



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Application for Individuals and Family

Section 1 - Instructions

- ◆ Please read carefully making sure to complete **all** sections of the application. Incomplete applications will be returned.
- ◆ **Use black or blue ink to complete and sign this application.** An application completed in pencil will be returned.
- ◆ If you need assistance completing this application, please contact your Agent or call us at 1-888-REGENCE (734-3623).

Section 2 - Enrollment Information

UTAH RESIDENCE ADDRESS			
Last Name	First Name	Middle Initial	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Address			
City, State, ZIP Code			
Home Phone Number ()	Work Phone Number ()	E-mail address	
Applicant's Employer	# Hrs. worked per week	Employer's Group Health Insurance (if none, write none)	
Spouse's Last Name	First Name	Middle Initial	
Spouse's Employer	# Hrs. worked per week	Employer's Group Health Insurance (if none, write none)	

BILLING ADDRESS (complete only if billing should be sent to an address other than listed above)	
Name C/O	Relationship to Applicant
Address	City, State, ZIP Code

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED (for additional children, attach a separate page)

Last Name of Family Member	First Name	MI	Relationship	Sex	Height	Weight	Birthdate	Social Security Number
Applicant			Subscriber				/ /	
Legal Spouse							/ /	
Child							/ /	
Child							/ /	
Child							/ /	
Child							/ /	
Child							/ /	

Section 3 - Agent Certification

FOR AGENT USE ONLY

I, the agent (producer), certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence BlueCross BlueShield of Utah (Regence BCBSU). I have informed the applicant that the effective date of coverage is assigned only by Regence BCBSU, and provided the Utah Disclosure Information required.

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Agent Name (please print or type)	Agent E-mail	Regence BCBSU Agent Number
Agency Name	Phone Number ()	Fax Number ()
Street Address	City	State ZIP Code
Agent's Signature (Required) X	FBL#	Date (Required)

AGENT: COLLECT NO PREMIUM WITH APPLICATION

OFFICE USE ONLY	Group No. & Pkg.	Identification No.	Contract Effective Date	Bill Period	Agent No.
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Section 4 - Plan Selection

SELECT ONE MEDICAL PLAN PER APPLICATION.

MEDICAL				
<p>I am applying for: <input type="checkbox"/> New enrollment <input type="checkbox"/> Addition of a spouse or dependent to my existing policy. (signature(s) required on page 7)</p> <p><input type="checkbox"/> Change to my existing individual plan or deductible ID Number _____</p> <p style="text-align: center;">ID Number _____</p>				
<p style="text-align: center;">Option 1 BLUE CHOICES ADVANTAGE (80%/20%) Office Visit Copay \$20</p> <p style="text-align: center;">DEDUCTIBLES:</p> <p style="text-align: center;"><input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000</p> <p style="text-align: center;">Provider Network (choose one)</p> <p><input type="checkbox"/> Regence BCBSU "Traditional"</p> <p><input type="checkbox"/> Regence ValueCare</p>	<p style="text-align: center;">Option 2 BLUE CHOICES ADVANTAGE (80%/20%)</p> <p style="text-align: center;">DEDUCTIBLES:</p> <p style="text-align: center;"><input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500</p> <p style="text-align: center;">Provider Network (choose one)</p> <p><input type="checkbox"/> Regence BCBSU "Traditional"</p> <p><input type="checkbox"/> Regence ValueCare</p>	<p style="text-align: center;">Option 3 BLUE CHOICES BASIC (70%/30%) Office Visit Copay \$30</p> <p style="text-align: center;">DEDUCTIBLES:</p> <p style="text-align: center;"><input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000</p> <p style="text-align: center;">Provider Network (choose one)</p> <p><input type="checkbox"/> Regence BCBSU "Traditional"</p> <p><input type="checkbox"/> Regence ValueCare</p>	<p style="text-align: center;">Option 4 BLUE CHOICES BASIC (70%/30%)</p> <p style="text-align: center;">DEDUCTIBLES:</p> <p style="text-align: center;"><input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500</p> <p style="text-align: center;">Provider Network (choose one)</p> <p><input type="checkbox"/> Regence BCBSU "Traditional"</p> <p><input type="checkbox"/> Regence ValueCare</p>	<p style="text-align: center;">Option 5 REGENCE HSA HEALTHPLAN</p> <p style="text-align: center;">Single/Family DEDUCTIBLES:</p> <p style="text-align: center;"><input type="checkbox"/> \$1,500/\$3,000 <input type="checkbox"/> \$2,500/\$5,000 <input type="checkbox"/> \$3,500/\$7,000</p> <p style="text-align: center;">Provider Network (choose one)</p> <p><input type="checkbox"/> Regence BCBSU "Traditional"</p> <p><input type="checkbox"/> Regence ValueCare</p>

