

BLUECROSS BLUESHIELD OF MINNESOTA



SIMPLY BLUE APPLICATION CHECKLIST

Application Process:

How To Apply:

- For faster service you may choose to apply online. To be set up for online enrollment please go to <http://www.mnhealthnetwork.com/applybcbsmn.htm>
- Complete the enclosed application or follow the link above to start an online application, being sure to answer all questions completely. **Important: for any/all yes answer to questions 17-22 must have complete corresponding information in section 24. Be sure to include reason for visit, results of physicals or test (i.e. results normal) any date of complete recovery if applicable.**
- If you currently have coverage, choose an effective date 30-60 days in advance. Underwriting review requires one month, typically. Should your medical records be requested from your doctor(s), a decision may take longer – up to 60 days. Your providers may charge for this service! BCBSM allows/pays up to \$30 dollars. If you do not currently have coverage, choose the application date as the effective date. If accepted, your coverage will be placed in force either on the date BCBSM received your application or on any future date specified at question 14. You may specify a future effective date up to 60 days from signature date.
- Send your first estimated premium with application (i.e. monthly, quarterly, semi-annual) your check will be cashed upon receipt by BCBSM. If you are not accepted your premium will be refunded. NOTE: Checks must be written from a personal account.**
- If you prefer to pay monthly, you must agree to the automatic checking withdraw or Pay-O-Matic program. Should you desire to pay monthly, please complete the Pay-O-Matic form and attach a voided check with the application.
- Sign and date the application. Applications must be received within 15 days of the signature date.
- Return the application to the address below. The application must be returned for application review and agent signature or the application may be returned.
**MN Health Insurance Network
151 W Burnsville Pkwy Suite 240
Burnsville, MN 55337**
- If coverage is issued, you will receive your ID card(s), contract and will be billed for future payments.
- If coverage is declined, BCBSM will refund your money.
- So that we can provide you application status updates complete the following contact information.

E-mail Address _____

Daytime Phone _____

There is no guarantee the coverage will be offered. BCBSM will either decline coverage, or offer coverage at the published rates... **Do not cancel your existing medical policy until you have verification of your acceptance.** Should you be declined coverage from any private health insurer, you would in most cases qualify for the Minnesota Comprehensive Health Association (MCHA) health coverage (<http://www.mchamn.com/> for more information).

We will be happy to assist you wherever possible. Please contact me at 952-224-0123 with any questions you might have. *For a complete provider directory see:* <http://www.bluecrossmn.com/>

Application for an Individual Health Contract for Simply Blue



BlueCross BlueShield of Minnesota
 An Independent licensee of the Blue Cross and Blue Shield Association
 P.O. Box 64024, St. Paul, MN 55164

FOR AGENT USE ONLY (Please print legibly)			
Agency code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Agent name	<input type="text"/>
Agent's number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		

Applicant must be 90 days or older to apply.

1. Applicant's name

LAST	FIRST
MIDDLE	

2. Applicant's social security number - -

3. Occupation

4. Date of Birth / / 5. Sex Male Female 6. Marital Status Single Married

Month Day Year

7. Applicant's address

STREET
CITY
STATE ZIP

8. Home phone # () _____ Work phone # () _____

9. Are you a permanent resident of Minnesota currently residing in Minnesota? Yes No If **No**, please explain.

10. **SELECT YOUR CHOICE OF CALENDAR YEAR DEDUCTIBLE:** \$5,000 \$7,500 \$10,000

NOTE: Simply Blue provides benefits for prenatal care only and does not cover maternity-related services. Newborns or newly born children under 90 days old are not covered under the Individual Simply Blue contract. This is single coverage only, no dependents can be added to the contract.

11. Payment mode (check one): Annual (12 months) Semiannual (6 months) Quarterly (3 months) Pay-O-Matic (1 month)

Payment must accompany application. Amount paid with this application \$ If paying by check, please make your check payable to Blue Cross and Blue Shield of Minnesota (BCBSM). **We do not accept business checks or any other form of payment from a business for payment of coverage (See exception on page 4).**

12. **BEHAVIORAL HEALTH SUBSTANCE ABUSE COVERAGE:**
 Coverage for substance abuse is included in the contract. You may choose to delete substance abuse coverage. Your premium will be slightly reduced if you delete substance abuse coverage.
 Check this box if you want to **EXCLUDE** substance abuse coverage

13. **TOBACCO USE DESIGNATION AND DECLARATION:**
 I have used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application Yes No

NOTE: tobacco-free rates are available only to persons who have not used tobacco and/or smokeless tobacco in the preceding 24 months.

14. **EFFECTIVE DATE:**
 Have you completed an application for an Insta-Care contract to precede this coverage? Yes No
 If **Yes**, please leave the requested effective date blank. We cannot process this application if the termination date of the Insta-Care contract is greater than 60 days beyond your signature date on this application.

