BlueCross BlueShield of Texas

Applicant Name _____

SSN# _____

Member ID: _____

Individual Plan

New Application or Change in Coverage

To help us process your application promptly, please remember to:

1	Print all answers in **blue or black ink**. Pencil will not be accepted.
2	Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.
3	If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information.
4	Please do not use correction fluid or tape.

Please submit an application via one of the following methods. If submitting by mail or fax, please complete the entire application and select a premium mode in Section D.

If you are working with a Blue Cross and Blue Shield of Texas Agent, please remember to include the name of your agent on the back of this application.

APPLY ONLINE	bcbstx.com
APPLY BY MAIL	Blue Cross and Blue Shield of Texas - Attn: Individual Enrollment, P.O. Box 3236, Naperville, IL 60566–7236
APPLY VIA FAX	888-697-0686

If you have any questions, please call your agent or call toll-free at 800-531-4456.

You have the option to choose a Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

Please answer the following questions only if you are applying outside of the annual open enrollment period (October 1, 2013 - March 31, 2014).
I am requesting enrollment outside of the Annual Enrollment Period because I have experienced one or more of these events during the last 60 days (check all that apply):

☐ **1.** I GAINED A DEPENDENT DUE TO MARRIAGE ON	DATE
☐ **2.** I GAINED A DEPENDENT DUE TO BIRTH, ADOPTION, OR PLACEMENT FOR ADOPTION ON	DATE
☐ **3.** I AM NO LONGER ELIGIBLE AS A DEPENDENT UNDER MY PRIOR HEALTH INSURANCE PLAN DUE TO REACHING THE MAXIMUM AGE, LEGAL SEPARATION, DIVORCE, OR DEATH OF THE POLICYHOLDER, AS OF	DATE
☐ **4.** I AM NO LONGER ELIGIBLE FOR MY PRIOR HEALTH INSURANCE PLAN DUE TO TERMINATION OF EMPLOYMENT, REDUCTION IN NUMBER OF HOURS OF EMPLOYMENT, LOSS OF EMPLOYER CONTRIBUTION TOWARD MY PREMIUMS, OR I HAVE EXHAUSTED MY COBRA BENEFITS AS OF	DATE
☐ **5.** I GAINED ACCESS TO NEW HEALTH PLAN OPTIONS BECAUSE OF A PERMANENT MOVE ON	DATE
☐ **6.** I AM NEWLY INELIGIBLE FOR PAYMENTS OF THE ADVANCE PREMIUM TAX CREDIT AS OF	DATE
☐ **7.** I AM NO LONGER RESIDING OR LIVING IN MY PRIOR HEALTH INSURANCE PLAN'S HMO SERVICE AREA AS OF	DATE
☐ **8.** AN ERROR OCCURRED IN MY PREVIOUS HEALTH PLAN ENROLLMENT ON	DATE
☐ **9.** I HAVE ADEQUATELY DEMONSTRATED THAT MY PREVIOUS HEALTH PLAN OR ISSUER SUBSTANTIALLY VIOLATED A MATERIAL PROVISION OF ITS CONTRACT WITH ME, AS OF	DATE
☐ **10.** I AND/OR MY DEPENDENT(S) LOST MINIMUM ESSENTIAL COVERAGE [DUE TO REASONS OTHER THAN NON-PAYMENT OF PREMIUM OR RESCISSION] ON	DATE
☐ **11.** OTHER QUALIFYING EVENT (AS REQUIRED OR PERMITTED BY APPLICABLE LAWS). PLEASE SPECIFY HERE:	DATE

Section A: Applicant(s)

Applicant Name ______________________

SSN# ______________________

PRIMARY APPLICANT

☐ NEW COVERAGE ☐ ADD DEPENDENT ☐ CHANGE IN COVERAGE ☐ TRANSFER AND CONVERSION

FIRST NAME, MIDDLE INITIAL, LAST NAME	**SOCIAL SECURITY NUMBER**	**SEX** M F	**DATE OF BIRTH**

ARE YOU A U.S. CITIZEN? Y N **ARE YOU AN ELIGIBLE NON-CITIZEN?** Y N	**DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH?** Y N IF YES, PLEASE SPECIFY:	**DO YOU HAVE A PREFERRED WRITTEN LANGUAGE BESIDES ENGLISH?** Y N IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

