



SELECT FAMILY Individual Products Miscellaneous Change Form Non-Underwritten Changes

P.O. Box 2034 Aurora, IL 60507-2034 888-697-0683

Prem: \_\_\_\_\_ Fee: \_\_\_\_\_ For Home Office Use

To help us process your application promptly, please remember to:

- Print all answers in black ink. Pencil will not be accepted.
• Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line. Parent/guardian must sign if primary applicant is a minor.

PART ONE Check one: [ ] Add Dependent [ ] Cancel Coverage [ ] Downgrade (decrease of benefits)

SECTION A - PERSON(S) APPLYING FOR COVERAGE (please print)

In addition to having a permanent residence in Texas, all persons applying for coverage must be a United States citizen, or if not a citizen, must be able to provide medical records from a licensed U. S. Physician, including but not limited to, a health evaluation conducted within the past two years. All others are ineligible for coverage.

Insured Information

Form with fields for First Name, Middle Initial, Last Name, Social Security #, Sex (M/F), Age, Date of Birth (mo/day/yr), Height (ft., in.), Weight (lbs.), Home Phone #, Business Phone #, Fax #, Occupation/Duties, Spouse's Business #, Residence Street Address, City/State/ZIP, County, Email, and Best place and time to call.

Cancel Coverage

[ ] Health and Dental (If covered for dental, cancelling health coverage automatically cancels dental coverage) [ ] Dental Only [ ] All Dependent(s) Coverage [ ] Cancel Spouse List Name of Dependent(s) to be cancelled \_\_\_\_\_

[ ] Cancel Insured Only - Continue Dependent(s) - a separate Continuation of Coverage Application Form must be completed.

Reason: [ ] Married [ ] Divorced [ ] Deceased [ ] Other \_\_\_\_\_

Cancelling all dependents from family coverage will change the deductible to an individual deductible and out-of-pocket maximum.

Add Dependent

Dependent CHILDREN you wish to cover (dependent children must be under age 25 and unmarried).

Table with 10 columns: Name (First, Middle Initial, Last), Relation (spouse or child), Sex (M/F), Height (ft., in.), Current Weight (lbs.), Date of Birth (mo/day/yr), Social Security Number, and Court Ordered for Dependents (Yes/No).

Is any Dependent coverage required by court order? [ ] Yes [ ] No If "yes," was it effective within the last 30 days? [ ] Yes [ ] No If "yes," to apply for court-mandated coverage for Dependent children, contact Blue Cross and Blue Shield of Texas for the appropriate form.

Please complete all pages 1-3.

**SECTION B – CHANGE HEALTH COVERAGE (please choose only one plan)**

Change Deductible To: (If changing to a higher deductible. If changing to a lower deductible form IND-MCF-UW-1 must be completed.)

- Select 2000<sup>SM</sup> Deductible Plan       \$250       \$500       \$1,000       \$2,500       \$5,000       \$8,000       \$10,000
- PPO Select<sup>SM</sup> Deductible Plan       \$250       \$500       \$1,000       \$2,500       \$5,000       \$8,000       \$10,000

**PPO Select<sup>®</sup> Advantage (make selection below)**

Options	Deductibles		Physician Office Visit Copayment	Coinsurance Amounts		Prescription Drug Plan	
	Network Individual/Family	Out-of-Network Individual/Family		Network Individual/Family	Out-of-Network Individual/Family	Brand	Generic
Plan I <input type="checkbox"/> Plan II <input type="checkbox"/>	\$250/\$750 \$500/\$1,500	\$500/\$1,500 \$1,000/\$3,000	\$20	\$2,000/\$4,000	\$3,000/\$6,000	\$20	\$12
Plan III <input type="checkbox"/> Plan IV <input type="checkbox"/>	\$1,000/\$3,000 \$2,500/\$7,500	\$2,000/\$6,000 \$5,000/\$15,000	\$25	\$3,000/\$9,000	\$5,000/\$15,000	\$25	\$15
Plan V <input type="checkbox"/> Plan VI <input type="checkbox"/> Plan VII <input type="checkbox"/> Plan VIII <input type="checkbox"/>	\$2,500/\$7,500 \$5,000/\$15,000 \$8,000/\$24,000 \$10,000/\$30,000	\$5,000/\$15,000 \$10,000/\$30,000 \$15,000/\$45,000 \$20,000/\$60,000	\$30	\$5,000/\$15,000	\$8,000/\$24,000	\$30	\$20

