



An Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans.

Application for Individual and Family Products

**BLUE CROSS AND BLUE SHIELD OF MONTANA (BCBSMT)
PO BOX 4309
HELENA MT 59604**

**TELEPHONE 1-800-447-7828
FAX (406) 441-3067
www.bcbsmt.com**

You must provide complete, accurate and current responses to all questions.

Read Prior to Completing this Application

All family members for whom coverage is desired must be listed. Your spouse and unmarried children or stepchildren under 25 years of age may be eligible for coverage, subject to applicable eligibility guidelines. Notice is required within 31 days to add a dependent as a result of birth, marriage, adoption, or placement for adoption. List only those dependents for whom coverage is desired (use additional application if necessary). If applicable, court documents verifying adoption or placement for adoption, legal guardianship, custody, and/or conservatorship must be attached.

To be eligible for this coverage, you must be a resident of the state of Montana and under the age of 65.

If you currently have health coverage, BCBSMT recommends that you maintain your current coverage until you receive written notice from BCBSMT regarding your application. BCBSMT may request additional information from care providers or others, requiring additional time to process your application.

Important Notice About Your Obligation to Provide Complete, Accurate and Current Information and Responses

This Application is a legal document. If BCBSMT issues coverage, this Application will become part of the insurance contract. BCBSMT is relying upon your statements and representations in this Application to determine whether to issue coverage, the scope of any coverage issued, and the premium rates for any coverage issued. BCBSMT will notify you in writing whether it will issue coverage, decline to issue coverage, or issue coverage only if you accept one or more elimination riders.

BCBSMT may obtain additional information about conditions, treatment or other items that you disclose on this Application. BCBSMT does not routinely have or obtain further information about health conditions, treatment or other matters that you do not disclose on this Application. In completing this Application, you may not omit any requested response or information for any reason, for example, because you believe that BCBSMT already has or will discover the information from another source, including any providers you have listed on your Authorization for Release of Medical Records or on other attachments.

If you do not provide complete, accurate and current responses and information, BCBSMT may reject your application. If BCBSMT does issue coverage and later finds that you did not provide complete, accurate and current responses and information on this Application or that you failed to supplement your Application responses with any additional information you learned before BCBSMT made a final decision to issue coverage, the entire policy may be subject to cancellation back to its initial effective date, in accordance with applicable law.

By accepting payment of dues or premiums, BCBSMT does not waive its right to decline to issue coverage, or to cancel coverage in accordance with applicable law retroactive to its initial effective date based upon an omission, concealment of facts, incorrect statement, material misrepresentation or fraudulent misstatement.

Your SSN will not be used as your health plan identification number.