If approved, coverage will be effective as of:

- the date that coincides with the termination date of the Insta-Care contract if you have applied for Insta-Care and we have received this completed application by that date, or
- the day the completed application is received by mail in the home office of BCBSM, or
- the day after the completed application is received in the home office of BCBSM if delivered to the lobby or submitted electronically, or
- a later effective date as requested here / / . (This date cannot be more than 60 days beyond the signature date.)
Month Day Year

If this application is not approved, no coverage will be effective.

15. **PREVIOUS HEALTH INSURANCE INFORMATION** - If you are approved for coverage, **your contract will not cover preexisting conditions for the first 12 months.** You will not be subject to this exclusion to the extent you have already fully satisfied this type of requirement under prior continuous coverage. Please provide details of other coverages below.

Do you currently have any health insurance or have you had any health insurance within the past 63 days? Yes No

If YES, you must fully complete the following section by providing all health insurance information for the past 12 months for yourself. Make sure to include information for other Blue Cross and Blue Shield of Minnesota coverages.

Insurance Company Name and Policy Number	Date Coverage Started month/day/year	Date Coverage Ended (If active, state active) month/day/year	Was the previous coverage individual or group coverage?
	/ /	/ /	
	/ /	/ /	

16. **Your Height:** _____ ft. _____ in. **Current Weight:** _____ lbs. **Weight One (1) Year Ago** _____ lbs.

17. **HEALTH HISTORY (Complete information is required)**

Have you ever had, been treated for or diagnosed as having diseases or disorders related to the following conditions? (Check each item either "Yes" or "No" and circle conditions.)

You do not have to disclose tests to detect the presence of human immune deficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), or other bloodborne pathogens which were administered to you at the time you were: (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) an emergency medical personnel who was tested as a result of performing emergency medical services while employed; (3) corrections employees or inmates; or (4) patients or employees of a secured facility.

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. HEART OR CIRCULATORY DISORDERS—Chest pain, rheumatic fever, heart murmur, stroke, high blood pressure, anemia, bleeding disorders, varicose veins, myocardial infarction or heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| B. GASTROINTESTINAL DISORDERS—Stomach, gallbladder, liver, intestinal bleeding or disorders, ulcers, hernia, hemorrhoids, chronic diarrhea, or rectal disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| C. GENITOURINARY DISORDERS—Kidney, urinary tract disorders, sexually transmitted diseases, infertility, disorders of the male reproductive system including prostate gland, disorders of the female reproductive system including menstrual disorders and abnormal pap smears | <input type="checkbox"/> | <input type="checkbox"/> |
| D. BREAST DISORDERS—Disorders of the male or female breast, including complications from breast implants..... | <input type="checkbox"/> | <input type="checkbox"/> |
| E. RESPIRATORY DISORDERS—Asthma, emphysema, bronchitis, allergy or allergic reaction, lung, or breathing disorder..... | <input type="checkbox"/> | <input type="checkbox"/> |
| F. NERVOUS, EMOTIONAL, MENTAL, OR PERSONALITY DISORDERS—Depression, anxiety, adjustment disorders, eating disorders, attention deficit disorders, hyperactivity, behavioral, or psychotic disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| G. ENDOCRINE OR GLANDULAR DISORDERS—Diabetes, thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement. | <input type="checkbox"/> | <input type="checkbox"/> |
| H. NEUROLOGICAL OR NEUROMUSCULAR DISORDERS—Headache or migraine, head injury, seizure disorder, multiple sclerosis, cerebral palsy, paralysis, or chronic fatigue syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| I. MUSCULOSKELETAL DISORDERS—Back disorders, scoliosis, temporomandibular joint disorder (TMJ), fibrositis, fibromyalgia, carpal tunnel syndrome, gout, arthritis, joint disorders, or amputation | <input type="checkbox"/> | <input type="checkbox"/> |
| J. CANCER, SARCOMA, TUMOR, CYST, OR POLYP | <input type="checkbox"/> | <input type="checkbox"/> |
| K. SKIN DISORDERS—Acne, rash, warts, or growth | <input type="checkbox"/> | <input type="checkbox"/> |
| L. COLLAGEN DISEASE—Lupus, scleroderma, or rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| M. GENERAL FATIGUE OR MALAISE, MONONUCLEOSIS, OR EPSTEIN-BARR SYNDROME | <input type="checkbox"/> | <input type="checkbox"/> |
| N. EYES, EARS, NOSE, THROAT DISORDERS—Impairment of sight, cataracts, eye muscle, otitis media, earache, hearing impairment, nasal or sinus disorders, tonsillitis, or adenoiditis | <input type="checkbox"/> | <input type="checkbox"/> |
| O. IMMUNE DISORDERS—Congenital or acquired disease or disorder of the immune system, including AIDS or an ARC (AIDS Related Complex) | <input type="checkbox"/> | <input type="checkbox"/> |

