Application and Health Questionnaire for Comprehensive Major Medical Preferred-Provider Coverage

An Individual Preferred-Provider Program Utilizing the Keystone Health Plan West Network of Providers

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association

How to complete this application:

1. Tear off this front page along the perforation. **Keep this page for your records.** You may want to refer to it if you have a question about your application or the appeals process.
2. On page one, provide all "General Information" and all "Enrollment Information" requested. Provide information about your spouse and dependents only if they are also applying for coverage.
3. Provide all "Medical Information" requested under Sections A, B, C and D on pages two through six. Provide information about yourself and each dependent who is also applying.
4. Read the "Conditions of Enrollment" on page seven. Be sure to sign and date where indicated. If both you and your spouse are applying for coverage, both of you must sign and date this application.
5. The "Producer's Certificate" on page eight should be completed only by an insurance producer acting on your behalf. Do not complete if you are applying on your own.
6. Return your completed application with a check or money order for your initial premium made payable to "Highmark Blue Cross Blue Shield." Mail to:

   Highmark Blue Cross Blue Shield
   P.O. Box 382555
   Pittsburgh, Pennsylvania 15250-8555

   Please Note:
   Receipt of your initial payment does not constitute enrollment under this program. Your coverage will not begin until this application has been accepted by Highmark Blue Cross Blue Shield and you have been notified that an effective date of coverage has been assigned. If your application is approved by the medical underwriting department on or before the 27th day of the month, your coverage will become effective on the first day of the following month. Failure to provide all the information requested may result in a delay in the processing of your application.

Keep this page for your records.

Date: ______________________

Check Number: ______________________

Amount Remitted: ______________________

Underwriting your application

The basic source of information we use to determine your eligibility for this insurance policy is your application. Experienced underwriters will carefully and promptly review the information you have provided. In addition, we may also obtain information from other sources, including attending physicians and hospitals, as authorized by you when you complete your application.

We do this to keep our insurance rates as low as possible. If we did not obtain adequate underwriting information about each of our applicants, the majority of policy owners who do provide accurate, complete information would have to bear the extra cost of insuring those individuals who do not.

A high percentage of our applicants are in good health and meet our underwriting standards. As a result, these applications are quickly approved and insurance policies issued. Some applicants, however, present a greater insurance risk, usually due to an abnormal physical condition or history of medical problems. In these cases, insurance coverage is denied. By underwriting policies in this way, we try to keep the cost of health care coverage affordable to as many people as possible.

Please note: If you, your spouse or any dependent applying for coverage receives medical advice or treatment from a physician or other professional provider for a condition which is incurred after this application is signed but prior to the effective date of coverage, you must notify Highmark Blue Cross Blue Shield's Underwriting Department immediately at 120 Fifth Avenue, Suite 1224, Pittsburgh, PA 15222-3099. A change in your medical condition that occurs *prior* to your effective date could result in a denial of coverage if your application has not yet been approved or cancellation of coverage if your application has been approved but coverage is not yet effective.

How to appeal a denial for insurance coverage

You have the right to appeal a denial for medical insurance. To do so, complete the following steps within 60 days of the date shown on the denial letter you receive:

1) Ask the attending physician to write a letter providing additional medical information about the condition(s) for which coverage was denied. Have the doctor include any pertinent clinical information to support your appeal.
2) Send the physician's letter, clinical information and a copy of the denial letter to:

Highmark Blue Cross Blue Shield
DirectBlue Appeal
Fifth Avenue Place
120 Fifth Avenue, Suite 1224
Pittsburgh, PA 15222-3099

Your appeal will be reviewed by a physician on our medical review staff, and a final decision will be issued to you in writing within 30 days.

For more information or help completing this application…

If you have questions about this coverage or how to complete this application, please call a Member Service Representative at 1-800-876-7639.