APPLICATION FOR INDIVIDUAL AND FAMILY PRODUCTS
PLEASE PRINT IN BLACK INK

Current BCBSMT Identification Number: _____

Purpose	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Add Family Member	<input type="checkbox"/> Change Benefit Plan Example: Currently covered on \$2,500 deductible Blue Evolution, changing to \$1,250 deductible <input type="checkbox"/> Transfer (Current ID Number) _____ Example: Changing from ID 000123456789 covered as a dependent child to ID 000234567890 <input type="checkbox"/> Request for Removal of Exclusion Rider	Select either 1st or 15th of month. Requested Effective Date (subject to BCBSMT approval) (mo/day/yr)																													
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; vertical-align:top;"> <input type="checkbox"/> Value Blue <input type="checkbox"/> HDHP: Individual Coverage* <input type="checkbox"/> Option 1: \$2,500 <input type="checkbox"/> Option 2: \$5,000 Family Coverage* <input type="checkbox"/> Option 1: \$5,000 <input type="checkbox"/> Option 2: \$10,000 </td> <td style="width:33%; vertical-align:top;"> <input type="checkbox"/> Blue Care (Supplement Application Required) <input type="checkbox"/> Other </td> <td style="width:33%; vertical-align:top;"> <input type="checkbox"/> Blue Evolution <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:33%;">Deductible and Out-of-Pocket Maximum</th> <th style="width:33%;">Coinsurance</th> <th style="width:33%;">Primary Care Benefit</th> </tr> <tr> <td></td> <td>In Network Out of Network</td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$1,250/\$7,500</td> <td><input type="checkbox"/> 60/40 50/50</td> <td><input type="checkbox"/> \$0</td> </tr> <tr> <td><input type="checkbox"/> \$1,250/\$10,000</td> <td><input type="checkbox"/> 70/30 60/40</td> <td><input type="checkbox"/> \$275</td> </tr> <tr> <td><input type="checkbox"/> \$2,500/\$7,500</td> <td><input type="checkbox"/> 80/20 70/30</td> <td><input type="checkbox"/> \$450</td> </tr> <tr> <td><input type="checkbox"/> \$2,500/\$10,000</td> <td></td> <td><input type="checkbox"/> \$750</td> </tr> <tr> <td><input type="checkbox"/> \$5,000/\$7,500</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$5,000/\$10,000</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$10,000/\$15,000</td> <td></td> <td></td> </tr> </table> </td> </tr> </table> <p>*If more than one person is covered by the same policy, it is a family policy. <input type="checkbox"/> Conversion** Plan _____ **Please verify your eligibility for Conversion prior to filling out this application. Complete only pages 2, top of 3, 6, and 7.</p> <p>Family deductibles and out-of-pocket maximums are two times the amounts shown above for individuals.</p>			<input type="checkbox"/> Value Blue <input type="checkbox"/> HDHP: Individual Coverage* <input type="checkbox"/> Option 1: \$2,500 <input type="checkbox"/> Option 2: \$5,000 Family Coverage* <input type="checkbox"/> Option 1: \$5,000 <input type="checkbox"/> Option 2: \$10,000	<input type="checkbox"/> Blue Care (Supplement Application Required) <input type="checkbox"/> Other	<input type="checkbox"/> Blue Evolution <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:33%;">Deductible and Out-of-Pocket Maximum</th> <th style="width:33%;">Coinsurance</th> <th style="width:33%;">Primary Care Benefit</th> </tr> <tr> <td></td> <td>In Network Out of Network</td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$1,250/\$7,500</td> <td><input type="checkbox"/> 60/40 50/50</td> <td><input type="checkbox"/> \$0</td> </tr> <tr> <td><input type="checkbox"/> \$1,250/\$10,000</td> <td><input type="checkbox"/> 70/30 60/40</td> <td><input type="checkbox"/> \$275</td> </tr> <tr> <td><input type="checkbox"/> \$2,500/\$7,500</td> <td><input type="checkbox"/> 80/20 70/30</td> <td><input type="checkbox"/> \$450</td> </tr> <tr> <td><input type="checkbox"/> \$2,500/\$10,000</td> <td></td> <td><input type="checkbox"/> \$750</td> </tr> <tr> <td><input type="checkbox"/> \$5,000/\$7,500</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$5,000/\$10,000</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$10,000/\$15,000</td> <td></td> <td></td> </tr> </table>	Deductible and Out-of-Pocket Maximum	Coinsurance	Primary Care Benefit		In Network Out of Network		<input type="checkbox"/> \$1,250/\$7,500	<input type="checkbox"/> 60/40 50/50	<input type="checkbox"/> \$0	<input type="checkbox"/> \$1,250/\$10,000	<input type="checkbox"/> 70/30 60/40	<input type="checkbox"/> \$275	<input type="checkbox"/> \$2,500/\$7,500	<input type="checkbox"/> 80/20 70/30	<input type="checkbox"/> \$450	<input type="checkbox"/> \$2,500/\$10,000		<input type="checkbox"/> \$750	<input type="checkbox"/> \$5,000/\$7,500			<input type="checkbox"/> \$5,000/\$10,000			<input type="checkbox"/> \$10,000/\$15,000	
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Applicant/Subsriber	Social Security Number: _____		Date of Birth (mo/day/yr)	Male/ Female	State or Country of Birth																											
	Last Name	First Name				MI																										
	Applicant/Subsriber Mailing Address			City	State	ZIP Code	Home Telephone																									
	Applicant/Subsriber Billing Address (If different from above, please provide. If Electronic Funds Transfer, do not complete.)			City	State	ZIP Code	Cell Phone																									
	Billing Address Contact Name: _____																															
	Email Address: (Please print clearly) _____				Marital Status	Date of Marriage (mo/day/yr)																										
					<input type="checkbox"/> Single <input type="checkbox"/> Married																											
Have you or any of your family members had different last names in the past 10 years? If yes, indicate who and provide the names. <input type="checkbox"/> Yes <input type="checkbox"/> No																																
Residency	Do all applicants reside in Montana? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide name(s) and addresses of person(s) residing outside Montana and reason(s) person(s) reside outside Montana.			BCBSMT Date Stamps Only																												
OFFICE USE ONLY	Org Policy			<input type="checkbox"/> Effective Date _____ <input type="checkbox"/> Declined _____ <input type="checkbox"/> Elimination Rider _____ <input type="checkbox"/> Elimination Rider _____ <input type="checkbox"/> Elimination Rider _____		<input type="checkbox"/> Approved as Applied _____ <input type="checkbox"/> Modified Approval _____ Name _____ Name _____ Name _____																										

