



INDIVIDUAL PRODUCT ENROLLMENT AND CHANGE FORM

Complete this application in blue or black INK. DO NOT USE A PENCIL OR A HIGHLIGHTER.

An Independent Licensee of the Blue Cross Blue Shield Association

Group # [] 2007 HIPAA COMPLIANT

Social Security Number (use boxes below) Applicant's Last Name First Name MI Effective Date

Street Address (PO Box Number NOT Acceptable) Must be a WV resident City State Zip County WV

Mailing Address (If different than Street Address) City State Zip County WV

Birthdate Phone Number(s) Gender Marital Status Date Married

COVERED DEPENDENT INFORMATION

Table with columns: Covered Dependents Relationship, Birthdate Mo/Da/Yr, Gender M/F, Last Name, First Name, Social Security #, Dependent Age Limit 19

Legal Documentation (Court Decree, Guardianship Papers, etc.) must be attached to this Application if relationship is Adoption or Other.

COVERAGE INFORMATION

Type of Contract: Single, Adult & Child, Two Adults, Adult & Child(REN), Family. Benefit Selection: SUPER BLUE PLUS, LIMITED BENEFIT*, HIGH DEDUCTIBLE HEALTH PLAN

MATERNITY RIDER (You must check one of the boxes) YES NO * There is an additional cost for this benefit rider.

REASON FOR COMPLETION: New Enrollee, Conversion, Changes, Cancel, Transfer from BCBS

DEPENDENT CHANGES OTHER CHANGES

YOUR PRIOR GROUP OR INDIVIDUAL HEALTH INSURANCE COVERAGE AND MEDICARE

LIST ALL GROUP and/or INDIVIDUAL COVERAGES YOU OR ANY OF YOUR ENROLLING DEPENDENTS HAVE HAD DURING THE PAST 18 MONTHS OR CHECK HERE FOR NO COVERAGE

Table with columns: Name(s) of Covered Person(s), Name of Other Insurance Co., Policy Number, Effective Date, Cancel Date, Coverage, Type

REASON FOR CANCELING Most Recent Coverage:

The above section can be used by MSBCBS in lieu of Certificate of Coverage and will be used, in part, as the basis in determining the pre-existing condition waiting period, if applicable.

HIPAA ELIGIBILITY Answer "YES" or "NO" to the following questions by checking the appropriate box.

In accordance with applicable law, Mountain State Blue Cross Blue Shield will guarantee access to individual insurance if you have had at least 18 months of continuous creditable coverage without a sixty-two (62) day lapse in such coverage AND you are not eligible for group coverage, Medicare, or Medicaid AND you do not have other health insurance coverage AND you have elected and exhausted any COBRA or state continuation coverage AND your most recent coverage did not terminate due to premium lapse or fraud AND your most recent coverage was group sponsored.

MEDICAL HISTORY INFORMATION

If you are an enrollee who is new, converting, transferring in, or adding a dependent, you must complete the medical history questions below. All questions must be marked YES or NO. IF THE ANSWERS ARE INCOMPLETE, THE APPLICATION WILL BE RETURNED WHICH MAY RESULT IN A DELAY IN ISSUANCE OF COVERAGE. Completion of this Medical History Section is not a guarantee of acceptance.

YOUR HEIGHT (ft./in.) _____ YOUR WEIGHT (lbs.) _____ SPOUSE'S HEIGHT(ft.in.) _____ SPOUSE'S WEIGHT (lbs.) _____

CHECK YES OR NO AND EXPLAIN IN EXPLANATION SECTION AT THE TOP OF THE NEXT PAGE ALL MEDICAL CONDITIONS AND DISEASES LISTED BELOW FOR WHICH YOU OR ANY OF YOUR DEPENDENTS NOW HAVE OR EVER BEEN DIAGNOSED, TREATED, OR COUNSELED:

1. Benign Conditions	Y	N	5. Immune System Conditions	Y	N	9. Psychological	Y	N
Tumor Cyst, or Growth	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Adjustment Reaction	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list site _____			ARC-AIDS Related Complex	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>
2. Cancerous Conditions	Y	N	HIV Positive Status	<input type="checkbox"/>	<input type="checkbox"/>	Attempted Suicide	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kaposi's Sarcoma	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list type _____			Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancers	<input type="checkbox"/>	<input type="checkbox"/>	6. Renal	Y	N	Psychosis	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list site _____			Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	10. Muscular/Skeletal	Y	N
3. Heart/Lung	Y	N	Other Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>	Back Strain/Sprain	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	7. Digestive System Conditions	Y	N	Fractures (list site below)	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis of Liver	<input type="checkbox"/>	<input type="checkbox"/>	Site _____		
Congenital Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Colostomy	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Marfans Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I _____ Type II _____	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis type A _____ B _____ C _____	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid _____ Osteo _____		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	11. Reproductive	Y	N
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer Reflux/GERD	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal PAP	<input type="checkbox"/>	<input type="checkbox"/>
Thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/>	8. Neurologic Conditions	Y	N	Benign Prostatic		
Valvular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Hypertrophy (BPH)	<input type="checkbox"/>	<input type="checkbox"/>
Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Infertility: In Vitro or GIFT	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Infertility treated w/meds	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Herniated/Degenerative Disc	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy (list due date)	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Due Date ____/____/____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>	Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart/Lung Treatments	Y	N	Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	Diseases		
Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida Cystica _____ Occulta _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Reproductive	<input type="checkbox"/>	<input type="checkbox"/>
Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Cardiac Catherization	<input type="checkbox"/>	<input type="checkbox"/>	Other Neurologic	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Valve Replacement	<input type="checkbox"/>	<input type="checkbox"/>						
Pacemaker Implant	<input type="checkbox"/>	<input type="checkbox"/>						

ANY QUESTIONS BELOW ANSWERED WITH A "YES" MUST BE EXPLAINED IN THE EXPLANATION SECTION

	Y	N
12. Have you or any of your dependents ever had or been advised to have an organ or bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you or any of your dependents have any other medical conditions not listed above that have been diagnosed or treated by a health care provider.	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you or any of your dependents been hospitalized or had surgery within the past FIVE years?	<input type="checkbox"/>	<input type="checkbox"/>
15. Have you or any of your dependents been advised to have surgery which has not yet been performed?	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you or any of your dependents have a scheduled office visit to a health care provider?	<input type="checkbox"/>	<input type="checkbox"/>
17. Are you or any of your dependents CURRENTLY taking prescription medications? If yes, please list patient's name, name of medication, dosage, and the reason taking the medication in the Explanation Section.	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you or any of your dependents been treated by a health care provider or been prescribed medication during the THREE YEARS prior to your proposed effective date?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you or any of your dependents ever been covered by Worker's Compensation, Disability, or Subrogation for any of the conditions listed in the Medical History Section above?	<input type="checkbox"/>	<input type="checkbox"/>

OFFICE USE ONLY (DO NOT WRITE IN THE SPACES BELOW)

Sales Received Date	Underwriting Received Date	Membership Received Date (1)
Info RQ Date	Membership Received Date (2)	On INSINQ
Memb Rec RQ Date		Inquiry Closed
Completed or Closed	Date On System	ID Mailed

Date Approved _____
Approved By _____
Date Denied _____
Coverage Effective Date _____
INSINQ Inquiry Number _____

Send to:
MOUNTAIN STATE BLUE CROSS BLUE SHIELD
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Parkersburg, WV 26102