



Individual Change of Coverage Application – For existing enrollments only.

Blue Cross Dental SelectHMO and all medical plans, except the Basic PPO 1000, BC Life Share 5000, BC Life Share 500, BC Life Share 1000, PPO Saver and PPO Dental, are offered by Blue Cross of California. The Basic PPO 1000, PPO Saver, BC Life Share 5000, BC Life Share 500, BC Life Share 1000 and PPO Dental are offered by BC Life & Health Insurance Company. Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association.



IMPORTANT: If you are applying for a change of coverage from any HMO or Basic Plan, you must complete the Individual Enrollment Application (IU2138).

1. Subscriber Information

Current subscriber must complete this section.

Last Name	First Name	M.I.
Street Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

Social Security No.	Marital Status
	<input type="checkbox"/> Married <input type="checkbox"/> Single

Mailing Address (If different than above [or P.O. Box])

City / State / ZIP Code

Home Phone No. ()	Business Phone No. ()
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Applicant/Spouse Maiden Name	Spouse Social Security No.
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Mail Service Agreement to:

Primary Subscriber Your BCC agent

2. Choice of Blue Cross Individual Coverage

MEDICAL COVERAGE:

PlanScape® Coverage:

- BC Life Basic PPO 1000 (7900)
- BC Life Basic PPO 1000 without Life (PE25)
- BC Life Share 5000 (H062)
- BC Life PPO Saver (NM31)
- BC Life PPO Saver without Life (PE27)
- BC Life Share 1000 (1930)
- BC Life Share 500 (1929)
- PPO Share 2500 (7891)
- PPO Share 1500 (7889)
- PPO Share 1000 (1393)
- PPO Share 500 (7895)
- EPO (MSA Compatible) (7892)

HMO Alternative Coverage*

- HMO Saver* (7896)
- Individual HMO* (7898)

DENTAL COVERAGE:

- BC Life Dental PPO (7874)
- Dental Saver SelectHMO (ZE6N)
- Dental SelectHMO (ZE7N)
- Dental Premier SelectHMO (ZE8N)

List dental applicants below. If you are adding dental coverage ONLY, do not complete Section 4, "Health History." You must complete all other sections.

BLUE CROSS DENTAL PROVIDER NO: _____
(Required for any Dental SelectHMO)

3. Subscriber Family Information

List yourself and all enrolled family members requesting a change in coverage.

If spouse's last name is different from yours, please explain: _____

***3A. Select an IPA or PMG for yourself and each family member. If an IPA is selected, also provide the Primary Care Physician (PCP) number.**

Please list your selections below.

	Last Name	First Name	M.I.	Height	Weight	Birthdate	Age	Social Security Number	PMG/IPA	Primary Care Physician (PCP)
10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	Subscriber									
30 <input type="checkbox"/> Male 40 <input type="checkbox"/> Female	Spouse									
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										



4. Health History of Members Listed on this Application

Your claims history with Blue Cross will also be used in addition to the history listed on this application.

Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months? Yes No

If Yes, please provide the required medical information below.

Member Name	Hospital / Provider Name and Address	Medication Prescribed	Condition / Illness Treated

Has any enrolled family member used any tobacco products within the last 24 months? Yes No

Is either the applicant or spouse, whether or not listed on application, currently pregnant? Yes No

If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application? Yes No

FEMALES ONLY – Please provide the following information. (Applicable to ALL females listed on this application.)

Do you menstruate?..... Yes No Has it been more than 40 days since her/their last menstrual period?..... Yes No

Are you currently pregnant?..... Yes No

5. Conditions of Application It is important that you carefully read and understand the following.

ELIGIBLE/INELIGIBLE APPLICANTS

All Applicants age 18 and over must personally read, agree to, and sign the following:

Applicant does read and write English. If an Applicant does not read English, the translator must sign and submit a Statement of Accountability (see Page 3).

Blue Cross will enroll all eligible family members unless otherwise instructed.

I, the Applicant, request that Blue Cross not enroll eligible applicants unless all family members qualify.

I, the undersigned, understand that:

1. If my application for Blue Cross coverage is accepted as applied for, Blue Cross will assign the effective date, but I agree that I have no coverage under this application **until notified in writing** by Blue Cross that I am accepted.

2. I understand that Blue Cross has the right to deny my application and if so, I will be notified in writing.

3. **MINOR CHILDREN:** I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. **If the responsible adult is not the natural parent, please submit court papers authorizing guardianship.**

PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing this plan, the custodial parent or guardian must complete the Health History Section and sign the Conditions of Application accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse.

4. **DEPENDENTS AGE 18 AND OVER:** To the best of my knowledge and belief, I represent that (1) my dependents age 18 and over have read this application and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application with my dependents age 18 and over, and (3) all information contained in this application regarding dependents age 18 and over is complete and accurate.

I understand and agree that if Blue Cross denies my application, under no circumstances will any benefits be payable for any person listed on this application.

5. If I am accepted, this application will become part of the agreement between Blue Cross and myself. Enrolled family members and I

agree to be bound by the arbitration clause in the Blue Cross contract instead of trial by court or jury.

6. Blue Cross may request additional information and this may delay processing of this application. If the health care provider bills for these services, Blue Cross will determine payment and I will be responsible for any difference.

7. The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or terms of any Blue Cross coverage.

8. **I alone am responsible for reading and accurately completing this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed on this application is eligible for benefits if any information on this application is false, incomplete, or omitted. Blue Cross will void all coverage from the original effective date of the agreement for such misstatements or omissions.**

9. My Blue Cross agent may receive copies of any correspondence about my medical history when correspondence is required.

I have personally read and completed this application. I understand and agree to all the Conditions of Application and the Authorization. I understand that coverage will come into effect only if this application is approved by Blue Cross of California. I, the Applicant, acknowledge that I have read and understand this application in its entirety.

REQUIREMENT FOR BINDING ARBITRATION: If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

X _____
Signature of Applicant/Parent or Legal Guardian Today's Date (Required)

X _____
Signature of Applicant's Dependent Age 18 or over Today's Date (Required)

X _____
Signature of Applicant's Spouse Today's Date (Required)

X _____
Signature of Applicant's Dependent Age 18 or over Today's Date (Required)



Authorization Signature and date are required.

Authorization to Obtain or Release Medical Information: I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give Blue Cross of California, its affiliates ("Blue Cross"), their respective agents, employees, designees, or representatives, including my Blue Cross agent, or broker, any and all information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-Related Complex), of me or any of my dependents applying for or having Blue Cross coverage. I understand that this information may be collected in connection with the review, investigation or evaluation of an enrollment form, or of any claim for benefits.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

I also authorize Blue Cross to disclose all such medical or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purpose of investigating or evaluating any claim for benefits.

This authorization is effective immediately and shall remain in effect for a period of thirty (30) months, except that it shall remain effective for use in connection with any claim for benefits for as long as Blue Cross coverage may be in effect. A photocopy of this authorization is as valid as the original, and my Blue Cross agent or broker and I are entitled to receive a copy of this form.

X _____
Signature of Applicant/Parent or Legal Guardian Today's Date (Required)

X _____
Signature of Applicant's Spouse Today's Date (Required)

X _____
Signature of Applicant's Dependent Age 18 or over Today's Date (Required)

X _____
Signature of Applicant's Dependent Age 18 or over Today's Date (Required)

Agent Instructions

Your client must personally read and complete this application. If your client does not read and write English, the Statement of Accountability below must be completed.

If the legal guardian is other than the natural parents, court-appointed guardianship papers must accompany this application. If the underage Applicant does not reside with the subscriber, the custodial parent must complete the minor's health questionnaire; the subscriber may sign for financial accountability.

Please answer all questions below after the Applicant(s) has completed the application.

1. Are you aware of any information not disclosed on this application relating to health, habits, or reputation of any person listed on this application which might have a bearing on risk? Yes No
(Please explain a "Yes" answer on a separate sheet of paper and submit with application.)
2. Did you personally see the Applicants at the time this application was completed? Yes No

Name of Agent (Print Name)		Agent's Street Address Suite No. / Personal Mail Box (PMB) No.	
Agent I.D. No.	Sub-Agent I.D. No.	City / State / ZIP Code	Location No.
Phone No. ()	Fax No. ()	E-mail Address	

Statement of Accountability – To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Individual Change of Coverage Application for the applicant named below because:

Applicant does not read English Applicant does not speak English Applicant does not write English

Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Conditions of Application."

Signature of Translator (Required) Today's Date (Required)





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