Applicant/Subscriber Name:

If additional space is needed to provide complete information, use a separate sheet of paper, signed and dated.

Spouse and Dependent(s)	List only those family members applying for coverage.		Social Security Number (SSN) Your SSN will not be used as your Health Plan identification number.	Date of Birth (mo/day/yr)	Male/ Female	Relationship to Applicant/ Subscriber	State or Country of Birth
	Last Name	First Name					

When completing A through I, if an applicant or family member received services while using a different last name from that shown on page 1, complete the "Name of Person" column.

Medical History	A. List current height and weight for all persons to be covered age 12 and older. Have height and weight been verified by a care provider within the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	Name of Person		Height Feet Inches	Weight Pounds	Name of Person		Height Feet Inches Weight Pounds
	B. Within the last three (3) years, have medications (except antibiotics) been recommended or prescribed for, been provided for (e.g., samples, injections), and/or been taken by any person to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information or provide a pharmacy printout for the last 12 months.						
	Name of Person	Name of Medication and How Often Refilled	Daily Dosage	Condition for Which Medication Was Prescribed or Taken	Dates From (mo/day/yr) To (mo/day/yr)		Complete Provider Name (First and Last)
C. Does any family member applying for coverage have reason to believe that she or he is an expectant mother or father (by adoption or by positive result of a home pregnancy test, provider test, laboratory results, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name(s) of person(s) and due date(s):							
D. For any person to be covered, has a health care provider EVER diagnosed the person with, or recommended or provided any medical advice, care, treatment, services, devices, or equipment for or in relation to, any of the following conditions, illness, disorders, diseases or circumstances, or recommended or provided any of the following care or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check each item that applies and provide specific information as requested below.							
1. <input type="checkbox"/> AIDS or AIDS-Related Complex 2. <input type="checkbox"/> Alcohol Use 3. <input type="checkbox"/> Blood or Coagulation Disorder 4. <input type="checkbox"/> Cancer 5. <input type="checkbox"/> Chemotherapy/Radiation Treatment 6. <input type="checkbox"/> Colon or Intestinal Disorder 7. <input type="checkbox"/> Congenital Defect		8. <input type="checkbox"/> Diabetes 9. <input type="checkbox"/> Drug Use 10. <input type="checkbox"/> Eating Disorder 11. <input type="checkbox"/> Heart Murmur 12. <input type="checkbox"/> Heart Problems 13. <input type="checkbox"/> HIV Positive 14. <input type="checkbox"/> Liver Disorder		15. <input type="checkbox"/> Lupus <input type="checkbox"/> Systemic <input type="checkbox"/> Discoid 16. <input type="checkbox"/> Mental Disease 17. <input type="checkbox"/> Nervous System Disorder (e.g., Multiple Sclerosis, Cerebral Palsy, Neuropathy) 18. <input type="checkbox"/> Osteopenia/Osteoporosis		19. <input type="checkbox"/> Rheumatic Fever 20. <input type="checkbox"/> Seizure Disorder/Epilepsy 21. <input type="checkbox"/> Sleep Apnea 22. <input type="checkbox"/> Stroke or Circulatory Problems 23. <input type="checkbox"/> Suicide Attempt 24. <input type="checkbox"/> Tumor 25. <input type="checkbox"/> Weight Loss Procedure (e.g., gastric bypass)	
Condition Number (1-25)	Name of Person	Diagnosis/Condition	Dates From (mo/day/yr) To (mo/day/yr)		Hospitalized?	Complete Provider Name (First and Last) or Facility Name and Address (City State ZIP)	
					<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		

Applicant/Subscriber Name:

If additional space is needed to provide complete information, use a separate sheet of paper, signed and dated.