RESIDENTIAL ADDRESS - STREET, CITY, STATE, ZIP (NO P.O. BOXES)	**COUNTY**

MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐	**SECONDARY PHONE** CAN WE SEND YOU TEXT MESSAGES? ☐	**OTHER PHONE** CAN WE SEND YOU TEXT MESSAGES? ☐

EMAIL ADDRESS	**PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY)	**PCP#** (FOR HMO ONLY)	**DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED (dependent children must be under age 26)†

FIRST NAME, MIDDLE INITIAL, LAST NAME	**RELATIONSHIP**	**SOCIAL SECURITY NUMBER**	**SEX** M F	**DATE OF BIRTH**

ARE YOU A U.S. CITIZEN? Y N **ARE YOU AN ELIGIBLE NON-CITIZEN?** Y N	***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE)	**COUNTY**

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐	**EMAIL ADDRESS**	**PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY)	**PCP#** (FOR HMO ONLY)	**DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

FIRST NAME, MIDDLE INITIAL, LAST NAME	**RELATIONSHIP**	**SOCIAL SECURITY NUMBER**	**SEX** M F	**DATE OF BIRTH**

ARE YOU A U.S. CITIZEN? Y N **ARE YOU AN ELIGIBLE NON-CITIZEN?** Y N	***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE)	**COUNTY**

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐	**EMAIL ADDRESS**	**PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY)	**PCP#** (FOR HMO ONLY)	**DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

FIRST NAME, MIDDLE INITIAL, LAST NAME	**RELATIONSHIP**	**SOCIAL SECURITY NUMBER**	**SEX** M F	**DATE OF BIRTH**

ARE YOU A U.S. CITIZEN? Y N **ARE YOU AN ELIGIBLE NON-CITIZEN?** Y N	***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE)	**COUNTY**

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐	**EMAIL ADDRESS**	**PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY)	**PCP#** (FOR HMO ONLY)	**DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

FIRST NAME, MIDDLE INITIAL, LAST NAME	**RELATIONSHIP**	**SOCIAL SECURITY NUMBER**	**SEX** M F	**DATE OF BIRTH**

ARE YOU A U.S. CITIZEN? Y N **ARE YOU AN ELIGIBLE NON-CITIZEN?** Y N	***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE)	**COUNTY**

PRIMARY PHONE CAN WE SEND YOU TEXT MESSAGES? ☐	**EMAIL ADDRESS**	**PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN (FOR HMO ONLY)	**PCP#** (FOR HMO ONLY)	**DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ?** (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

* Age 18 and over
† The designation of spouse shall include domestic partners. If applying for domestic partner coverage, please complete the AFFIDAVIT OF DOMESTIC PARTNERSHIP at bcbstx.com and submit with this application.

Section B: Applying for Coverage

Applicant Name _____

SSN# _____

NOTE: Effective dates are available on the 1st of the month only, unless otherwise required by law. Applications must be received by Blue Cross and Blue Shield of Texas within the defined enrollment period to be accepted.

PLAN SELECTION	DEDUCTIBLE
☐ Blue Choice Bronze PPO℠ 005	$5,000
☐ Blue Choice Bronze PPO℠ 006	$6,000
☐ Blue Choice Silver PPO℠ 004	$3,000
☐ Blue Choice Silver PPO℠ 003	$6,000
☐ Blue Choice Gold PPO℠ 011	$1,000
☐ Blue Choice Gold PPO℠ 002	$1,500
☐ Blue Choice Gold PPO℠ 001	$3,250

CONSUMER CHOICE OF BENEFITS HEALTH MAINTENANCE ORGANIZATION	
☐ Blue Advantage Bronze HMO℠ 005	$5,000
☐ Blue Advantage Bronze HMO℠ 006	$6,000
☐ Blue Advantage Silver HMO℠ 004	$3,000
☐ Blue Advantage Silver HMO℠ 003	$6,000
☐ Blue Advantage Gold HMO℠ 007	$1,000
☐ Blue Advantage Gold HMO℠ 002	$1,500
☐ Blue Advantage Gold HMO℠ 001	$3,250

PLAN SELECTION	DEDUCTIBLE
☐ Blue Advantage Gold HMO℠ 008	$0

TRANSFER & CONVERSION PLAN	DEDUCTIBLE
☐ Blue Choice Gold PPO℠ 012	$1,000

Show your present Blue Cross and Blue Shield coverage numbers.