General Information:

An Individual Preferred-Provider Program Utilizing the Keystone Health Plan West Network of Providers

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association

Check one: ☐ **I am applying for new Comprehensive Major Medical Preferred-Provider coverage (new applicant)**
☐ **I am adding dependent(s) to my existing coverage**

If applying for husband and wife or family coverage, applicant must be the older spouse.
If children only are applying, youngest child must be the applicant.

(PLEASE PRINT) Applicant's Last Name	First Name	Middle Initial	County

Home Address	City	State	Zip Code

Home Phone Number	Work Phone Number
( )	( )
Home Email	**Work Email**

Enrollment Information:

This Comprehensive Major Medical Preferred-Provider Subscription Agreement for Individual Members Utilizing the Keystone Health Plan West Network of Providers, Without a Gatekeeper ("Agreement") renews on a month-to-month basis. The premium is payable in advance to Highmark Blue Cross Blue Shield on a monthly basis. Once enrolled, you can choose to pay your monthly premium via electronic funds transfer through the Pay It Easy program.

Monthly premium: $ ____________________

List spouse and/or eligible child(ren) you are enrolling. (Eligible children are unmarried children under age 19.)

	Self	Spouse	Child	Child	Child
Name					
Do you smoke or use smokeless tobacco?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Social Security Number					
Birth Date (MM/DD/YY)	/ /	/ /	/ /	/ /	/ /
Present Age					
Sex					
Height					
Weight					
Current Physician					
Physician's Phone Number	( )	( )	( )	( )	( )
HBCBS Use Only					

1. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have in force? This includes any current Highmark Blue Cross Blue Shield policy.
   ☐ YES If "yes," proceed to 1 (a) and (b). ☐ NO If "no," proceed to question 2.

   1 (a). If you answered "yes" to question 1, please provide the insurance company name and applicable group and identification number(s):

   Company Name: ______________________________

   Group No: ____________________ Agreement or I.D. No: ____________________

   1 (b). If you answered "yes" to question 1, please complete the enclosed *Notice to Applicant Regarding Replacement of Accident and Sickness Coverage* form and mail it with your application.

2. Have you or any applicants ever applied and been rejected for any: Name or Person(s) Rejected and Reason

   Medical policies ☐ Yes ☐ No ____________________

   Life Insurance policies ☐ Yes ☐ No ____________________

3. Are you or any of your dependents who are applying for this coverage enrolled in or eligible for Medicare due to age and/or disability? ☐ Yes ☐ No

ANY PERSON ELIGIBLE FOR MEDICARE OR MEDICARE DISABILITY BENEFITS IS NOT ELIGIBLE FOR THIS COVERAGE.

4.

Payment Enclosed	Group Number	Applicant's Social Security Number
$	039000-00	

Mail to: Highmark Blue Cross Blue Shield, P.O. Box 382555, Pittsburgh, PA 15250-8555

Medical Information:

Section A.

Please answer each question completely. If it is found that you have supplied fraudulent information, or made fraudulent statements or omissions with the intent to deceive, your Agreement may be voided.

1. Do you – or any family member applying – use any medical equipment (such as a walker, wheelchair, cane or hospital bed)? ☐ Yes ☐ No
2. Are you – or any family member applying – currently receiving home health care? ☐ Yes ☐ No
3. If you answered "YES" to question 1 or 2, please provide the name(s) of the affected person(s) and specifics about the condition:

Name of Person ____ Condition/Reason ____

____ ____

4. Give date of last menstrual period for each female family member applying:

Name of Person ____ Date of Last Period ____

____ ____

5. Have you — or any family member applying — been recently (i.e., within the past nine (9) months) medically diagnosed or treated for pregnancy? ☐ Yes ☐ No

Name(s) of pregnant person(s): ____________________________Date medically diagnosed or treated: _________________________

6. Have you – or any family member applying – gained or lost more than 20 pounds over the past 3 months? ☐ Yes ☐ No If "YES," provide person's name and amount gained or lost.