E. For any person to be covered, within the last five (5) years, has a health care provider diagnosed the person with, or recommended or provided any medical advice, care treatment, services, devices or equipment for or in relation to, any of the following conditions, illnesses, disorders, diseases or circumstances, or recommended or provided any of the following care or treatment?
 Yes No If yes, please explain:

26. <input type="checkbox"/> Allergy 27. <input type="checkbox"/> Anxiety/Depression 28. <input type="checkbox"/> Arthritis 29. <input type="checkbox"/> Asthma 30. <input type="checkbox"/> Attention Deficit Disorder (ADD/ADHD) 31. <input type="checkbox"/> Counseling 32. <input type="checkbox"/> Fractures 33. <input type="checkbox"/> Gastric Reflux (e.g., heartburn)	34. <input type="checkbox"/> Headaches/Migraines 35. <input type="checkbox"/> Hernia (specify type) 36. <input type="checkbox"/> High Blood Pressure (complete blood pressure table below in Section F) 37. <input type="checkbox"/> Hyperactivity 38. <input type="checkbox"/> Infertility 39. <input type="checkbox"/> Ulcer (specify type) 40. <input type="checkbox"/> Disease, Condition, or Disorder of: A. <input type="checkbox"/> Breasts	B. <input type="checkbox"/> Back/Neck (specify area) C. <input type="checkbox"/> Prostate D. <input type="checkbox"/> Reproductive Organs E. <input type="checkbox"/> Joints (specify area, left or right if applicable) F. <input type="checkbox"/> Urinary Tract G. <input type="checkbox"/> Thyroid H. <input type="checkbox"/> Kidneys	I. <input type="checkbox"/> Lungs J. <input type="checkbox"/> Nasal/Sinus (e.g., infection, malformation, deviated nasal septum) K. <input type="checkbox"/> Ear (e.g., infection, hearing impairment) L. <input type="checkbox"/> Eyes (e.g., crossed eyes, detached retina, cataract, glaucoma) 41. <input type="checkbox"/> Other
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Item Number (26 - 41)	Name of Person	Diagnosis/Condition	Dates		Hospitalized?	Complete Provider Name (First and Last) or Facility Name and Address (City State ZIP)
			From (mo/day/yr)	To (mo/day/yr)		
					<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	

F. Blood Pressure readings must be provided if answered "Yes" to #36. (Give the three most recent readings, at least one month apart.)

Name of Person	Date Taken (mo/yr)	Blood Pressure Reading	Date Taken (mo/yr)	Blood Pressure Reading	Date Taken (mo/yr)	Blood Pressure Reading
		/		/		/
		/		/		/

G. Has any person to be covered received, or been recommended to receive, any medical treatment that has not been disclosed on another part of this application? Examples include counseling, follow-up for abnormal laboratory studies or other findings (including abnormal Pap smears), examinations/tests/laboratory studies/x-rays (MRI, CT scan, ECG, ultrasound, mammogram, etc.) or other testing or medical care, treatment, services, devices or equipment recommended by a health care provider or a legal authority.
 Yes No If yes, please indicate whether the treatment has been received or recommended, and provide date(s), name(s) of person(s), and detailed explanation(s).

H. Has any person to be covered been fitted with any implants or orthopedic device (including pins, screws, plates, orthotics, or braces) or does any person regularly use durable medical equipment (e.g., a wheelchair, splints or crutches, oxygen, CPAP or other equipment)?
 Yes No If yes, please provide date(s), name(s) of person(s), and detailed explanation(s). Also, state whether the device or equipment is temporary or permanent.

I. Within the past five (5) years, has any person to be covered been declined medical coverage, offered medical coverage on a restricted basis, (e.g. offered an elimination rider), or offered a nonstandard/structured premium for medical coverage (e.g. "rated up")?
 Yes No If yes, please provide the information requested below:

Name of Person	Name of Company	Date of Decision (mo/day/yr)	Reason for Decision

Medical History, continued

Applicant/Subscriber Name:

If additional space is needed to provide complete information, use a separate sheet of paper, signed and dated.

