by category. After reviewing all conditions and/or questions within each category, answer NO or YES. For all YES answers, circle all condition/question number(s) that apply for that category and complete Section 7 below. With respect to medical conditions, has anyone applying for coverage ever been diagnosed, treated, or had a recommendation for treatment for any condition listed below?

A. ❑ NO ❑ YES (Circle all that apply)

BONE/SKELETAL/MUSCLE

1 Abdominal / Inguinal Hernia
2 Back Injury or Impairment
3 Bulging Disc / Herniated Disc
4 Fibromyalgia
5 Knee Injury or Impairment
6 Neck Injury
7 Osteoarthritis
8 Pituitary Dwarfism / Growth Hormones
9 Rheumatoid Arthritis
10 Scoliosis
11 Spina Bifida
12 Osteoporosis
13 Gout
14 Other Bone/Skeletal/Muscular Condition

B. ❑ NO ❑ YES (Circle all that apply)

INTESTINAL/ENDOCRINE

15 Adult/Juvenile Diabetes (non-gestational)
16 Bleeding Ulcer
17 Chronic Pancreatitis
18 Cirrhosis of the Liver
19 Crohn's Disease
20 Diverticulosis / Diverticulitis
21 Gastroesophageal Reflux Disease (GERD)
22 Hiatal Hernia
23 Hepatitis B
24 Hepatitis C
25 Irritable Bowel Syndrome (IBS)
26 Colon Polyps
27 Ulcerative Colitis / Ulcerative Proctitis
28 Thyroid Disease
29 Other Intestinal/Endocrine Condition

C. ❑ NO ❑ YES (Circle all that apply)

URINARY/KIDNEY

30 Chronic Prostatitis
31 Dialysis
32 Enlarged Prostate
33 Kidney Stones
34 Neurogenic Bladder
35 Polycystic Kidney Disease
36 Renal Failure
37 Other Urinary/Kidney Condition

D. ❑ NO ❑ YES (Circle all that apply)

LUNG/RESPIRATORY

38 Asthma
39 Allergies
40 Cystic Fibrosis
41 Emphysema
42 Pneumonia
43 RSV Shots
44 Sleep Apnea
45 Tuberculosis
46 Chronic Bronchitis
47 Chronic Obstructive Pulmonary Disease (COPD)
48 Other Lung or Respiratory Condition

E. ❑ NO ❑ YES (Circle all that apply)

HEART / CIRCULATORY

49 Anemia
50 Aneurysm
51 Angina
52 Angioplasty and / or Bypass Surgery
53 Congestive Heart Failure
54 Heart Attack
55 Heart Murmur
56 Hemophilia
57 High Blood Pressure/Hypertension
58 High Cholesterol/Lipid Disorders
59 Mitral Valve Prolapse
60 Stroke/Transient Ischemic Attacks (TIA's)
61 Other Heart or Circulatory Condition

F. ❑ NO ❑ YES (Circle all that apply)

BRAIN / NERVOUS

62 Alzheimer's or Dementia
63 Cerebral Palsy
64 Epilepsy/Seizures
65 Migraine/Chronic or Severe Headache
66 Multiple Sclerosis
67 Muscular Dystrophy
68 Paralysis
69 Parkinson's Disease
70 Developmental Disorders / Delays
71 Other Brain/Nervous Condition

G. ❑ NO ❑ YES (Circle all that apply)

CANCER

72 Breast Cancer
73 Chemotherapy/Radiation
74 Colon Cancer
75 Hodgkin's/Lymphoma
76 Leukemia
77 Liver Cancer
78 Lung Cancer
79 Melanoma
80 Other Cancer or Malignancy

H. ❑ NO ❑ YES (Circle all that apply)

IMMUNE SYSTEM

81 AIDS/HIV Infection
82 Connective Tissue Disease
83 Discoid (subcutaneous) Lupus
84 Systemic Lupus Erythematosus
85 Other Immune System Condition

I. ❑ NO ❑ YES (Circle all that apply)

TRANSPLANTS

86 Bone Marrow Transplant/Organ Transplant
87 Discussed Possible Transplant or Organ Donation

J. ❑ NO ❑ YES (Circle all that apply)

EYES/EARS/NOSE/THROAT/SKIN

88 Acne
89 Acoustic Neuroma
90 Adenoiditis
91 Cataracts
92 Chronic Ear Infections / Ear Tubes
93 Chronic Sinusitis
94 Chronic Tonsillitis
95 Cleft Lip/Cleft Palate
96 Eczema or Psoriasis
97 Glaucoma
98 Retinopathy
99 TMJ Syndrome
100 Other Eye/Ear/Nose/Throat/Skin Condition

K. ❑ NO ❑ YES (Circle all that apply)

CONSUME ALCOHOL?