Name of Person ____ Weight Gained/Lost ____

____ ____

Section B.

Please indicate by checking the appropriate block(s) below if you — or any family member applying — have been treated by, diagnosed by, or received medical advice from a physician or other health care provider for any condition, illness, injury or surgery listed below WITHIN THE LAST FIVE (5) YEARS.

			List Dependent(s) by Name			
Conditions	**Applicant**	**Spouse**				
7. AIDS or Positive Test for HIV, HTLV-III/LAV Antibodies						
8. Alcoholism						
9. Alzheimer's Disease						
10. Amputation of Limb (Specify) ________________________						
11. Arterio-Venous Malformation (AVM)						
12. Arthritis						
*13. Other Joint Disease (Specify) ________________________						
14. Asthma						
*15. Back Disabilities						
*16. Back Pain - Chronic						
17. Brain Tumor						
18. Cancer						
19. Cataract(s) right __________ left ___________						
20. Chest Pain or Angina						
21. Chiropractic Visits (Specify Number of Visits) ________						
22. Cholesterol (Specify Current Reading) ________						
23. Cirrhosis						
24. Other Liver Disease (Specify) ________________________						
25. Congenital Anomalies and Conditions (Specify) ________________________						
26. Dementia, "Senility" or Increasing Forgetfulness with Age						
27. Diabetes – Controlled with Diet (Specify Current Fasting Blood Sugar) ________						
28. Diabetes – Controlled with Medication						

*If you check this condition, you must list under Section C or on a separate sheet of paper the name(s) of the attending physician, osteopath or chiropractor and date(s) of treatment for each family member.

Medical Information (Continued)

Conditions	Applicant	Spouse	List Dependent(s) by Name			
29. Diseases of the Esophagus, Stomach or Intestine (for example, Crohn's Disease or Ulcerative Colitis) (Specify) ______						
30. Drug Dependency						
31. Ear Conditions (including frequent ear infections) (Specify) ______						
32. Emphysema						
33. Other Lung Disease (including work-related, for example, "Black Lung") (Specify) ______						
34. Gynecological (Specify) ______ If recent delivery, please provide date of medical release (post-partum check-up) from Obstetrician/Gynecologist: ______						
35. Heart Attack						
36. Other Heart Disease (Specify) ______						
37. Hepatitis						
38. High Blood Pressure (if checked, indicate usual blood pressure) ______						
39. Infertility (Specify) ______						
40. Immunization for Children Name and address of pediatrician: ______ ______ ______						
41. Kidney/Renal Failure						
42. Other Kidney Disorder (Specify) ______						
43. Leukemia						
44. Other Hematologic (Blood) Disorder (Specify) ______ ______						
45. Musculoskeletal (pertaining to muscle or bone) Injury or Illness (Specify) ______ ______						
46. Neurologic Deficit or Disorder, including head or spinal injury or paralysis (Specify) ______ ______						
47. Psychiatric Disorder/Behavioral Health						
48. Severe Injury or Burns (Specify) ______ ______						
49. Severe Visual Impairment/Blindness						
50. Spinal Injuries						
51. Stroke						
52. Surgery of any kind (Specify) ______ ______						
53. Temporomandibular Joint Syndrome (TMJ)						
54. Transient Ischemic Attacks (TIA's)						
55. Urological						
56. Any other conditions, injuries or ailments not specifically mentioned above for which you or your eligible dependents have been treated by, diagnosed by, or received medical advice from a physician or other health care provider within the last five (5) years? Please explain:	______ ______ ______ ______					

Please note: Any physician charges or other fees incurred during the process of completing this application are the responsibility of the applicant.

Medical Information (Continued)

Section C.

If any of the conditions in Section B are checked, please explain below. Use additional paper if necessary. Please provide details of the condition.

