

# Application and Health Questionnaire for



An Individual HMO  
from *Keystone Health Plan West*

*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:

To avoid processing delays, we ask that you take your time to carefully and accurately complete all appropriate sections. First select a Primary Care Physician (PCP)/Group Practice from the *Physician Directory*. Indicate the name and the PCP number of the physician or practice you have selected for yourself and each of your covered dependents. Each of you can choose a different PCP.

**Please note that the underwriting process can take several weeks. Therefore, you may want to continue your existing health care coverage while waiting for the response to 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. Provide all the information requested on the Enrollment Form. Provide information about your spouse and dependents only if they are also applying for coverage. Please remember to select a PCP and indicate if you are currently a patient of the PCP you choose.
3. Provide "Medical Information" requested under Sections A, B, C and D. Provide information about yourself and any other applicants.
4. Read the "Conditions of Enrollment" on page 7. 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 8 should be completed only by an insurance producer acting on your behalf. This section should not be completed 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 "Keystone Health Plan West." Mail to:

KeystoneBlue Individual HMO  
P.O. Box 382062  
Pittsburgh, PA 15250-8062

**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 Keystone Health Plan West 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 information requested may result in a delay in the processing of your application.**

Keep this page for your records.

Date: \_\_\_\_\_

Check Number: \_\_\_\_\_

Amount Paid: \_\_\_\_\_

## 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 the Keystone Health Plan West 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:

Keystone Health Plan West 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.

All information must be complete and accurate to process your application without delay. You must select a Primary Care Physician for yourself and dependents you are enrolling. (Eligible children are unmarried children under age 19.) If you have any questions or need additional forms, please call our Member Service Department toll-free at 1-800-544-6679.

**If applying for family coverage, applicant must be the older spouse. If children only are applying, youngest child must be applicant.**

Please complete the information requested about yourself and any other family members you are enrolling. Failure to provide all information requested may result in a delay in the processing of your application. All shaded fields are for Keystone Health Plan West and Producer use only.

<input type="checkbox"/> One Person <input type="checkbox"/> Hus./Wife <input type="checkbox"/> Hus./Wife-One Child <input type="checkbox"/> Par./Child <input type="checkbox"/> Par./Children <input type="checkbox"/> Hus./Wife-Two+ Children		Work Phone (    )	Home Phone (    )	
		Work Email	Home Email	
Home Address	City	State	Zip	County

Monthly premium: \$ \_\_\_\_\_

This KeystoneBlue Individual HMO Subscriber Agreement renews on a month-to-month basis. The premium is payable to Keystone Health Plan West on a monthly basis. Once enrolled, you can choose to pay your monthly premium via electronic funds transfer through the Pay It Easy program.

	Applicant	Spouse	Dependent	Dependent	Dependent
<b>Social Security Number</b>					
<b>Name</b>					
<b>Do you smoke or use smokeless tobacco?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sex</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Membership Status</b>	<input type="checkbox"/> Single (1) <input type="checkbox"/> Married (2)	(2) Spouse	(3) Child	(3) Child	(3) Child
<b>Birth Date (MM/DD/YY)</b>	/  /	/  /	/  /	/  /	/  /
<b>Height / Weight</b>	/	/	/	/	/
<b>Primary Care Phys. Name</b>					
<b>Primary Care Phys. No.</b> <small>Obtain from PCP Directory</small>					
<b>Primary Care Phys. Phone No.</b>	(    )	(    )	(    )	(    )	(    )
<b>Primary Care Physician Status</b>	<input type="checkbox"/> Check here if presently a patient of this physician	<input type="checkbox"/> Check here if presently a patient of this physician	<input type="checkbox"/> Check here if presently a patient of this physician	<input type="checkbox"/> Check here if presently a patient of this physician	<input type="checkbox"/> Check here if presently a patient of this physician
<b>KHPW Use Only</b>					

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 Keystone Health Plan West, Blue Cross and/or Blue Shield policy.  
 Yes     No – If “yes,” please provide the insurance company name and applicable group and identification number(s):  
 Company Name: \_\_\_\_\_ Agreement or I.D. No. \_\_\_\_\_

**If you answered “yes” to the above question, please complete the enclosed *Notice to Applicant Regarding Replacement of Accident and Sickness Coverage* form and mail it with your application.**

Have you or any applicants ever applied and been rejected for any:	Name of Person(s) Rejected and Reason
Medical policies <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Life Insurance policies <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**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.

<b>Payment Enclosed</b> \$	<b>Group Number</b> 058908-00	<b>Box 382062</b>	<b>Applicant's Social Security Number</b>
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**I request this coverage to become effective** \_\_\_\_\_

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

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. To avoid delays in processing your application, this form must be received by Keystone Health Plan West within fifteen (15) days of the date of your signature.

# 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 terminated.

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.

Conditions	Applicant		List Dependent(s) by Name			
	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		List Dependent(s) by Name			
	Applicant	Spouse				
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.	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date ____/____/____	Name: _____ Address: _____ Phone: (    ) _____ Hospital Name: _____	From: _____ To: _____
58.	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient Date ____/____/____	Name: _____ Address: _____ Phone: (    ) _____ Hospital Name: _____	From: _____ To: _____
59.	<input type="checkbox"/> Inpatient <input type="checkbox"/> 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)

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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

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

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

# Conditions of Enrollment

**IMPORTANT: PLEASE READ AND SIGN BELOW:**

**If you and your spouse are applying for coverage, your spouse also must read and understand the “Conditions of Enrollment,” and sign and date this application.**

I, the undersigned, hereby apply for coverage for myself and all my listed eligible dependents. I understand and agree that the terms and conditions of our coverage will be controlled by the written Agreement with Keystone Health Plan West 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 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 Keystone Health Plan West 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 Keystone Health Plan West. 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 Keystone Health Plan West 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 (Keystone Health Plan West 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. Immediately terminate my coverage if it is found that any material information was omitted by or for me on this questionnaire.

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 \_\_\_\_\_

\_\_\_\_\_

