



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
Email: micro_imaging@bcbsmt.com**

Read Prior to Completing this Application

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

All family members for whom coverage is desired must be listed. Your spouse, and married or unmarried children or stepchildren up to 26 years of age, may be eligible for coverage, subject to applicable eligibility guidelines. Notice is required from you 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.

Single Coverage for Applicants under 19 years of Age

If the Applicant is eligible for or is covered by a state or federal children's insurance program or a state high risk pool program, or is eligible or is covered as an employee with coverage under any group Contract issued by Blue Cross and Blue Shield of Montana, including HMO Montana, or any Contract issued by a Blue Cross and Blue Shield of Montana partnership or affiliate, then the Applicant is not eligible for a BCBSMT individual plan. Applicants who are eligible for or covered by Medicaid are also eligible for a BCBSMT individual plan.

Single Coverage for Applicants over 19 years of Age

If the Applicant is eligible or is covered as an employee with coverage under any group Contract issued by Blue Cross and Blue Shield of Montana, including HMO Montana, or any Contract issued by a Blue Cross and Blue Shield of Montana partnership, or affiliate, then the Applicant is not eligible for a BCBSMT individual plan.

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 health care providers or others, for any Applicant who is age 19 or older, which may require 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 coverage was issued based upon fraud or intentional misrepresentation of any fact material to the acceptance of the risk assumed by BCBSMT, the entire policy may be subject to cancellation back to its initial effective date, in accordance with applicable law. You are required to supplement your Application responses with any additional information you learned before BCBSMT makes a final decision to issue coverage.

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 fraud or any intentional misrepresentation of a material fact made in this application for coverage.

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:50%; vertical-align:top;"> <input type="checkbox"/> HDHP Premier PPO Options: <input type="checkbox"/> \$3,000 Deductible, 100/0 Coinsurance, \$3,000 Out-of-Pocket Maximum <input type="checkbox"/> \$3,000 Deductible, 70/30 Coinsurance, \$4,000 Out-of-Pocket Maximum <input type="checkbox"/> \$3,000 Deductible, 50/50 Coinsurance, \$5,000 Out-of-Pocket Maximum <input type="checkbox"/> \$5,950 Deductible, 100/0 Coinsurance, \$5,950 Out-of-Pocket Maximum </td> <td style="width:50%; vertical-align:top;"> <input type="checkbox"/> Blue Evolution <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;">Deductible and Out-of-Pocket Maximum</th> <th style="width:20%;">Coinsurance</th> <th style="width:20%;">Primary Care Benefit</th> </tr> <tr> <td></td> <td style="text-align:center;">In Network Out of Network</td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$1,250/\$7,500</td> <td style="text-align:center;"><input type="checkbox"/> 60/40 50/50</td> <td style="text-align:center;"><input type="checkbox"/> \$0</td> </tr> <tr> <td><input type="checkbox"/> \$1,250/\$10,000</td> <td style="text-align:center;"><input type="checkbox"/> 70/30 60/40</td> <td style="text-align:center;"><input type="checkbox"/> \$275</td> </tr> <tr> <td><input type="checkbox"/> \$2,500/\$7,500</td> <td style="text-align:center;"><input type="checkbox"/> 80/20 70/30</td> <td style="text-align:center;"><input type="checkbox"/> \$450</td> </tr> <tr> <td><input type="checkbox"/> \$2,500/\$10,000</td> <td></td> <td style="text-align:center;"><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>			<input type="checkbox"/> HDHP Premier PPO Options: <input type="checkbox"/> \$3,000 Deductible, 100/0 Coinsurance, \$3,000 Out-of-Pocket Maximum <input type="checkbox"/> \$3,000 Deductible, 70/30 Coinsurance, \$4,000 Out-of-Pocket Maximum <input type="checkbox"/> \$3,000 Deductible, 50/50 Coinsurance, \$5,000 Out-of-Pocket Maximum <input type="checkbox"/> \$5,950 Deductible, 100/0 Coinsurance, \$5,950 Out-of-Pocket Maximum	<input type="checkbox"/> Blue Evolution <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;">Deductible and Out-of-Pocket Maximum</th> <th style="width:20%;">Coinsurance</th> <th style="width:20%;">Primary Care Benefit</th> </tr> <tr> <td></td> <td style="text-align:center;">In Network Out of Network</td> <td></td> </tr> <tr> <td><input type="checkbox"/> \$1,250/\$7,500</td> <td style="text-align:center;"><input type="checkbox"/> 60/40 50/50</td> <td style="text-align:center;"><input type="checkbox"/> \$0</td> </tr> <tr> <td><input type="checkbox"/> \$1,250/\$10,000</td> <td style="text-align:center;"><input type="checkbox"/> 70/30 60/40</td> <td style="text-align:center;"><input type="checkbox"/> \$275</td> </tr> <tr> <td><input type="checkbox"/> \$2,500/\$7,500</td> <td style="text-align:center;"><input type="checkbox"/> 80/20 70/30</td> <td style="text-align:center;"><input type="checkbox"/> \$450</td> </tr> <tr> <td><input type="checkbox"/> \$2,500/\$10,000</td> <td></td> <td style="text-align:center;"><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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Desired Plans	<input type="checkbox"/> HDHP Montana: 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 *If more than one person is covered by the same policy, the family coverage deductible would apply.	<input type="checkbox"/> Value Blue <input type="checkbox"/> Other																													
	<input type="checkbox"/> Conversion** **Please verify your eligibility for Conversion prior to filling out this application. Complete only pages 2, top of 3, 6, and 7. Family deductibles and out-of-pocket maximums are two times the amounts shown above for individuals, except for HDHP Montana.																														
Applicant/Subscriber	Social Security Number: _____		Date of Birth (mo/day/yr)	Male/ Female	State or Country of Birth																										
	Last Name	First Name	MI																												
	Applicant/Subscriber Mailing Address			City	State	ZIP Code																									
	Applicant/Subscriber Billing Address (If different from above, please provide. If Electronic Funds Transfer, do not complete.)			City	State	ZIP Code																									
	Billing Address Contact Name:					Home Telephone																									
	Email Address: (Please print clearly)			Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Date of Marriage (mo/day/yr)																									
	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																												
	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 _____																											
OFFICE USE ONLY																															