	Patient's Name/Diagnosis Type of Treatment/Surgery	Hospital Treatment?	Attending Physician	Dates of Illness
57.		☐ Inpatient ☐ Outpatient Date ____/____/____	Name: ____________ Address: ____________ Phone: ( ) ____________ Hospital Name: ____________	From: ________ To: ________
58.		☐ Inpatient ☐ Outpatient Date ____/____/____	Name: ____________ Address: ____________ Phone: ( ) ____________ Hospital Name: ____________	From: ________ To: ________
59.		☐ Inpatient ☐ Outpatient Date ____/____/____	Name: ____________ Address: ____________ Phone: ( ) ____________ Hospital Name: ____________	From: ________ To: ________

60. When was the last time each person applying for coverage visited a doctor (other than at an emergency room)? Include date of visit, name and address of physician or other provider (gynecologist/obstetrician, osteopath, chiropractor, etc.) and reason for visit. Use additional paper if necessary.

Applicant: ______________________ Date of Exam ______________________

Provider's Name and Address ______________________________________

____

____

Reason ______________________________________

Spouse: ______________________ Date of Exam ______________________

Provider's Name and Address ______________________________________

____

____

Reason ______________________________________

Dependent Child: ______________________ Date of Exam ______________________

Provider's Name and Address ______________________________________

____

____

Reason ______________________________________

Dependent Child: ______________________ Date of Exam ______________________

Provider's Name and Address ______________________________________

____

____

Reason ______________________________________

Medical Information (Continued)

61. When was the last time each person applying for coverage visited an emergency room at a hospital or other medical facility? Include date of visit, name and address of emergency room, attending physician's name and reason for visit. Use additional paper if necessary.

Applicant: ______________________ Date of Visit ______________________

Hospital Name and Address ______________________

Physician ______________________

Reason ______________________

Spouse: ______________________ Date of Visit ______________________

Hospital Name and Address ______________________

Physician ______________________

Reason ______________________

Dependent Child: ______________________ Date of Visit ______________________

Hospital Name and Address ______________________

Physician ______________________

Reason ______________________

Dependent Child: ______________________ Date of Visit ______________________

Hospital Name and Address ______________________

Physician ______________________

Reason ______________________

Dependent Child: ______________________ Date of Visit ______________________

Hospital Name and Address ______________________

Physician ______________________

Reason ______________________

Medical Information (Continued)

Section D.
If you — or any family members applying —

62. — Drink alcoholic beverages, please indicate frequency of use:

Name of Person	Number of Drinks per Week (Serving size per drink equals 1½ oz. liquor, 12 oz. beer, 5 oz. wine)

63. — Have ever smoked, please indicate amount of cigarettes, cigars, pipes or smokeless tobacco (snuff, chewing tobacco, etc.) used and length of use:

Name of Person	Amount per Day/Type	Dates of Use	
		From:	To:
		From:	To:
		From:	To:
		From:	To:
		From:	To:

64. — Have taken prescribed drugs within the last year, please list drug(s) taken and reason:

Name of Person	Medication/Dosage	Dates of Use		Condition/Reason
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	
		From:	To:	

Conditions of Enrollment

I, the undersigned, hereby apply for coverage for myself and all my listed eligible dependents.
I represent, to the best of my knowledge and belief, that:

1. I have read and have supplied all the requested information on this form with regard to myself and any family members applying for coverage. (If not, I have attached a letter which explains why.)
2. All applicants for this policy are in good health except for those conditions listed in the Medical Information portion of the application.
3. No material information has been withheld or omitted about the past or present state of my health or any family member(s) applying.

I understand and agree that:

1. Any person eligible for Medicare or Medicare disability benefits is not eligible for this coverage.
2. This coverage does not begin until this application is accepted by Highmark Blue Cross Blue Shield and an Effective Date of coverage is assigned; and
3. Initial payment must be submitted with the application; and
4. Receipt of my money (check or money order) does not constitute enrollment under any program; and
5. This coverage is provided only to residents of the geographical area of western Pennsylvania served by Highmark Blue Cross Blue Shield. We reserve the right to investigate and confirm your residence from time to time.
6. If applicant is under age 18, the signature of a parent or guardian is required on this application.

