



**Blue Cross  
Blue Shield  
of Michigan**

## Application for Individual Coverage

**MyBlue**<sup>SM</sup>  
My Life, My Health Plan

Print in black or blue ink or type your information. **All fields are required to be completed except where otherwise noted.** Review your application for completeness and accuracy, and sign and date the application where requested. The information provided will be used and disclosed only as permitted by our Notice of Privacy Practices. You can find a copy of our Notice of Privacy Practices on our website ([bcbsm.com](http://bcbsm.com)).

**Requested Effective Date (must be a future date and either the 1st or 15th of the month):** \_\_\_\_\_  
**Final effective date will be determined by Blue Cross Blue Shield of Michigan.**

### Part 1: Applicant Information

#### Application

Last Name		First Name		M.I.	Suffix <input type="checkbox"/> Sr. <input type="checkbox"/> Jr. <input type="checkbox"/> Other: _____	
Street Address (cannot be a P.O. Box)		City		State	Zip Code	County
Daytime Phone Number ( )		Evening Phone Number ( )		Cell Phone Number ( )		
Date of Birth (MM/DD/YY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Height ____ Feet ____ Inches		Weight ____ Pounds
Social Security Number	Applicant's Driver's License or State ID (required): Issue state: _____ Number: _____					
Applicant's E-mail Address						

#### Spouse and Dependent Children

List your spouse and dependent children you wish to cover. **Dependent children must be age 25 or under and a Michigan resident to be eligible for coverage.**

Spouse Name	Date of Birth (MM/DD/YY)	Gender	Height	Weight	Social Security Number	Drivers License or State ID for all dependents age 19 or older.
		<input type="checkbox"/> M <input type="checkbox"/> F				Issue State: _____ Number: _____
Child Name	Date of Birth (MM/DD/YY)	Gender	Height	Weight	Social Security Number	Drivers License or State ID for all dependents age 19 or older.
		<input type="checkbox"/> M <input type="checkbox"/> F				Issue State: _____ Number: _____
Child Name	Date of Birth (MM/DD/YY)	Gender	Height	Weight	Social Security Number	Drivers License or State ID for all dependents age 19 or older.
		<input type="checkbox"/> M <input type="checkbox"/> F				Issue State: _____ Number: _____
Child Name	Date of Birth (MM/DD/YY)	Gender	Height	Weight	Social Security Number	Drivers License or State ID for all dependents age 19 or older.
		<input type="checkbox"/> M <input type="checkbox"/> F				Issue State: _____ Number: _____
Child Name	Date of Birth (MM/DD/YY)	Gender	Height	Weight	Social Security Number	Drivers License or State ID for all dependents age 19 or older.
		<input type="checkbox"/> M <input type="checkbox"/> F				Issue State: _____ Number: _____

If you have additional dependents you wish to cover, please provide information on a separate sheet of paper and attach to application.

Have you used tobacco products in the past 12 months?  Yes  No Are you eligible for Medicare?  Yes  No

**Note:** height, weight, gender and smoking status will not be used in determining plan eligibility or premium.

Are you applying for group conversion coverage?  Yes  No

**Note:** If you qualify for a group conversion plan, we will align your effective date with the termination date of your group coverage, to ensure continuous coverage.

Have you been covered under a Blue Cross Blue Shield of Michigan health plan within the past 60 days?  Yes  No

If yes, please complete: Group Name: \_\_\_\_\_ Contract Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Termination date \_\_\_\_/\_\_\_\_/\_\_\_\_ Termination date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Part 2: Choose Your Coverage**

Select Individual or Group Conversion

**Individual Coverage**

A 180 day pre-existing conditions waiting period applies to Individual coverage unless you are a child under age 19 or you meet the requirements outlined in the Terms and Conditions of this application.