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)	Date of Birth	Male/ Female	Relationship to Applicant/ Subscriber	State or Country of Birth
	Last Name	First Name	<small>Your SSN will not be used as your Health Plan identification number.</small>	(mo/day/yr)			

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.
 Please do not provide any information regarding any genetic tests you or any family member have had, the results of such tests, or any family medical history (other than medical history requested in this application) that may indicate genetic predisposition to any disease or disorder.

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	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 and provide a pharmacy printout if available.							
Name of Person	Name of Medication and How Often Refilled	Daily Dosage	Condition for Which Medication Was Prescribed or Taken	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	8. <input type="checkbox"/> Diabetes	15. <input type="checkbox"/> Lupus	19. <input type="checkbox"/> Rheumatic Fever	2. <input type="checkbox"/> Alcohol Use	9. <input type="checkbox"/> Drug Use	16. <input type="checkbox"/> Systemic <input type="checkbox"/> Discoid	20. <input type="checkbox"/> Seizure Disorder/Epilepsy
3. <input type="checkbox"/> Blood or Coagulation Disorder	10. <input type="checkbox"/> Eating Disorder	17. <input type="checkbox"/> Mental Disease	21. <input type="checkbox"/> Sleep Apnea	4. <input type="checkbox"/> Cancer	11. <input type="checkbox"/> Heart Murmur	18. <input type="checkbox"/> Nervous System Disorder (e.g., Multiple Sclerosis, Cerebral Palsy, Neuropathy)	22. <input type="checkbox"/> Stroke or Circulatory Problems
5. <input type="checkbox"/> Chemotherapy/Radiation Treatment	12. <input type="checkbox"/> Heart Problems	23. <input type="checkbox"/> Suicide Attempt	24. <input type="checkbox"/> Tumor	6. <input type="checkbox"/> Colon or Intestinal Disorder	13. <input type="checkbox"/> HIV Positive	24. <input type="checkbox"/> Tumor	25. <input type="checkbox"/> Weight Loss Procedure (e.g., gastric bypass)
7. <input type="checkbox"/> Congenital Defect	14. <input type="checkbox"/> Liver Disorder	18. <input type="checkbox"/> Osteopenia/Osteoporosis					
Condition Number (1-25)	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		

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

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 smoked a pipe or cigar or used smokeless tobacco more than once per week during the past year?	Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>
		No	<input type="checkbox"/>	No	<input type="checkbox"/>	No	<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 1/2 pack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
		1/2 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"/>				
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"/>				

Single Coverage for Applicant Under Age 19 only	<p>The following sections regarding Earned Income and Unearned Income are to be filled out <u>only</u> if the Applicant is under 19 years of age and is applying for single coverage. <u>This information will be used to determine if the Applicant may be eligible for a state or federal children's insurance program.</u></p> <p>Earned Income - Please fill out the following information for <u>all</u> family members in the household and list every employer for each adult. (Earned income is your monthly income before taxes are taken out of your wages.)</p>			
	Last Name	First Name	Employer	Earned Income (Gross) Per Month
	Total Monthly Gross Earned Income \$ _____			
	How many adults in the household are working? _____			
	Dependent care expenses, e.g. daycare, are <u>paid</u> for how many persons in the household? _____			
<p>Unearned Income - Please list <u>all</u> monthly sources of unearned income for the family, e.g. child support, Unemployment, Worker's Compensation, etc.</p>				
Last Name	First Name	Source	Unearned Income per Month	
Total Monthly Unearned Income \$ _____				

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: The preexisting exclusion period only applies to members 19 years of age and older. Therefore, if you or your dependents 19 years of age and older, 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
		(mo/day/yr)	(mo/day/yr)	(mo/day/yr)	(mo/day/yr)
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 eligible or 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: _____
- Group coverage too expensive
- Benefit Plan unsuitable
- 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.

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

1. 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.
2. 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.
3. 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.
4. The responses and information I/We have provided in this application and are complete, accurate and current. I/We understand that even if BCBSMT has accepted any dues or premium payment, BCBSMT may decline to issue coverage or may cancel any coverage issued from its beginning based upon any fraud or intentional misrepresentation of any fact that is material to the acceptance of the risk assumed by BCBSMT; with respect to which, had the true facts been made known to BCBSMT, BCBSMT would not have issued any policy or would not have issued the particular policy for which this application is being submitted.
5. 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.
6. I/We understand that a preexisting condition exclusion period may apply, although preexisting exclusion periods do not apply to members under 19 years of age.
7. 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.
8. 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.
9. I/We have received the Notice of Privacy Practices.
10. 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) 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	⋮ ⋮ ⋮

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

1. Have you advised the Applicant/Subscriber to read, complete, and sign this Application form completely and accurately? Yes No
2. 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
3. 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
4. Have you explained the preexisting condition exclusion period to the Applicant/Subscriber? Yes No

Signature of Representative	Date
⋮ ⋮ ⋮	⋮ ⋮ ⋮

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

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 as applicable?

