

# BlueChoice<sup>®</sup> Individual Coverage

## Application

### Important Instructions

- Please print in ink or type.
- Completed application must be received by BlueChoice HealthPlan within 30 days of the signature date.
- The application must be signed where indicated.
- Attach a copy of the applicant's Social Security card along with the first month's premium payment. Make all payments payable to BlueChoice HealthPlan.
- Incomplete or ineligible applications will be returned.
- The completed application and check for the first month's premium should be sent to BlueChoice HealthPlan, AX-430, P.O. Box 6170, Columbia, S.C. 29260-6170.

Coverage does not become effective under any circumstances until an application has been approved by BlueChoice HealthPlan. Coverage will begin the first day of the month after the application has been approved.



An independent licensee of the  
Blue Cross and Blue Shield Association



**HEALTH INFORMATION**

11. Applicant's Height: \_\_\_\_\_ ' \_\_\_\_\_ "      Recent gain or loss of weight? (circle one)      Amount: \_\_\_\_\_  
Current Weight: \_\_\_\_\_ lbs.      Reason for weight change: \_\_\_\_\_

12. In the last 10 years, has the applicant ever had a diagnosis of, advice for, indication of, symptoms related to, treatment for, or injury related to any of the following?

NOTE: If any answer to this section is "yes," please indicate the doctor's name and address, treatment dates, results, medications and any other pertinent information in the space below.

- |    | YES                      | NO                       |   |       |
|----|--------------------------|--------------------------|---|-------|
| A. | <input type="checkbox"/> | <input type="checkbox"/> | Heart or circulatory system, including heart murmur or irregular heartbeat  | _____ |
| B. | <input type="checkbox"/> | <input type="checkbox"/> | Lung or respiratory system, including shortness of breath, asthma, hayfever or other allergies  | _____ |
| C. | <input type="checkbox"/> | <input type="checkbox"/> | Genito-urinary system, including kidney stones, urinary tract infection, menstrual disorder, nephritis, or other kidney or bladder disease  | _____ |
| D. | <input type="checkbox"/> | <input type="checkbox"/> | Digestive system, including ulcer, hernia, gastritis or problems of the stomach, intestines, bowels, rectum, appendix, liver or gallbladder   | _____ |
| E. | <input type="checkbox"/> | <input type="checkbox"/> | Muscular or skeletal system, any disease or disorder of the back, spine, bones, joints or muscles, including arthritis, or lupus, muscular dystrophy, loss of limb or fracture (indicate location of any screws, pins, rods or plates). | _____ |
| F. | <input type="checkbox"/> | <input type="checkbox"/> | The nervous system, including severe headaches, paralysis, seizures, convulsions, epilepsy, fainting, dizziness, mental or emotional disorders, psychiatric care, cerebral palsy, behavior disorders and educational disorders.         | _____ |
| G. | <input type="checkbox"/> | <input type="checkbox"/> | Eye, ear, nose, throat, mouth or teeth  | _____ |
| H. | <input type="checkbox"/> | <input type="checkbox"/> | Any type of cancer, tumor, cyst or other growth, skin disorder, anemia, hemophilia or other glands, blood and blood-forming organs  | _____ |
| I. | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or elevated blood sugar  | _____ |
| J. | <input type="checkbox"/> | <input type="checkbox"/> | Sugar, blood or albumin in the urine  | _____ |
| K. | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or drug dependency, overdose, reaction, abuse or counseling by Alcoholics Anonymous or similar organization   | _____ |
| L. | <input type="checkbox"/> | <input type="checkbox"/> | Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex, or ever tested positive for the HIV virus   | _____ |
| M. | <input type="checkbox"/> | <input type="checkbox"/> | Sudden weight loss, night sweats, persistent fever, fatigue, mouth infection or lymph node enlargement  | _____ |
| N. | <input type="checkbox"/> | <input type="checkbox"/> | Any other abnormality, deformity, birth defect, developmental defect, anomaly, disease or disorder  | _____ |

\_\_\_\_\_  
\_\_\_\_\_

13. Is applicant pregnant?  Yes  No

14. In the last 10 years, has the applicant seen a doctor, had surgery, been hospitalized, institutionalized or had an injury requiring medical treatment not already disclosed in this application?

Yes  No If "yes," please explain. \_\_\_\_\_

\_\_\_\_\_

15. In the last 12 months, has the applicant taken prescription drugs?  Yes  No If "yes," list drug(s) below.

\_\_\_\_\_

16. In the last 5 years, has the applicant had symptoms of, or trouble with, any physical, mental or emotional condition for which the applicant has not yet seen a doctor or for which treatment has been recommended?  Yes  No

If "yes," please explain. \_\_\_\_\_

17. List the name and address of applicant's doctor(s).

DOCTOR'S NAME

DOCTOR'S ADDRESS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**APPLICANT, PARENT OR LEGAL GUARDIAN – READ CAREFULLY BEFORE SIGNING:**

I authorize release to BlueChoice HealthPlan of South Carolina, Inc. all past and future medical records of applicant needed to underwrite this application for coverage and to process claims.

I also understand that the coverage I am applying for to cover applicant will not be in effect until this application is accepted by BlueChoice HealthPlan and until the premium plus any policy fee is paid. BlueChoice HealthPlan assigns effective dates only on the first of the month. Further, I understand that I, as contract holder, will receive a contract and identification card for the applicant if this application is approved. If this application is not approved, any premium and policy fee I have paid will be returned to me.

I agree that the information given by me on this application is complete, true and correctly recorded.

**I HAVE READ AND UNDERSTOOD EACH AND EVERY PART OF THIS APPLICATION.**

Applicant's, Parent's or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If a grandparent is applying to cover applicant, please complete Parental Consent below:**

**Note:** Applicants 18 years of age or older must sign their own applications. Applications for individuals under 18 years old must be signed by parent or legal guardian.

**Parental or Guardian Consent**

This will serve to notify you that the grandparent of my child, \_\_\_\_\_, who is under 18 years of age is making application  
(name of child, please print)

for BlueChoice HealthPlan individual coverage for my child, with my full knowledge and consent, and I request that you consider my child for such coverage.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Agent's Signature: \_\_\_\_\_ Agent's 6-Digit Code: \_\_\_\_\_

For BlueChoice HealthPlan use only:

Applicant Accepted  Not Accepted  Effective Date: \_\_\_\_\_

BlueChoice HealthPlan Identification Number: \_\_\_\_\_ Underwriter's Signature: \_\_\_\_\_ Date: \_\_\_\_\_