18. Female applicant: Are you pregnant? Yes No

19. Have you:
- A. Ever had an operation? Yes No
 - B. Been advised to have treatment or testing for a medical, dental or mental health condition that has not yet been performed? Yes No
 - C. Been hospitalized within the last 10 years? Yes No
 - D. Seen a doctor, chiropractor, psychologist, therapist, or any other health care professional within the past five (5) years? Yes No
 - E. Received speech, physical, behavioral, or occupational therapy within the past five (5) years? Yes No

Yes No

- F. Ever had any positive test for or any disease or disorder of the immune system?
- G. Had a health-related screening or diagnostic test such as a blood test, mammogram, or x-ray during the last five (5) years?
- H. Taken any prescription medication within the past 24 months? If **Yes**, give type of medication and reason in number 24.
- I. Ever been treated for or currently have a congenital abnormality?

20. Have you:

- A. In the past five (5) years, used drugs on a regular basis, other than drugs prescribed by an attending physician, or been treated for the abuse of any drugs or alcohol?
- B. In the past five (5) years, have you been convicted of DWI or DUI or have you had your driver's license suspended or revoked for driving while under the influence of alcohol or a controlled substance? If **Yes**, give details, including names, dates, and driver's license numbers in number 24.
- C. Ever been advised by a health care professional to quit or reduce use of alcohol or drugs? If **Yes**, please provide details including individuals involved, dates, and driver's license number in number 24.
- D. Do you drink alcohol? If **Yes**, please explain in number 24 the average amount used weekly.

21. Do you have any condition that may necessitate medical, surgical, or hospital care?

22. Have you ever been declined coverage, charged an increased rate, or had benefits excluded for health coverage?

23. Do you plan to travel in a foreign country in the next year?

If **Yes**,

Date of Departure	Destination	Date of Return

24. IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS (17-22), PLEASE COMPLETE THIS SECTION. GIVE COMPLETE DETAILS. ADD AN ADDITIONAL PAGE IF YOU NEED MORE SPACE.

Ques. no. & letter	Date of onset	Diagnosis, treatment, or reason for physical check-up including all results of physical examinations and diagnostic tests	Days in hospital	Date of complete recovery (If ongoing, state ongoing)	Doctor, Clinic or Hospital Name

25. PROVIDE NAMES OF THE PHYSICIANS/HEALTH CARE PROFESSIONALS WITH THE MOST COMPLETE KNOWLEDGE OF YOUR MEDICAL HISTORY:

26. TO BE SIGNED BY APPLICANT:

I understand and agree that coverage, if approved, will commence in accordance with question 14. I have included payment with this application. For administrative convenience, BCBSM will deposit in a bank any payment I submit with this application, but such deposit shall not constitute an approval of this application or issuance of coverage. If this application is rejected, any money submitted will be refunded to me.

I have read the preceding statements and declare them to be true and complete. I understand and agree that BCBSM will act in reliance upon the information I have provided herein and that any misstatements in this application which materially affect either the acceptance of risk or hazard assumed by BCBSM may result in denial of a claim(s) or rescission of the contract as applied for herein. I also understand and agree that payment of a claim does not preclude the right of the company to deny future claims or take any action it determines appropriate.

I agree to notify BCBSM of any change in my health condition between the date of this application and the effective date of coverage. Failure to notify BCBSM of any change in my health condition may result in denial of claim(s) and/or rescission of the contract.

 X
Signature Date

 X
Applicant's Signature

 X
Signature Date

 X
Parent or Legal Guardian's Signature (if applicant is a minor)

PLEASE ANSWER ALL QUESTIONS, OTHERWISE YOUR APPLICATION OR EFFECTIVE DATE MAY BE DELAYED. YOUR PAYMENT MUST ACCOMPANY THIS APPLICATION.

EXCEPTION FOR BUSINESS CHECKS OR OTHER FORMS OF PAYMENT FROM A BUSINESS

We do not accept business checks, Pay-O-Matic electronic payments, or any other form of payment from employers with two (2) or more individuals working 20 hours or more per week.

The only exception is if the business does not have two (2) or more individuals working 20 hours or more per week. If this exception applies to your application, you must sign and date the following statement:

I am paying for this coverage with a business check, Pay-O-Matic electronic payment, or other form of payment from a business. I confirm this business does not have two (2) or more individuals working 20 hours or more per week.

X

_____ Date

X

_____ Applicant's Signature

IF APPLICATION COMPLETED BY AGENT, COMPLETE AND SIGN BELOW

If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded in this application are complete and accurate as given.

X

_____ Agent's Signature

()

_____ Agent's Phone Number

_____ Date