101 If "Yes," please indicate the family members' name(s) and number of drinks consumed per day in Section 6 below.

L. ❑ NO ❑ YES (Circle all that apply)

BEHAVIORAL HEALTH/CHEMICAL DEPENDENCY

102 ADD/ADHD
103 Alcoholism or Alcohol Abuse
104 Anorexia/ Bulimia or Other Eating Disorder
105 Anxiety/Depression
106 Bipolar Disorder/Manic Depressive Disorder
107 Counseling
108 Driving Under Influence (DUI)/Driving While Intoxicated (DWI)
109 Illegal Drug Use (including misuse of prescription medications)
110 Suicide Attempt within the last 10 years
111 Other Behavioral Health Condition

M. ❑ NO ❑ YES (Circle all that apply)

REPRODUCTIVE

112 Currently Pregnant/Expectant Parent (including Father)
113 Currently in the Process of Adoption
114 Born Premature (<37 weeks)
115 Breast Cyst or Lump
116 Endometriosis
117 History of Pregnancy Complications
118 Polycystic Ovarian Disease
119 Sexually Transmitted Disease
120 Uterine Fibroids
121 Abnormal Pap Smear
122 Other Reproductive System Condition

N. ❑ NO ❑ YES (Circle all that apply)

MISCELLANEOUS

123 Abnormal Lab Results
124 Advised to have Surgery and / or Testing
125 Currently taking, using or has taken or used any medications, including topical gels and creams, within the last 12 months
126 Seen any physicians and/or practitioners within the last 2 years
127 Resided outside of the U.S. within the last 12 months
128 Breast or Other Fluid Filled Implants
129 Inpatient or Outpatient Surgery
130 Physical Exam with Abnormal Results
131 Unintentional weight loss within the past year

O. ❑ NO ❑ YES (Circle all that apply)

TOBACCO PRODUCTS USED WITHIN THE LAST 5 YEARS

132 Tobacco use within the past year. If "Yes," please indicate the family member(s) in Section 6 below.
133 Past tobacco use. If "Yes", indicate the family member(s), last date of use, and the number of years used in Section 6 below.

SECTION 7 – 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 and Address/Phone	Was Recovery Complete?

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

Identification Number | Subscriber Last Name | Subscriber First Name | MI

SECTION 8 - Affirmation of Understanding and of Statements Made on BlueCross BlueShield of Tennessee Individual Coverage Application

By signing and dating below, it is understood and agreed as follows:

- I (we) 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 (we) understand that BlueCross BlueShield of Tennessee is relying on the truthfulness and completeness of the statements and answers on this application in making the decision to issue any policies of health insurance.
- I (we) understand that if my (our) answers on this application are incorrect or untrue, BlueCross BlueShield of Tennessee may, in its own discretion, as permitted by applicable laws, terminate or rescind my policy or amend it so that my (our) coverage, including my (our) premium, would be the same as it would have been had the answers on the application been correct.
- 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, including this application.
- This insurance coverage is not designed or marketed as employer-provided insurance. I (we) certify that I (we) understand that I am applying for personal health coverage.
- I (we) understand that without my (our) signature and date below and without appropriate signatures and dates in the Authorization section, no policy can be issued.
- I (we) understand that I (we) do not have coverage with BlueCross BlueShield of Tennessee until my (our) application has been approved, my (our) initial premium payment has cleared my (our) bank account and BlueCross BlueShield of Tennessee has issued a policy to me (us).
- I (we) understand that a broker or agent may receive a portion of my (our) premiums as commission. For more information I (we) will contact my (our) 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.
- If I (we) have other health coverage, such coverage will be terminated upon the issue of the BlueCross BlueShield of Tennessee policy for which I (we) have applied.
- I (we) understand that during the underwriting review of the application it may be determined that a Benefit Exclusion Rider is necessary to be placed on my (our) policy. If a Benefit Exclusion Rider is placed on a policy issued for me or my dependents, then coverage for those specific conditions in the rider will not be available for benefit payment for the lifetime of the policy. I (we) understand that I (we) may request reconsideration if I (we) feel the rider was placed in error, or there is a significant change in health status of the person(s) named in the rider.
- By submitting this application, I (we) agree that BlueCross BlueShield of Tennessee's grievance process will govern any dispute with the application or any policy issued.
- I (we) understand that my broker or agent cannot change any of the terms, conditions or rates of a BlueCross BlueShield of Tennessee Policy.