**PPO Select<sup>®</sup> Saver (make selection below)**

Options	Health Deductible		Coinsurance Amount		Prescription Drug Plan			
	Network Individual/Family	Out-of-Network Individual/Family	Network	Out-of-Network	Generic	Preferred Brand Name	Non-Preferred Brand Name	Deductible
Plan I <input type="checkbox"/>	\$500/\$1,500	\$1,000/\$3,000	\$3,000/\$9,000	\$5,000/\$15,000	\$10	\$50	\$65	\$100
Plan II <input type="checkbox"/> Plan III <input type="checkbox"/>	\$1,000/\$3,000 \$1,500/\$4,500	\$2,000/\$6,000 \$3,000/\$9,000	\$3,000/\$9,000	\$5,000/\$15,000	\$10	\$50	\$65	\$200
Plan IV <input type="checkbox"/> Plan V <input type="checkbox"/> Plan VI <input type="checkbox"/> Plan VII <input type="checkbox"/>	\$2,500/\$7,500 \$5,000/\$15,000 \$8,000/\$24,000 \$10,000/\$30,000	\$5,000/\$15,000 \$10,000/\$30,000 \$16,000/\$48,000 \$20,000/\$60,000	\$3,000/\$9,000	\$5,000/\$15,000	\$10	\$50	\$65	\$300

**PPO Select<sup>®</sup> Choice (make selection below)**

Options	Health Deductible		Physician Office Visit Copayment	Coinsurance Amount		Prescription Drug Plan			
	Network Individual/Family	Out-of-Network Individual/Family		Network	Out-of-Network	Generic	Preferred Brand Name	Non-Preferred Brand Name	Deductible
Plan I <input type="checkbox"/> Plan II <input type="checkbox"/>	\$250/\$750 \$500/\$1,500	\$500/\$1,500 \$1,000/\$3,000	\$25	\$3,000/\$6,000	\$5,000/\$10,000	\$15	\$25	\$40	\$100
Plan III <input type="checkbox"/> Plan IV <input type="checkbox"/>	\$1,000/\$3,000 \$1,500/\$4,500	\$2,000/\$6,000 \$3,000/\$9,000	\$25	\$3,000/\$6,000	\$5,000/\$10,000	\$15	\$25	\$40	\$200
Plan V <input type="checkbox"/> Plan VI <input type="checkbox"/> Plan VII <input type="checkbox"/> Plan VIII <input type="checkbox"/>	\$2,500/\$7,500 \$5,000/\$15,000 \$8,000/\$24,000 \$10,000/\$30,000	\$5,000/\$15,000 \$10,000/\$30,000 \$16,000/\$48,000 \$20,000/\$60,000	\$25	\$3,000/\$6,000	\$5,000/\$10,000	\$15	\$25	\$40	\$300

**PPO Select<sup>®</sup> Blue Advantage (make selection below)**

Options	Deductibles		Copayment Amounts		Coinsurance Amount		Prescription Drug Plan		
	Network Individual/Family	Out-of-Network Individual/Family	Office Visit	Emergency Room Visit (Facility Only)	Network Individual/Family	Out-of-Network Individual/Family	Copayment Amounts		
							Generic	Preferred Brand Name	Non-Preferred Brand Name
Plan I <input type="checkbox"/> Plan II <input type="checkbox"/>	\$250/\$750 \$500/\$1,500	\$500/\$1,500 \$1,000/\$3,000	\$30	\$75	\$2,000/\$4,000	\$3,000/\$6,000	\$12	\$25	\$40
Plan III <input type="checkbox"/> Plan IV <input type="checkbox"/>	\$1,000/\$3,000 \$1,500/\$4,500	\$2,000/\$6,000 \$3,000/\$9,000	\$35	\$75	\$3,000/\$6,000	\$5,000/\$10,000	\$15	\$30	\$45
Plan V <input type="checkbox"/> Plan VI <input type="checkbox"/> Plan VII <input type="checkbox"/> Plan VIII <input type="checkbox"/>	\$2,500/\$7,500 \$5,000/\$15,000 \$8,000/\$24,000 \$10,000/\$30,000	\$5,000/\$15,000 \$10,000/\$30,000 \$16,000/\$48,000 \$20,000/\$60,000	\$45	\$75	\$5,000/\$10,000	\$8,000/\$16,000	\$20	\$35	\$50

Applicant name: \_\_\_\_\_

Subscriber no. \_\_\_\_\_

**Change Name/Address**

New Name _____	Reason for Change	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
New Address _____	City _____	State _____	ZIP _____
Home Phone # (     ) _____	Effective Date of Change _____		

As a Supplement to my previous application, I request the change(s) in coverage as indicated on page 1. I understand that fraud or any intentional misrepresentation of a material fact knowingly made by me in this Supplement to my Application, **including, if applicable, the Health Statement**, on page 2 may result in rescission of coverage or denial of a claim under the terms of the policy(ies) of those for whom I am applying for coverage.

**Medical Authorization:** I authorize any hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

**Important:** Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant's* Signature: _____	Date Signed: _____
Spouse's signature (ONLY if to be insured): _____	Date Signed: _____
*Parent/Guardian Signature (if Primary Applicant is a Minor): _____	Date Signed: _____
Dependent's Signature (ONLY if 18 or over and only to be insured): _____	Date Signed: _____
Dependent's Signature (ONLY if 18 or over and only to be insured): _____	Date Signed: _____