GROUP NUMBER:	CERTIFICATE NUMBER:

LOCATION OF BLUE CROSS AND BLUE SHIELD PLAN (CITY/STATE)

The plan below covers essential health benefits, but only after out-of-pocket cost sharing reaches the high deductible/out-of-pocket maximum required by law.

Select this plan only if you are under 30 before the plan year begins, or have received a certification from an exchange that you are exempt from the individual mandate because you do not have an affordable coverage option or because you qualify for a hardship exemption. Please enclose a copy of your certificate of exemption with your application.

☐ Blue Security Choice PPO℠ 010	$6,350

For HMO Only:

ATTENTION FEMALE MEMBERS: In selecting your PCP, remember that your PCP's network may affect your choice of OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, for HMO members, the OB/GYN from whom you receive services must belong to the same physician practice group or independent practice association (IPA) as your PCP. This is another reason to make certain that your PCP's network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

Section C: Dental Coverage

The Affordable Care Act ("ACA") requires us to be reasonably assured that you and each member on this policy have coverage for pediatric dental services that are essential health benefits. The Affordable Care Act requires these benefits even if there is no one on the policy who is eligible for these services.

Carriers can offer this required pediatric dental coverage to you through benefit plans called "Exchange-certified stand-alone dental plans." These plans are also known as Dental Qualified Health Plans or Dental QHPs.

There are three ways to meet this requirement.

1. You can enroll in **BlueCare Dental℠**, our Full Dental QHP, which contains coverage for adults and pediatric dental essential health benefits; or
2. You can enroll in **BlueCare Dental 4 Kids℠**, our Limited Dental QHP, which only contains pediatric dental essential health benefits; or
3. You can confirm that you have obtained coverage for pediatric dental essential health benefits somewhere else.

Please review your options below and select **one**:

If you do not select an option then you and each member on the policy will be enrolled in BlueCare Dental 4 Kids 1B, our Limited Dental QHP, in order to meet ACA's requirement that we provide you coverage with pediatric dental services that are essential health benefits.

BlueCare Dental (For All Applicants)	DEDUCTIBLE
☐ 1A	$25
☐ 1B	$75
☐ 2A	$75

BlueCare Dental 4 Kids℠ (For Child[ren] Applicants)	DEDUCTIBLE
☐ 1A	$25
☐ 1B	$75

NOTE: Dental plans include an additional premium. For premium information, please call 800-531-4456, or contact your authorized independent Blue Cross and Blue Shield of Texas agent.

☐ **I/WE ALREADY HAVE THE NECESSARY COVERAGE** (I AND EACH APPLICANT LISTED ON THIS APPLICATION, ETC.) HAVE OBTAINED COVERAGE FOR PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS THROUGH ANOTHER POLICY.

DATE	SIGNATURE	CARRIER

Section D: Billing Information

Applicant Name _____

SSN# _____

Note: Do not cancel any current coverage you may have until your application is approved and your new plan is effective.

Please select one of the following options to make arrangements for paying your premium.

☐ BANK DRAFT

Bank Draft includes initial and ongoing payments. Payment will be drafted upon receipt of this application. You must complete the Authorization Agreement below.

☐ 1-MONTH BANK DRAFT ☐ 2-MONTH BANK DRAFT ☐ 3-MONTH BANK DRAFT ☐ 6-MONTH BANK DRAFT ☐ 12-MONTH BANK DRAFT

AUTHORIZATION AGREEMENT

Required for Bank Draft Payments Only
I request and authorize Blue Cross and Blue Shield of Texas (BCBSTX) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer–sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future. I also understand that both the financial institution and BCBSTX reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advance notice to Blue Cross and Blue Shield of Texas by telephone prior to a scheduled withdrawal date.

Please complete the following – print or type information
I authorize BCBSTX to deduct the premium payments from my checking or savings account. If the draft date falls on a non–business day or a holiday, the premium payment will be deducted from my account on the next business day.

Please ensure adequate funds are available at the time of application. Blue Cross and Blue Shield of Texas is not responsible for fees incurred due to insufficient funds.