Primary Applicant's Signature X _____ **Date (mm/dd/yyyy):** 2 0 **Relationship:** _____
(If signed by parent or guardian and primary applicant is under age 18)

Legal Spouse's Signature X _____ **Date (mm/dd/yyyy):** 2 0

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

Agent's Signature X _____ **Agent's ID:** **Date (mm/dd/yyyy):** 2 0 **Agent's Name:** _____
(Please Print)

Agent's Email Address:

Identification Number | Subscriber Last Name | Subscriber First Name | MI

SECTION 9 -Term Life Benefit Selection - Coverage Provided by USAble Life*

OPTIONAL TERM LIFE

Underwritten by USAble Life* and billed with your individual medical premiums. Term Life is available only on the insured and spouse. (Applicant must be 19 - 64 years of age.)

Verify the following:

❑ Add Spouse (Primary applicant must already have USAble Life Coverage, and spouse must be applying for health insurance coverage on this application)

— Coverage amount for the spouse will be the same as the amount the Primary already has in place.

If both the applicant and spouse choose Term Life, the coverage amounts will be the same.

— Benefits will be paid to the designated beneficiary(ies) in one lump sum.

— Premiums are based on the age of each member applying for coverage and increase when that person's age moves to the next age bracket. Your monthly premiums will be billed with your individual medical coverage by BlueCross BlueShield of Tennessee.

— Your Term Life coverage will become effective at the same time as your Personal Health Coverage.

Beneficiary Designation for Optional Term Life Insurance Benefits

I hereby designate the following beneficiary(ies) for the USAble Life* Term Life Insurance and revoke the appointment of any existing beneficiary, if making a change in beneficiary(ies). If I designate more than one beneficiary, those who survive me will share equally unless specified otherwise.

The beneficiary for the Term Life insurance on a covered spouse will be the insured.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of insured.)

Name (Last, First, MI)	Address	SSN	Birth Date	Relationship	Percentage Distribution
					+
					+
					+

Total must equal 100% =

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if all primary beneficiary(ies) are not living.)

Name (Last, First, MI)	Address	SSN	Birth Date	Relationship	Percentage Distribution
					+
					+
					+

**USAble Life is an independent company that does not provide BlueCross BlueShield of Tennessee products or services. USAble Life is solely responsible for the Life and coverage above.*

Total must equal 100% =

Identification Number | Subscriber Last Name | Subscriber First Name | MI

SECTION 10 – Term Life Coverage Provided by USAble Life* - PLEASE READ BEFORE SIGNING

I (WE) UNDERSTAND:

— This application may be rejected.

— If accepted, the insurance for which I have applied will not become effective until the date shown on my (our) policy and the initial premium is paid in full. I (we) understand that a broker or agent may receive a portion of my (our) premiums as commission. For more information on the compensation involved in this transaction, please direct your inquiry to your agent or broker.

— If my (our) application is accepted relying on my (our) representations on this document, any coverage which may be issued to me (we) shall be invalid if based on false information.

— Any provider of medical services or supplies is authorized and directed to furnish USAble Life*, its agents or any of its subsidiaries, all records or copies thereof, relating to such services or supplies.

— USAble Life* may phone me (us) for additional information that may help with the timely processing of my (our) application.

— The Term Life insurance applied for will not be effective on any proposed insured unless there has been no change in the health of any proposed insured between the date this application is signed and dated and the effective date of coverage.

In signing and dating below, I (we):

— Represent that the statements and answers given in this application and any signed and dated addendum to this application are true, complete and correctly recorded;

— Authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company or any third party engaged by USAble Life* to secure medical or non-medical information having information with respect to any physical or mental condition, treatment or any non-medical information on me, or any member of my family (if applicable), to give USAble Life*, its reinsurers, or its legal representative any and all such information to use for underwriting insurance.

— Authorize all said sources to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission.

— Agree that this authorization shall be valid without time limit.

— Agree that a photocopy of this authorization shall be as valid as the original and I (we) understand that a copy is available to me (us) upon request.

— Authorize the Office of Driver Services to release my traffic violation record to USAble Life*.

**USAble Life is an independent company that does not provide BlueCross BlueShield of Tennessee products or services. USAble Life is solely responsible for the Life coverage above.*

I certify that

— **I signed and dated this application in the state of Tennessee.**

— **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

Primary Applicant's Signature X _____ **Date (mm/dd/yyyy):** 2 0

Legal Spouse's Signature X _____ **Date (mm/dd/yyyy):** 2 0