Lifestyle Questionnaire	Height and weight from page 3 will be included in our evaluation of the Lifestyle Questionnaire. This questionnaire must be completed for each person to be covered age 16 or older.					NAME:	NAME:	NAME:	NAME:
	What is the average amount of time you exercise each week? Consider only aerobic exercise such as running, swimming, brisk walking, tennis, racquetball, basketball, bicycling, or any activity done at a steady pace over an extended period of time that requires elevated heart rate and oxygen intake. The activity may be either occupational or recreational.	0 to 1 hour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		1 to 2 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		2 to 3 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		3 or more hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	Have you used any tobacco product in the past five years?		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"/>			
	On the average, for the past year, how many cigarettes have you smoked per day?	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		Less than ½ pack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		½ to 1 pack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		1 to 2 packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		2 packs or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
	Have you smoked a pipe or cigar or used smokeless tobacco more than once per week during the past year?		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"/>			
	What is the average number of alcoholic drinks you consume per week? (One drink equals one 6-ounce glass of wine, one ounce of hard liquor, or one 12-ounce beer.)	None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		1 to 14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		15 to 28	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		29 to 42	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		43 or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

This section intentionally left blank.
Please continue to next page to complete this application.

Applicant/Subscriber Name:

Other Coverage Information

Creditable Coverage:

- Including but not limited to Medicare, Medicaid, group health plan, and health insurance coverage.
- Does not include limited benefit plans such as a cancer policy, a hospital indemnity plan, or a life insurance policy.

Creditable Coverage: If you or your dependents had health coverage within the last 63 days or within 63 days of the date on which a Certificate of Creditable Coverage was issued, the preexisting condition exclusion period will be reduced by any combination of the periods of Creditable Coverage that the member had as of the enrollment date of this plan. In addition, please attach verification(s) of Creditable Coverage to this form OR complete the table below for you and your dependents. The previous health insurance carrier must provide a certificate of Creditable Coverage with the end date of that coverage. If necessary, BCBSMT will assist you and your dependents in obtaining this certificate or the necessary information from your previous health insurance carrier(s).

Omissions or incomplete answers regarding other health coverage may delay the processing of your application.
This section must be completed for all applicants and dependents applying for coverage.

Have you or your dependents had health coverage within the last 63 days? Yes No
If yes, attach verification of Creditable Coverage to this form OR complete the following information for you and your dependents. Please complete the table below to verify Creditable Coverage if applicable.

Name of Person Covered (include last name if different from Applicant/Subscriber)	Self: ID #*:	Spouse: ID #*:	Dependent: ID #*:	Dependent: ID #*:
Full Name, Address, and Telephone Number of Insurance Company or Carrier				
Type of Coverage (check)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	<input type="checkbox"/> Medical <input type="checkbox"/> Dental
Enrollment Date	From			
Cancel Date	To			
Will this coverage be continued?	<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

*ID # is your identification number under previous or current insurance company or carrier.

If you are currently covered as an employee under a BCBSMT group, complete the following to indicate the reason you are canceling that coverage: No longer with employer, or employment will be terminated as of: _____
If you are remaining with the firm as an employee:
 Dropped below the required hours as of: _____ Benefit Plan unsuitable
 Group coverage too expensive Other (indicate reason): _____

ATTESTATION REGARDING EMPLOYER GROUP HEALTH PLAN COVERAGE AND EMPLOYER PAYMENT

Blue Cross and Blue Shield of Montana Individual Plans are available only to persons not covered under an employer-sponsored group health plan. By signing this Application, you are attesting to the following:

1. I, along with any spouse and dependents listed on this Application, will not be enrolled in or covered under an employer's group health plan during the effective period of coverage under the Individual Plan for which I/we am/are applying;
2. My/Our employer is not paying any portion of the premium for this individual coverage;
3. My/our employer is not taking any tax deductions for premiums paid for this coverage (unless I am self employed);
4. My/our employer will not exclude, from my reported gross income, any premium amounts paid for this coverage (unless I am self employed).

Applicant/Subscriber Name:

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential; however, Blue Cross and Blue Shield of Montana (BCBSMT) may make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, and the telephone number is (617) 426-3660. BCBSMT may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life, disability, or medical insurance, or to whom a claim for benefits may be submitted.