I also understand and agree that Highmark Blue Cross Blue Shield may:

1. Require me and any family member(s) applying to provide upon request medical history or to have a medical examination, blood test or other applicable medical test prior to acceptance of the application (Highmark Blue Cross Blue Shield may choose to specify the provider);
2. Deny this application, in which case any premium submitted will be refunded and accepted by me; or
3. Void this Agreement or deny a claim for loss incurred or disability (as defined in the Agreement) during the first three (3) years from the effective date of this Agreement if the applicant made a material misrepresentation of a material fact in the application that affected the risk or hazard assumed by the Plan.
4. Void this Agreement or deny a claim for loss or disability (as defined in the Agreement) after three (3) years from the Effective Date only for fraudulent material misstatements made by the applicant in the application for such Agreement.

I also understand and agree that the Agreement will not provide benefits for me or any enrolled dependents during the twelve-month period following the Effective Date on which I and any dependents become enrolled under the Agreement for any condition for which medical advice or treatment was recommended by or received from a physician within a five-year period prior to the Effective Date of the Agreement.

I understand and agree that the terms and conditions of our coverage will be controlled by the written Agreement with Highmark Blue Cross Blue Shield and that it may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I recognize that our coverage will only apply to admissions that occur and services that are provided on or after the effective date of our coverage.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations.

A copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

To the best of my knowledge and belief, the information provided on this application is true and correct.

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I request this coverage to become effective _______________.

Your requested Effective Date must be within two (2) months of your date of signature below.

Note: The Effective Date of coverage is usually the first day of the month following medical underwriting approval. However, we cannot guarantee that your requested Effective Date can be met. The Effective Date is in all cases the date on which your coverage begins following medical underwriting approval and assignment of an Effective Date.

Please note: To avoid delays in processing your application, this form must be received by Highmark Blue Cross Blue Shield within fifteen (15) days of the date of your signature.

If you and your spouse are applying for this coverage, your spouse also must read and understand these "Conditions of Enrollment," and sign and date this application below.

Applicant's Signature	**Date**
Spouse's Signature	**Date**

DO NOT WRITE IN THIS AREA

R FLAG: ______________________

DEC DATE: ______________________

DEPT. CD: ______________________

DEN CD: ______________________

OVR EFF DATE: ______________________

INITIAL RECEIPT DATE: ______________________

CLERK NO: ______________________

C.O. REASON: ______________________

C.O. DECISION DATE: ______________________

WHO DENIED: ______________________

REAPPLY DATE: ______________________

REMARKS: ______________________

FOR PRODUCER USE ONLY

Producer's Certificate

Attention Producer:

If this section is not fully completed, commission will not be paid.

Blue Cross Blue Shield Agency No. | | | | | |

Producer No. | | | | | |

Agency Name ____________________

Producer's Name ____________________
LAST FIRST MI

Producer's Signature ____________________

Business Phone (________) ____________________
Area Code

Completion of this section is required BY A PRODUCER if the producer wishes to act on the applicant's behalf.

1. Except for the information set forth in the Medical Information Section of this application, I am not aware, based on the applicant's responses to my inquiries, of any additional factors impacting the insurability and/or eligibility of the applicant and each of his/her dependents applying for this coverage.

   Producer Signature: ____________________ Date:

   Agency: ____________________

2. Is this applicant a current customer of Highmark Blue Cross Blue Shield? ☐ YES ☐ NO

3. Have you attached to this application a replacement of coverage form, if necessary? ☐ YES ☐ NO

Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the application or policy; or
3. Waive any of Highmark Blue Cross Blue Shield's rights or requirements.

Highmark® Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

Highmark Inc. d/b/a
Highmark Blue Cross Blue Shield
120 Fifth Avenue
Pittsburgh, PA 15222-3099

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