PLEASE CHECK ONE ☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT	NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT

NAME AND LOCATION OF BANK WHERE ACCOUNT IS AUTHORIZED

BANK TRANSIT NUMBER	DEPOSITOR'S ACCOUNT NUMBER

☐ I HAVE READ AND ACCEPT THE ABOVE AGREEMENT

DEPOSITOR'S SIGNATURE	DATE	RELATIONSHIP TO APPLICANT

☐ BILLING OPTIONS

FIRST MONTH PREMIUM AMOUNT OF $ ENCLOSED

☐ SEND ME A BILL BY EMAIL ☐ SEND ME A PAPER BILL ☐ SEND ME A BILL BY MOBILE PHONE

☐ 1-MONTH DIRECT BILL ☐ 2-MONTH DIRECT BILL ☐ 3-MONTH DIRECT BILL ☐ 6-MONTH DIRECT BILL ☐ 12-MONTH DIRECT BILL

NOTE: Cashing of the Premium Deposit does not constitute approval of this Application. If this Application is not approved, the Premium Deposit will be returned to the Primary Applicant and neither the Primary Applicant nor any other person applying for coverage under this Application shall be entitled to benefits or coverage.

☐ LIST BILL

LIST BILL (INDICATE NAME OF BILL-TO PARTY BELOW.)

EXISTING LIST BILL NUMBER

BILLING NAME AND ADDRESS

If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless requested otherwise.

FIRST NAME, MIDDLE INITIAL, LAST NAME

BILLING ADDRESS - STREET, CITY STATE, ZIP (NO P.O. BOXES)

NAME OF BILL-TO PARTY (IF REQUESTING LIST BILL ONLY)

Section E: Proxy Statement

PROXY STATEMENT

PROXY STATEMENT
The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

PRIMARY APPLICANT'S PROXY SIGNATURE (OPTIONAL) YOU MUST ALSO SIGN IN "SECTION G" BELOW:	DATE

PRINT YOUR NAME AS YOU SIGNED IT:

Section F: Other Coverage Information

Applicant Name _____

SSN# _____

OTHER COVERAGE INFORMATION

DOES ANY PERSON APPLYING FOR COVERAGE CURRENTLY HAVE, OR DID THEY PREVIOUSLY HAVE **WITHIN THE LAST 5 YEARS**, BLUE CROSS AND BLUE SHIELD OF TEXAS COVERAGE, OR HEALTH OR MAJOR MEDICAL INSURANCE COVERAGE WITH ANY OTHER INSURER, EITHER AS A PRIMARY INSURED, SPOUSE OR AS A DEPENDENT? Y N **IF "YES", PLEASE COMPLETE THE FOLLOWING:**

APPLICANT NAME	NAME ON PREVIOUS POLICY (IF APPLICABLE)	MEMBER/GROUP NUMBER (OPTIONAL)
APPLICANT NAME	**NAME ON PREVIOUS POLICY (IF APPLICABLE)**	**MEMBER/GROUP NUMBER (OPTIONAL)**

REPLACEMENT OF COVERAGE

WILL THIS INSURANCE REPLACE ANY HEALTH INSURANCE CURRENTLY IN FORCE? Y N **IF "YES," READ THE STATE MENT BELOW AND COMPLETE THE FOLLOWING:**

LIST ALL COVERAGE THAT WILL BE REPLACED

INSURED	NAME OF COMPANY	POLICY NUMBER	TERMINATION DATE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Blue Cross and Blue Shield of Texas. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning any person applying for coverage. Failure to include all material information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
3. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Blue Cross and Blue Shield of Texas.

Section G: Required Signatures

Acknowledgements: The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows:

1. This application does not provide coverage of any kind unless approval is provided by Blue Cross and Blue Shield of Texas (the Company); and the application, if not previously approved or declined, will be considered withdrawn on the 60th day after its date.
2. Medical expense coverage will not be available until the effective date of the health contract and payment, in full, of the first month's premium.
3. No agent can accept risks or modify policies or requirements of the Company.
4. The Company is not bound by any statement not written in this application.
5. If a spouse and/or dependant(s) is/are included for medical expense coverage, the premium will be calculated based on the age of each individual covered, subject to applicable law and regulations.
6. I understand that an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days' advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage. The undersigned Applicant further acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an Individual Policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by the Company in connection with the issuance of the Individual Policy, they should contact the agent.

Agreement: I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following payment in full of the first month's premium. The undersigned Applicant and agent acknowledge that the Applicant has read the completed application and that he/she realizes that any false statement material to the risk or misrepresentations therein may result in loss of coverage under the policy. This application will become a part of the contract between BCBSTX and the applicant.

Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency, pharmacy benefit manager, retail pharmacy, pharmacy clearinghouse or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the prescription and use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information. I understand that Blue Cross and Blue Shield of Texas will only disclose collected information as needed to medical entities related to my care.

I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and will no longer protected by the federal privacy laws.

This Authorization is valid for two years from today, or until I terminate coverage. I understand that I have the right to revoke the Authorization at any time, in writing, by contacting Blue Cross and Blue Shield of Texas. I further understand that I or any authorized representative will receive a copy of this authorization upon request. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Signatures: I acknowledge receipt of the Required Outline of Coverage and I certify that:

1. Premiums are being paid by me as a personal expense.
2. My employer is not contributing to any part of the premium, either directly or through reimbursement.
3. Since my employer does not sponsor an employee health plan, neither my employer nor I deduct any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code.

The Disclosure Statement will be provided upon request. (Also available at www.bcbstx.com)

At any time when Blue Cross and Blue Shield of Texas is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Policy, Blue Cross and Blue Shield of Texas may at its option make an offer to reform the policy already in force and/or change the rating category/level. In the event of reformation, the Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

PRIMARY APPLICANT'S SIGNATURE	**DATE**
SPOUSE'S SIGNATURE (IF APPLYING)†	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**

IF THIS AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE, ON BEHALF OF AN INDIVIDUAL (OTHER THAN A PARENT FOR A MINOR CHILD), COMPLETE THE FOLLOWING:

PERSONAL REPRESENTATIVE'S NAME (PLEASE PRINT)	**RELATIONSHIP:**

† The designation of spouse shall include domestic partners. If applying for domestic partner coverage, please complete the AFFIDAVIT OF DOMESTIC PARTNERSHIP at bcbstx.com and submit with this application.

Section H: Agent Information

Applicant Name _____

SSN# _____

AGENT'S CERTIFICATION

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the Required Outline of Coverage, and if requested, the Disclosure Statement.

POLICY(IES) SHOULD BE MAILED TO ☐ AGENT ☐ APPLICANT

AGENT INFORMATION (if applicable)

AGENT'S SIGNATURE	DATE	AGENT ID	P&C CROSS REFERENCE
PRINT AGENT'S NAME	**AGENT'S PHONE**		**AGENT'S FAX**

Section I: HMO Disclosure

Texas Department of Insurance Required Disclosure Notice for All **Individual HMO** Consumer Choice Benefit Plans Issued in Texas

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Health Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or excluded completely from the plan.

MANDATED BENEFIT DESCRIPTION	BENEFIT REDUCED	BENEFIT EXCLUDED
COPAYMENTS Section 11.506(2)(A), Subchapter F, Title 28 Texas Insurance Code: A reasonable copayment option may not exceed 50 percent of the total cost of services provided. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrolled in that calendar year total two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee.	For some services and supplies, this plan may include cost-sharing that exceeds the limits imposed by the mandated.	
DEDUCTIBLES Section 11.506(2)(B), Subchapter F, Title 28 Texas Insurance Code: A deductible shall be for specific dollar amount of the cost of the basic, limited or single health care service. An HMO shall charge a deductible only for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.	Deductibles may apply to some services provided by HMO Participating Providers in the HMO service area. Deductibles may apply to Professional Services, Inpatient Hospital Services, Outpatient Facility Services, Outpatient Lab and X-Ray Services, Rehabilitation Services, Maternity Care and Family Planning, Behavioral Health Services, Emergency and Ambulance Services, Extended Care Services, some Preventive Care Services, Dental Surgical Procedures, Cosmetic, Reconstructive or Plastic Surgery, Allergy Care, Diabetes Care, Prosthetic Appliances, Orthotic Devices, Durable Medical Equipment, Hearing Aids and Prescription Drugs.	

I also understand that if I purchase a health plan that excludes or reduces coverage for a certain condition, I may be limiting my ability to obtain individual insurance coverage for that condition, in the event the health of any individual covered under the plan changes. I understand that I may obtain addition information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov/consumer/index.html, or by calling 1-800-252-3439.

SIGNATURE OF APPLICANT	NAME OF APPLICANT (PRINT NAME)	DATE
BILLING ADDRESS - STREET, CITY STATE, ZIP (NO P.O. BOXES)		

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure free of charge.** A new form must be completed upon each subsequent renewal of this policy.

Thank you for applying.

Please include all necessary materials when submitting this application.
If legal guardian, please enclose signed court decree.