Section 5 - Other Coverage Information

Are you or any dependents who are applying for coverage currently covered on any group, individual or self-insured plan? Yes No

If **yes**, do you intend to replace your current plan with this contract?..... Yes No

Regence BCBSU Individual Plans contain a 12-month preexisting condition limitation period. Please provide the following information, and attach a copy of your Certificate of Coverage from your current or prior carrier or a similar document showing the beginning and ending dates of your current coverage, if applicable.

Name (First, Last)	Birthdate	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
				Date Coverage Began	Date Coverage Ended (indicate Active if you are currently covered)	
1.						◆ Employer Group ◆ Individual ◆ Medicare ◆ COBRA ◆ High Risk Pool ◆ Other (describe)
2.						
3.						
4.						
5.						
6.						
7.						
8.						

Section 6 - Additional Information

Is any employer contributing to, reimbursing or paying the premium for this individual policy? Yes No

Individual benefit plans are not intended for use as an employer-sponsored health benefit plan for employees. For information on small employer health benefit plans, contact the Regence BCBSU Group Marketing department at (801) 333-2520.

Are all eligible family members applying for coverage? Yes No

If not, please state the reason _____

Does any listed proposed insured live, reside, work or attend school outside of the state of Utah at any time during the year?

Yes No

If yes, indicate the person(s) and the percentage of time spent outside of the state. _____

How did you hear about Regence BCBSU?

Please check the box that best describes how you heard about us.

Friend Agent Direct mailing Web site Other _____

Effective Date

Upon approval, unless otherwise indicated, the effective date will be the first of the month following receipt of an application. However, applications that are incomplete or require additional information may receive a later effective date. Only the 1st of the month effective dates are permitted.

Notes _____

Section 7 - Standard Health Statement

Notice to Applicant: You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information.

Each question must be checked "Yes" or "No" (for you and any family members requesting coverage). This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being canceled retroactively. It is your responsibility to notify the carrier of any change in health while application is pending. Provide details on Page 6 to any questions answered "Yes." **(For the purpose of these questions, *chronic* means persistent, continuous, periodic, or a combination of any of these terms.)**

Within the last five years, has **anyone** listed on this application had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional; or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement related to any of the following conditions:

Section 7 (continued) - Standard Health Statement

Respond to the following questions:

- | | YES | NO |
|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you, your spouse or any eligible child (whether or not proposed for insurance) currently pregnant or missed her last menstrual period?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you or your spouse financially responsible for an unborn child, or anticipate adopting a child in the next 12 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. To the best of your knowledge, has anyone been denied health or life insurance or been issued a modified or rated policy?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Within the past 12 months has any applicant:

- | | YES | NO |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 4. Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine and wellness care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Had a health condition, problem, or disorder for which medical advice or treatment has not been sought?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Within the past 5 years has any applicant been diagnosed with, treated for, or had any of the following conditions:

