



Alliance  
BlueCross  
BlueShield

*Diversified*  
Life Insurance Agency  
of Missouri, Inc.

BlueCHOICE®

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# Member Application for HMO Group Coverage

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**For the purposes of this form, the Companies are:** Alliance Blue Cross Blue Shield (ABCBS), which is the name RightCHOICE® Managed Care, Inc. uses to do business in Missouri; its parent company, Blue Cross and Blue Shield of Missouri (BCBSMo); and ABCBS subsidiaries, including BlueCHOICE, which is the name HMO Missouri, Inc. uses to do business. Programs are administered by ABCBS and benefits are underwritten by BlueCHOICE. ABCBS, BCBSMo and BlueCHOICE are independent licensees of the Blue Cross and Blue Shield Association.

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**1. Employment Information**

Employee's Last Name	First Name	M.I.	Date of Full-Time Employment ____/____/____ mo day year	Occupation	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed
Home Address: Street	City	State	Zip Code	County	Home Telephone ( )
Group Name			Group no., if known		Work Telephone ( )

Are you:  a full-time active employee  a retiree  currently off work because of illness or injury  
 a former full-time employee\* *\*If you checked former employee or former covered dependent, give the date you became eligible for continuation of group coverage (mo / day / yr):*  
 a former covered dependent\*

**2. Group Health Coverage Information**

Certain coverages and coverage types **may be required or may not be available to you.** If you are unsure, check with your Group Administrator. If you are declining any of the coverage(s) available to you, be sure to read "Declining Coverage and Applying at a Later Date" on page 4.

<b>Medical coverage</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , please check one coverage type: <input type="checkbox"/> employee <input type="checkbox"/> emp. & spouse <input type="checkbox"/> emp. & children <input type="checkbox"/> family	<b>Type of medical coverage you are applying for (check one):</b> <input type="checkbox"/> BlueCHOICE <input type="checkbox"/> HealthNet Blue POS* <i>*Not available for new group sales.</i>	<b>Dental coverage</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , please check one coverage type: <input type="checkbox"/> employee <input type="checkbox"/> emp. & spouse <input type="checkbox"/> emp. & children <input type="checkbox"/> family
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Do you have any other coverage with us at this time?  Yes  No If **yes**, give current identification #: \_\_\_\_\_

**3. Applicant and Family Information** (Complete for yourself and eligible family members you want to be covered on your membership. Attach an additional sheet if necessary.)

First Name / M.I. / Last (if different)	Social Security Number	Relationship to Applicant	Sex M/F	Birthday Mo/Day/Yr	Height ft / in	Weight	<b>BlueCHOICE applicants only:</b>	
							Primary Care Physician's (PCP) Name*	Office Code #*
<b>Applicant</b>		<b>Self</b>						

*\*If patient is already seeing this doctor and if BlueCHOICE directory shows this doctor's office is accepting current patients only, please attach a letter from the doctor or a BlueCHOICE Primary Office Change Form signed by the doctor, stating that this patient can be added to the doctor's panel of BlueCHOICE patients.*

**A) If you or any dependents are enrolled in Medicare, please give the following information (attach an additional sheet if necessary):**

Name: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_ Medicare Claim No.: \_\_\_\_\_  
 Part A / Part B eff. date(s): \_\_\_\_/\_\_\_\_ Reason(s) for Medicare eligibility:  Age  Disability  End-stage renal disease

**B) Other Medical Insurance Policies** — Are you and/or any family members listed above covered by any other medical insurance **that will remain in effect?**  Yes  No If "yes", please provide the following information for each person listed above who has other coverage. Attach an additional sheet if necessary.

Name of Person Covered:	Coverage Type: <input type="checkbox"/> Individual <input type="checkbox"/> Family	Name and Address of Insurance Company:
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Type of Policy (check one):  individually purchased **or** \* provided through an employer group?

*\*If you checked this box, please provide name of employer: \_\_\_\_\_*

**C) Total Disability** — If you or any family member to be covered is totally disabled, please provide the following information:

Name \_\_\_\_\_ Beginning date of disability: \_\_\_\_\_

Description of disability: \_\_\_\_\_

**4. Health Information (to be completed only by applicants in groups with 26-99 eligible employees)**

**A)** Are you or any family member listed on page 2 now pregnant? . . . . .  Yes  No

**B)** Within the last five years, have you or any family member listed on page 2 been diagnosed or treated for any of the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Back or Neck Disorder         | <input type="checkbox"/> Drug or Alcohol Abuse                   | <input type="checkbox"/> Liver Disorder                   |
| <input type="checkbox"/> Blood Disorder                | <input type="checkbox"/> Heart/Circulatory Disorder              | <input type="checkbox"/> Mental or Nervous Disorder       |
| <input type="checkbox"/> Bone/Joint/Muscular Disorder  | <input type="checkbox"/> High Blood Pressure                     | <input type="checkbox"/> Nervous System/Brain Disorder    |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Human Immunodeficiency Virus (HIV)      | <input type="checkbox"/> Respiratory/Lung Disorder/Asthma |
| <input type="checkbox"/> Diabetes/Pancreatic Disorder  | <input type="checkbox"/> Infertility/Reproductive Organ Disorder | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Digestive/Intestinal Disorder | <input type="checkbox"/> Kidney/Bladder/Urinary Disorder         | <input type="checkbox"/> Tumor or Cyst                    |

Any other condition(s), diagnosed or treated in the last 5 years, not mentioned above: \_\_\_\_\_

**C)** Do you or any family member listed on page 2 take any medicine(s), drugs or pills, or require shots? . . . . .  Yes  No

**If you checked any items in Question B and/or answered “yes” to Question C, please complete the following (use additional application form, if necessary):**

Name of Person	Condition	Dates Diagnosed and Treated	Type of Treatment / Names of Medications	Is Treatment Ongoing?

**5. Life and Disability Products (These coverages are provided through Diversified Life Insurance Agency of Missouri, Inc.)**

**(Complete all appropriate sections below.)**

**Note:** AD&D is not available without Basic Life. Optional Life, Dependent Life, STD and LTD are not available without Basic Life and AD&D. If any of these coverages are paid for by the employer, applicants **must** check “yes” for that coverage. If you are declining any of the coverage(s) available to you, be sure to read “Declining Coverage and Applying at a Later Date” on page 4.

Job Class	Average hours worked per week _____	Earnings \$ _____	per <input type="checkbox"/> Hour <input type="checkbox"/> Month <input type="checkbox"/> Week <input type="checkbox"/> Year
<b>Basic Life</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>AD&amp;D</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Optional Life</b> <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____	<b>Dependent Life</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
		<b>Short-Term Disability (STD)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Long-Term Disability (LTD)</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**Beneficiary Information (for Life and AD&D Benefits):**

Primary Beneficiary's Last Name	First	MI	Relationship to Applicant	Social Security No., if known
Street Address			City	State ZIP
Contingent Beneficiary's Last Name	First	MI	Relationship to Applicant	Social Security No., if known
Street Address			City	State ZIP

**I represent that all information provided on this application is true and complete. I hereby agree to the conditions of enrollment on page 4 of this application.**

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Office Use Only**

<b>Group #</b>	<b>Identification #</b>	<b>Effective Date</b>	<b>Package #</b>	<b>Contract Type</b>
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# Application Agreement

(Please read this before signing application.)

**Applicant/Subscriber** (the person completing and signing this form) **understands and agrees to all the items listed below, on behalf of himself/herself and as the authorized representative of his/her spouse and other covered dependents.**

## **Requesting Coverage:**

Unless indicated otherwise in section 2 of this form, I request the group coverage to which I am entitled, or may become entitled, under the provisions of the Certificate issued by the Companies and/or under the contract of the underwriting life insurance company.

I authorize proper deductions, if any, from my earnings as my contribution toward the cost of this coverage and agree that my employer may act as my agent under this coverage. I understand that I cannot transfer my or my covered dependents' right to receive benefit payments.

I certify that the information provided on this form is true and correct and attest to the eligibility of all persons listed.

I understand that the Companies rely upon the information I provide on this Application in issuing my health coverage. If I omit any information or provide any false or incomplete information, this can result in the cancellation of my coverage. I agree to repay promptly any benefit payment to which I or my dependents were not entitled.

I understand that if I live outside the service area for my program, I must live in a county that the Companies have designated as a *close-proximity* county.

I understand that I will not have an exclusion period for coverage of preexisting medical conditions.

## **Release of Information:**

I will furnish all information required by the Companies.

Any physician, dentist, hospital, clinic, medically-related facility or other provider of health care services or supplies, as well as any insurance or reinsurance company, health services corporation, health maintenance organization, medical information bureau, Medicare fiscal agent, consumer reporting agency, employer or third-party administrator, is authorized and directed to release to the Companies, their affiliates, agents or designees all information relating to any medical history, diagnosis, prognosis, treatment or care provided to me or any of my covered dependents relating to any physical or mental condition, including but not limited to alcohol/substance abuse and HIV.

The Companies, their affiliates, agents or designees are authorized to receive and release such information in connection with investigating, evaluating and/or processing claims; utilization, credentialing, quality or medical management programs; managing the provision of services; insurance; and carrying out any other lawful purpose relating to participation in the health benefits plan.

This authorization remains valid unless I expressly revoke the authorization by notifying the Companies in writing. Any such revocation would not apply to actions taken prior to the revocation or

to the release of any information required or authorized by law.

Also, any such revocation or any refusal to consent to the release of such information to the Companies shall permit the Companies to deny claims for benefits.

## **Declining Coverage and Applying at a Later Date:**

■ **BlueCHOICE:** *If I decide to apply for BlueCHOICE medical coverage later, I understand that I and any dependents will be accepted and I/we will not have an exclusion period for coverage of preexisting conditions. As long as I apply within 31 days after: (1) my other coverage ended because I lost eligibility; (2) the employer stopped contributing to the cost of other coverage; or (3) marriage, or the birth, adoption or placement for adoption of a child, coverage will be effective on the date of the event.*

However, if I wish to apply because of any other situation, I will be considered a Late Enrollee. I will have to wait until my group's next annual open enrollment period before I can enroll.

As a Late Enrollee, my coverage would begin on the first of the month after the Companies receive all necessary information.

■ **HealthNet Blue POS:** *If I decide to apply for HealthNet Blue POS coverage later, I understand that I and any dependents will be accepted. Also, unless my group applies an exclusion period to all enrollees, we will not have an exclusion period for coverage of preexisting conditions as long as I apply within 31 days after: (1) my other coverage ended because I lost eligibility; (2) the employer stopped contributing to the cost of other coverage; or (3) marriage, or the birth, adoption or placement for adoption of a child. Then, coverage will be effective on the date of the event.*

However, if I wish to apply because of any other situation, other rules apply. I will be considered a Late Enrollee and will have an 18-month exclusion period for coverage of care received from non-network providers for any preexisting conditions. However, if I do not receive any medical advice or treatment for any preexisting condition during a continuous 12-month period after coverage begins, then any preexisting conditions will be covered after that 12-month period. In any case, I can reduce or eliminate this exclusion period based on the length of my prior Creditable Coverage, as long as there was no break in that coverage of more than 63 consecutive days.

As a Late Enrollee, my coverage would begin on the first of the month after the Companies receive all necessary information.

■ **If I decide to apply for dental coverage later,** I understand that in most cases I must wait until the next open enrollment period of my group before I can enroll.

■ **If I decide to apply for life and disability coverage later,** I understand that I must complete a health statement and might not be accepted for coverage.