Conditions of Enrollment

I/We hereby apply for coverage with BCBSMT. I/We certify and understand the following:

- All of the statements and responses in this application are complete, accurate, and current for the Applicant/Subscriber, and for the spouse and all dependents for whom coverage is requested.
- I/We personally completed the Medical History section of this form, filling in all requested information. If any agent or other person has assisted me/us in completing this application, I/we have reviewed this completed application carefully before signing and all statements and representations in this Application are mine/ours and not those of any agent or other person.
- I/We understand that I/we have a continuing obligation to update this Application by providing BCBSMT with any additional responsive information that arises after I/we sign the Application and before BCBSMT has made a final determination to issue coverage, so that this Application contains complete, accurate and current responses and information through the date that BCBSMT has made a final determination to issue coverage.
- I/We understand that if this Application, including any required supplementation, does not contain complete, accurate and current responses and information, the entire policy may be denied or, if issued, may be subject to cancellation from its beginning in accordance with applicable law. By accepting payment of dues or premiums, BCBSMT does not waive its right to decline coverage, or to cancel coverage in accordance with applicable law retroactive to its effective date based upon an omission, concealment of facts, incorrect statement, material misrepresentation or fraudulent misstatement.
- This is an application only. No right is conferred upon the Applicant/Subscriber, spouse or dependents listed on this Application until and unless BCBSMT issues coverage and dues or premiums are paid.
- I/We understand that a preexisting condition exclusion period may apply.
- I/We, the undersigned, am/are applying for issuance of health coverage by BCBSMT. I/We agree to the terms and conditions of any policy or contract issued by BCBSMT to the Applicant/Subscriber and/or Parent/Legal Guardian.
- I/We understand that BCBSMT maintains contracts with certain providers of medical services. I/We understand that BCBSMT will pay those providers and any other provider it chooses directly.
- I/We have received the Notice of Privacy Practices.
- I/We must be a resident/residents of the state of Montana to be eligible for coverage.

I/We understand and agree that the coverage I/we am/are applying for is subject to eligibility requirements and the effective date will be assigned by Blue Cross and Blue Shield of Montana. I/We have read the Conditions of Enrollment. I/We understand and agree to them.

Signature(s) of spouse and/or all dependent(s) age 18 and over are required if applying for coverage.

Signature(s)

Signature(s) DO NOT PRINT	Signature Date (mo/day/yr)	Signature(s) DO NOT PRINT	Signature Date (mo/day/yr)
Applicant/Subscriber	Spouse
Occupation	Occupation
Dependent	Dependent
Dependent	Dependent

Representative Information

To be completed by the Blue Cross and Blue Shield of Montana Representative

- Have you advised the Applicant/Subscriber to read, complete, and sign this Application form completely and accurately? Yes No
- Have you advised the Applicant/Subscriber that coverage will not commence until he/she is notified that Blue Cross and Blue Shield of Montana has made a final determination to issue coverage and upon the effective date specified in BCBSMT's written notice? Yes No
- Have you advised the Applicant/Subscriber that if his/her Application, including any required supplementation, does not contain complete, accurate and current responses and information, any coverage issues may be subject to cancellation retroactive to its initial effective date in accordance with applicable law? Yes No
- Have you explained the preexisting condition exclusion period to the Applicant/Subscriber? Yes No

Signature of Representative	Date (mo/day/yr)
.....

Representative Name	Representative Number	Telephone Number
Dick Gagliardi	B4	406-541-8080



BLUE CROSS AND BLUE SHIELD OF MONTANA
 PO BOX 4309
 HELENA MT 59604

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Applicant/Subscriber Name:

Billing Frequency

Check the appropriate box below for the desired billing frequency. If no option is selected, Blue Cross and Blue Shield of Montana will bill monthly.

Monthly
 Quarterly

Semiannually
 Annually

Policy Information

Type of Election: New EFT Enrollment Change Bank Information Discontinue EFT Service

Complete this page if you wish to have your health insurance premiums deducted electronically from your bank.

Banking Information

Financial Institution Name City State

Bank Routing (ABA) Bank Account Number

Account funds are to be transferred from (please select only one): Checking Savings

Authorization, Conditions, and Signature

I hereby authorize Blue Cross and Blue Shield of Montana (BCBSMT) to initiate funds transfers for the health insurance premiums due and owing for the above named Policy from my designated Bank Account and hereby authorize my Financial Institution to honor these transfers. I understand that this Agreement and Authorization will remain in effect until BCBSMT has received written notice from me that it should be canceled, and that any such written notice must be given by me not less than **ten** days before the next scheduled payment. I also understand that this Agreement and Authorization does not affect BCBSMT's right to cancel my Policy for nonpayment (if there are insufficient or no funds in my designated Bank Account) as authorized by and in accordance with my Policy and applicable law.