- | | YES | NO |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 7. Physical, neurological, or neuromuscular impairments?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Mental health counseling, psychotherapy, depression, stress, anxiety, mental health disorder, or chemical imbalance that required consultation or medication?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Eyes, ears, nose, sinus, or throat disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Jaw disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Allergies, hay fever or adverse drug reactions and side effects?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. RSV, reactive airway disease, lung disease, or any other respiratory system disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Thyroid disorder, goiter or any other lymph system disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Within the past 5 years has any applicant been diagnosed with, treated for, or had any of the following conditions:

- | | YES | NO |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 16. Breast lumps, breast augmentation, or breast reduction?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Back, neck, spinal, or joint disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Connective tissue disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Hemophilia, anemia, blood or bleeding disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Obesity, bulimia, anorexia, or any other eating disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Hemorrhoids, polyps, or any other rectal disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Impotence, prostate or testicular disorder, or abnormal PSA?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, or any other gallbladder or digestive disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Bladder or urinary disorder, or incontinence?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Sexually transmitted diseases?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Irregular bleeding, abnormal Pap smears/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy including premature births or any other disorder of the reproductive system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Varicose veins, or any other circulatory disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Foot, knee or bone disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Fracture or dislocation?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Tobacco use (chewing or smoking)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Inability to work or to perform routine daily functions for more than 2 weeks (other than pregnancy)?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Section 7 (continued) - Standard Health Statement

Please provide specific details below to each question answered "yes" on pages 3 - 5.

Question Number	Name of Applicant	Dates of Care		Name of Condition	Symptoms	Type of surgery, tests, treatments, consultations or medications received/contemplated	Recovery		Attending Physician, healthcare provider or hospital
		From	To				Resolved <input type="checkbox"/>	Unresolved <input type="checkbox"/>	
							Resolved <input type="checkbox"/>	Unresolved <input type="checkbox"/>	
							Degree of recovery _____%	Degree of recovery _____%	
							Resolved <input type="checkbox"/>	Unresolved <input type="checkbox"/>	
							Degree of recovery _____%	Degree of recovery _____%	
							Resolved <input type="checkbox"/>	Unresolved <input type="checkbox"/>	
							Degree of recovery _____%	Degree of recovery _____%	
							Resolved <input type="checkbox"/>	Unresolved <input type="checkbox"/>	
							Degree of recovery _____%	Degree of recovery _____%	
							Resolved <input type="checkbox"/>	Unresolved <input type="checkbox"/>	
							Degree of recovery _____%	Degree of recovery _____%	
							Resolved <input type="checkbox"/>	Unresolved <input type="checkbox"/>	
							Degree of recovery _____%	Degree of recovery _____%	
							Resolved <input type="checkbox"/>	Unresolved <input type="checkbox"/>	
							Degree of recovery _____%	Degree of recovery _____%	

List all medications not listed above that are **currently** being taken by any person applying for coverage.

Name	Medication(s)	Dosage	Medical condition being treated	Date Prescribed

Section 8 - Certification, Authorization and Signature

Be sure to sign and date the application below. Spouse's signature is required if applicable. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Regence BCBSU to enroll in their coverage. I understand that Regence BCBSU will rely on each answer in making coverage and rating determinations. For the protection of all of the Regence BCBSU members, knowingly providing Regence BCBSU with false, incomplete or misleading information may result in Regence BCBSU taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. If coverage is rescinded for fraud or intentionally misleading statements, Regence BCBSU will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence BCBSU in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence BCBSU. Regence BCBSU may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I further affirm that I received a disclosure statement and outline of coverage from Regence BCBSU or its authorized agent describing the individual contract.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the application form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence BCBSU may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at www.ut.regence.com or by telephone request at 1 (888) REGENCE (734-3623).

Signature of applicant (applicant must be 16 years of age or older) X	Date
Signature of applicant's legal spouse X	Date

*** If signed by a personal representative of the member/enrollee please complete the following:**

Personal Representative's Name (please print) _____

Relationship to Individual _____ (Attach legal documentation)

If additional health information is required to qualify you or a family member for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

PLEASE CONTINUE TO SECTION 9