Select one of the following health plans which are **ONLY** available for Individual coverage:

**Individual Care Blue Plus**

Optional Flexible Blue Dental Plus

**Flexible Blue II**

\$1,500 deductible

Optional Maternity

Optional Flexible Blue Dental Plus

\$2,500 deductible

Optional Maternity

Optional Flexible Blue Dental Plus

\$5,000 deductible

Optional Flexible Blue Dental Plus

**Group Conversion Coverage**

A 180 day pre-existing conditions waiting period does not apply to Group Conversion (GC) coverage, however you must meet certain criteria to be eligible for this coverage:

- Your previous BCBSM group plan coverage had at least 2 subscribers covered.
- Your group contributes to the subsidy required by the State of Michigan.
- You had coverage for at least 3 months.
- You applied for this GC plan within 60 days of the termination date of group coverage.
- Termination of coverage was based upon a qualifying event.

NOTE: Final determination of GC eligibility will be made by Underwriting.

Select one of the following health plans which are **ONLY** available for Group Conversion coverage:

**Flexible Blue II**

\$2,500 deductible

Optional Maternity  Optional Flexible Blue Dental Plus

\$5,000 deductible

Optional Flexible Blue Dental Plus

**Part 3: Eligibility**

Eligibility Information

1. Are you a permanent resident of Michigan residing here at least six months of the year?  Yes  No
2. Have you or any family members applying for coverage had health coverage in the past six months?  Yes  No

If yes, please complete:

Name of insurance company: \_\_\_\_\_

Type of coverage:  Group  Individual  COBRA  Medicare/Medicare Advantage  Medicaid

Other: \_\_\_\_\_

Contract/ID number: \_\_\_\_\_ Effective date of coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_

Expected termination date of coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_

Are benefits provided through a Sole Proprietorship?  Yes  No

3. Are you or your spouse currently employed?  Yes  No

If yes, name of employer: \_\_\_\_\_

4. Does your employer or your spouse's employer offer a group health plan?  Yes  No

If no, please skip to #7.

If yes, are you eligible for it or currently enrolled? Eligible:  Yes  No Enrolled:  Yes  No

If currently enrolled, when will your coverage terminate? \_\_\_\_/\_\_\_\_/\_\_\_\_

If currently enrolled, why will your coverage terminate?

No longer employed by employer

Costs too much

No longer eligible for coverage

Employer cancelled plan or no longer offers plan

Other reason:

5. If you are eligible for the group health plan:

Does the employer pay for or reimburse eligible employees for any portion of their coverage?  Yes  No

If known, what amount does the employer contribute towards the employee premium (percentage or amount)? \_\_\_\_\_

Does the employer pay for or reimburse towards eligible dependents for any portion of their coverage?  Yes  No

If known, what amount does the employer contribute towards the dependents premium (percentage or amount)? \_\_\_\_\_

6. Under this individual health policy for which you are applying, will your employer pay any portion of the premium?  Yes  No

If yes, will the premium be paid through a qualified HRA (Health Reimbursement Account) or Section 125 (Flexible Spending Account)?  Yes  No

If yes, are you the business owner?  Yes  No

Eligibility Information (continued)

7. Who will be paying the premium for this individual health policy? Please check all that apply:

- Self
  My employer  
 Other family member
  Other:  
 Legal guardian

8. Are you applying for this individual coverage because you are HIPAA eligible?  Yes  No  
 Do you believe you are eligible for waiver of pre-existing under HIPAA guidelines?  Yes  No

Please refer to the Terms and Conditions page of this application under "pre-Existing Conditions" for information on HIPAA Eligibility. If you answered "Yes", you must sign and submit the *Application for Waiver of Pre-Existing Waiting Period*.

The application can be found at: [http://www.bcbsm.com/pdf/application\\_waiver\\_pre-existing\\_waiting\\_period.pdf](http://www.bcbsm.com/pdf/application_waiver_pre-existing_waiting_period.pdf)

9. Has any person applying for coverage been rejected for coverage within the past 6 months by another insurance carrier?  Yes  No

If yes, please indicate which person(s): \_\_\_\_\_

Name of carrier: \_\_\_\_\_

What was the reason?

- Ongoing medical condition(s)
  Residence outside the carrier's service area  
 Past medical history
  Eligible for or covered under a group health plan  
 Current pregnancy or in the process of adoption
  Eligible for or enrolled in Medicare  
 Primary residence outside the U.S.
  Employer paying premium for Individual plan  
 Not a U.S. citizen or a citizen for less than one year
  Ineligible occupation  
 Residence outside of Michigan more than 6 months a year
  Other \_\_\_\_\_

10. Education (optional):

- High school
  College
  Grad school
  Vocational/technical school

11. Home ownership (optional):  Rent  Own

12. Household income (optional):  \$15,000 or less  \$16,000 to \$35,000  \$36,000 to \$50,000

- \$51,000 or \$75,000
  \$76,000 to \$100,000
  \$100,000 +

**Part 4: Health Information**

**General Health Information**

1. In order for us to help you manage your chronic health condition(s) through one of our Care Management Programs, please provide us with the following medical information. The answers you provide will not be used in determining plan eligibility or your premium. If you qualify and meet eligibility guidelines, you may be eligible for member discounts in the future.

Have you ever been diagnosed or treated within the past 5 years for any of the following conditions? Please check all that apply, list the specific condition and description of the illness if applicable.

**Details or Description of Illness**

<input type="checkbox"/> AIDS HIV/ARC	
<input type="checkbox"/> Amyotrophic Lateral Sclerosis/ALS (Lou Gehrig's Disease)	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Brain Surgery	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Cirrhosis of Liver	
<input type="checkbox"/> Congestive Heart Failure	
<input type="checkbox"/> Coronary Artery Disease (including Heart Attack, Bypass, Angioplasty)	
<input type="checkbox"/> Cerebral Palsy	
<input type="checkbox"/> COPD (Emphysema, Chronic Bronchitis)	
<input type="checkbox"/> Crohn's Disease	

<b>General Health Information (cont.)</b>	
<input type="checkbox"/> Cystic Fibrosis	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Guillian-Barre Syndrome	
<input type="checkbox"/> Hemophilia or other bleeding disorder	
<input type="checkbox"/> Hepatitis C, D or G	
<input type="checkbox"/> Hodgkin's Disease	
<input type="checkbox"/> Huntington's Disease	
<input type="checkbox"/> Hydrocephalus	
<input type="checkbox"/> Infertility	
<input type="checkbox"/> Leukemia	
<input type="checkbox"/> Lupus	
<input type="checkbox"/> Muscular Dystrophy	
<input type="checkbox"/> Myasthenia Gravis	
<input type="checkbox"/> Paraplegia or Quadriplegia	
<input type="checkbox"/> Parkinson's Disease	
<input type="checkbox"/> Polycystic Kidney	
<input type="checkbox"/> Renal Failure	
<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Scleroderma	
<input type="checkbox"/> Sclerosis (Multiple, Disseminated or Postero-Lateral)	
<input type="checkbox"/> Sickle Cell Anemia	
<input type="checkbox"/> Transplant (Heart, Kidney, Liver or Lung)	
<input type="checkbox"/> Wilson's Disease	
<input type="checkbox"/> Major Psychiatric Disorders (Alzheimer's, Dementia, Paranoia, Schizophrenia, Major Depression, Bipolar Disorder)	
<input type="checkbox"/> <b>None of the Above</b>	
<input type="checkbox"/> Applicant declines to answer health information	

**Part 5: Billing Information**

How would you like to pay your initial premium?

Bill Me    Automatic withdrawal (EFT)    Credit Card (Please complete the last page of this application)

Please select a billing frequency for future payments:

Monthly (must be automatic payment)    Quarterly

This option automatically deducts premium payments from an account you designate.

Full Name (first, middle, last)

Social Security Number

Street Address

E-mail Address

City

State

Zip Code

Daytime Phone Number

Name of Financial Institution

Type of Account

Checking    Savings

Bank Account Number

ABA/Routing Number (9 digits)

**Automatic payment cannot be processed without your signature.** I authorize Blue Cross Blue Shield of Michigan to deduct payments from the bank account listed above. I understand that I control my payments and if at any time I decide to discontinue the payment, I will notify Blue Cross Blue Shield of Michigan. I also understand that all information provided will remain confidential.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Part 6: Consent, Terms and Conditions**

You are eligible for individual coverage if:

- You are a permanent resident of Michigan and live in the state at least six months of the year, and
- You are not eligible for group coverage through an employer or your spouse's employer, and
- You are not currently covered by another health plan, excluding medicare, and
- You do not have Medicare and are not eligible for Medicare supplemental coverage

We will consider you to be eligible for group coverage if your employer or spouse's employer pays you or Blue Cross Blue Shield of Michigan any part of your premium. You may be eligible for Blue Cross Blue Shield of Michigan group conversion coverage if, in addition to meeting the eligibility requirements for individual coverage listed above, you have been enrolled in a Blue Cross Blue Shield of Michigan group that contributes to the subsidy required by the State of Michigan.

**Note:** If you voluntarily terminate your Blue Cross Blue Shield of Michigan coverage as sole proprietor or one-subscriber group, or your benefits as a member in an association that offers Blue Cross Blue Shield of Michigan coverage to its members, you are not eligible for the Group Conversion programs.

I am applying for Blue Cross Blue Shield of Michigan coverage subject to the terms and conditions of this application and I agree that I will be bound by all provisions in the Blue Cross Blue Shield of Michigan certificate and riders. Approval of this application and coverage effective date will be determined by Blue Cross Blue Shield of Michigan and shall be subject to requirements by Blue Cross Blue Shield of Michigan for additional information and payment of bills.

I certify that the requirements of eligibility are met and that the information supplied on this application is true, correct and complete to the best of my knowledge. I understand that the information will be used in reviewing my application and administering coverage and that any misrepresentation and/or false or misleading information regarding my eligibility may result in termination of coverage. This 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 that my or my spouse's employer will not contribute any part of the premium, nor will I be reimbursed for any part of the premium by the employer now, or in the future.

## Authorization for Use and Disclosure of Protected Health Information (PHI)

I understand that Blue Cross Blue Shield of Michigan may collect personal and protected health information (PHI) about me in order to complete my application for coverage. Blue Cross Blue Shield of Michigan will use and disclose this information only in accordance with their Notice of privacy Practices which is available in **bcbsm.com** or by calling 313-225-9000.

I authorize:

- Use and disclosure of my PHI, including membership, eligibility and claims data stored on Blue Cross Blue Shield of Michigan and its subsidiaries' computer systems.
- Physicians, health care professionals, hospitals, clinics, laboratories, pharmacies or pharmacy benefit managers, or other health care providers that have provided treatment or services to me to disclose medical records information, prescription history, medications prescribed and other PHI as requested to Blue Cross Blue Shield of Michigan.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or have knowledge of my medical information to disclose medical records information, prescription history, medications prescribed and other PHI as requested by Blue Cross Blue Shield of Michigan.

My authorization includes disclosure of information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes disclosure of psychotherapy notes.

This authorization includes and applies to any and all protected health information related to treatments or services where I have requested a restriction and/or for any health care item or service for which the health care provider has been paid out of pocket in full.

This PHI is to be disclosed so that Blue Cross Blue Shield of Michigan may: (1) perform case, care and disease management, (2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits, and (3) for other legally permissible purposes, including but not limited to, health care operations. If Blue Cross Blue Shield of Michigan discloses this information, the recipient must obtain an additional authorization from me before it may re-disclose the information and if I provide this authorization information may re-disclosed by the recipient and no longer protected.

I understand that my enrollment with Blue Cross Blue Shield of Michigan is conditioned upon my authorization to release PHI for the purposes stated above and that if I do not provide authorization, I may not be eligible for enrollment. My signature on this form indicates my approval for the release of the PHI from Blue Cross Blue Shield of Michigan and its subsidiaries and from any parties listed above to Blue Cross Blue Shield of Michigan. A photographic copy of this authorization shall be valid as the original.

This authorization will expire after 30 months or upon rejection of coverage. I understand that I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request on a standard form available online at **bcbsm.com** or by contacting my agent. I understand that revocation will not affect actions taken before Blue Cross Blue Shield of Michigan or any of the parties identified above receive my request.

### Pre-existing conditions

A pre-existing condition is any medical condition for which medical advice, diagnosis, care or treatment was recommended or received in the 6 months prior to the date your application was received by Blue Cross Blue Shield of Michigan.

#### 180-day pre-existing condition waiting period

Blue Cross Blue Shield of Michigan provides no coverage for treatment of a pre-existing condition for individuals 19 years of age or older for 180 days following your effective date of coverage.

You will be subject to the 180 day pre-existing condition waiting period:

- If you have no prior coverage or most recent coverage was an individual policy. If your previous individual coverage was Blue Cross Blue Shield of Michigan, you may receive credit toward the waiting period for the number of days you were covered under the previous certificate provided there is no lapse in coverage.
- If you were covered under COBRA but have not exhausted your COBRA benefit.

You will not be subject to the 180-day pre-existing condition waiting period if all the following conditions are met **(HIPAA Eligibility)**:

- Prior to your application for this coverage, you were continuously covered under one or more health plans for a total of at least 18 months, with no more than a 62-day break. Coverage may include group health plans, individual health insurance, Medicare, Medicaid, public health plans, military or federal benefit programs, Indian Health Services, freestanding prescription drug coverage or other health plans. Freestanding dental and vision cannot be counted as prior health coverage.
- Your most recent health coverage must have been through a group health plan (Please note that if health coverage was provided through an association or other organization, it is considered to be "individual" health insurance if it is not provided through an employer sponsored group health plan. Also, a business owner and spouse are usually not considered employees of a business if no other employees take part in the health plan. If this is the case, the health plan cannot be defined as a "group" health plan but is instead an individual plan. If, however the spouse of the business owner is a bona fide employee of the business, the plan may be a group health plan).
- You have elected and exhausted and COBRA coverage for which you were eligible
- You are no longer eligible for group coverage and you are not eligible for medicare or medicaid
- Your prior coverage was not terminated due to premium non-payment or fraud.

**Part 7: Signature**

Please review your application for completeness and accuracy. Sign and date your application. If you are enrolling through an independent agent, submit your application directly to your agent so that he or she can process the application for you. If you are enrolling directly with Blue Cross Blue Shield of Michigan, please mail your completed application to:

RICK YOUNG & ASSOCIATES  
 2993 CORINTHIA SUITE A  
 ROCHESTER HILLS MI 48309

<b>Signature</b>	<b>Date</b>
<b>Spouse Signature</b>	<b>Date</b>
<b>Dependent Signature age 18 or older</b>	<b>Date</b>
<b>Dependent Signature age 18 or older</b>	<b>Date</b>

Have questions? Visit [bcbsm.com/myblue](http://bcbsm.com/myblue) for information, or call 877-4MY-BLUE (877-469-2583) or our Authorized Independent Agent for Blue Cross Blue Shield of Michigan.

Area below for Agent Use Only			
Agent Code	MA/GA Code <b>74</b>	Agent's e-mail address	Date Signed (mm/dd/yy)
Assoc./Chamber Code			
Area below for BCBSM Use Only			
Group #	Service Code	Eff. Date (mm/dd/yy)	U/W
Pre-existing Date (mm/dd/yy)			DEID

**Credit Card Payment (for initial premium payment only)**

**Note:** If you are submitting your application through an agent or by U.S. Mail and do not want your first premium payment paid by credit card, please remove this page before submitting the application.

**This option offers the convenience of making your first premium payment by credit card. Your coverage is assigned an effective date upon Underwriting approval, but it is not active until payment is received by Blue Cross Blue Shield of Michigan. Using a credit card to pay your premium will activate your coverage more quickly. Your Identification Card is issued immediately, but coverage will not be activated until payment is received. Credit card payment can be used for your initial premium payment only.**

Credit Card

VISA    Mastercard

Cardholder's Name (exactly as it appears on the card)

Social Security Number

Credit Card Number

Card Expiration Date

Card Verification Code

**Cardholder Billing Address**

Street Address

City

State

Zip Code

Daytime Phone Number

**Credit card payment cannot be processed without your signature.** I authorize Blue Cross Blue Shield of Michigan to charge my credit card for my health care premium payment amount. If at any time I decide to discontinue the payment, I will notify Blue Cross Blue Shield of Michigan. I also understand that all information provided will remain confidential.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**