I understand and agree that it is my responsibility to ensure that the information provided on this form is complete and accurate, and to provide prompt notice to BCBSMT of any changes. I agree to indemnify and hold harmless BCBSMT for any claims or losses arising out of any transfers or deductions from my Bank Account pursuant to this Agreement and Authorization

Account Owner's Name (Print):

Please sign and date below.

Account Owner Signature

Date

PLEASE RETURN A VOIDED CHECK WITH THIS FORM

NAME OF DEPOSITOR
STREET ADDRESS
CITY, STATE, ZIP CODE

101

**Please attach copy _____ 20 _____
of
voided check.**

PAY TO THE
ORDER OF:

NAME OF YOUR BANK

021001082

1231567

0101

Routing Number

Account Number

PLEASE MAIL COMPLETED FORM AND VOIDED CHECK TO:

Blue Cross and Blue Shield of Montana, P.O. Box 4309, Helena, MT 59604

If you have questions, please call 1-800-447-7828

Application Checklist

Have you ...

- Answered all the questions and explained all “yes” responses, including “from” and “to” dates for all?
- Completed Blood Pressure Table in page 4, Section F, if “yes” response in page 4, Section E, No. 36?
- Signed and dated the Application (age 18 or over)?
- Enclosed a voided check or savings account deposit slip from the account to be charged if EFT is requested?
- Completed the enclosed Authorization for Release of Medical Records?

Blue Cross and Blue Shield of Montana

Authorization for Disclosure of an Individual's Health Information

Subscriber or Dependent Whose Information is to be Disclosed
Please print information in this section.

Name	Policyholder's Subscriber ID Number	
Street Address	Daytime Telephone	
City	State	ZIP Code

Person(s) or Entity(ies) to Whom Information May Be Disclosed
Please print information in this section.

Name	Daytime Telephone	
Street Address	Daytime Telephone	
City	State	ZIP Code

Information to be Disclosed by Blue Cross and Blue Shield of Montana at the request of the individual authorized to do so

Check all that apply.

- Health Plan Benefit Information:** Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information.)
- Claims Information:** Includes information related to payment of your claims for services you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions, claim payment or denial reasons, etc.)
- Authorization Information:** Includes information regarding precertification and authorization, including specific medical information related to requests and determinations
- Premium Information:** Includes information related to billing cycles, bank draft changes, etc.
- Services from (provider or supplier and date(s):** _____ from: _____ to: _____
(Includes information related to services rendered by a specific provider or supplier, during the specific time period)
- Other:** _____
(Specify other information authorized for disclosure if it is not listed in one of the categories above, please be specific regarding the reason for disclosure)
- Other reason for disclosure (other than "at the request of the individual authorized to do so"):

Length of Time for Which This Authorization is Valid

Under applicable law, this authorization is valid up to 24 months (or a shorter period of time if so indicated) or for a particular event that has occurred, as stated in the authorization. If you are making this authorization for an extended period, the authorization will have to be renewed after its expiration. This authorization will remain in effect until:

- 24 months from the date of signature of this authorization; **or**
- Until _____, but no longer than 24 months from the date of signature.
(Month/Day/Year)
- All information relating to a certain event or injury has been provided (e.g., "Back injury from April 2002" or "formal research").
Specify event(s) and approximate date(s) of event(s) _____

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect the ability to obtain treatment, payment, or eligibility for benefits with BCBSMT. However, there may be consequences with the intended recipient of this information.
- I understand this authorization is not valid without the required signature.
- I understand I have the right to revoke this authorization at any time in writing, except to the extent that Blue Cross and Blue Shield of Montana has already provided the information. To revoke this authorization, contact Customer Service at 1-800-447-7828.
- I understand that the recipient of this information may possibly re-disclose the information to others without my knowledge or authorization therefore; the privacy law may no longer protect my information.

Print Full Name	Signature	Date
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RELATIONSHIP/AUTHORITY

Please check one. Include documentation with this form for items marked with an asterisk (*) below.

- | | | |
|--|---|---|
| <input type="checkbox"/> Member | <input type="checkbox"/> Power of Attorney* | <input type="checkbox"/> Other Personal Representative Designation* |
| <input type="checkbox"/> Parent of Minor Child | <input type="checkbox"/> Legal Guardian* | |

Tracking No:

Name: