

Miscellaneous Change Form

Section 1 Insured Information

My name is now recorded as:		Subscriber #	Group #	Date of Birth			Hgt.	Wgt.
Last	First	Middle Initial		Mo.	Day	Year		
Home Address			City	State	ZIP	Home Phone # ()		
						Work Phone # ()		
E-mail Address								
Occupation		Name of Employer			Employer's Phone #			
					()			

Section 2 Add Dependent Coverage Health & Dental Health Only

Important

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

Relationship	Name:	Last	First	MI	Occupation	Social Security #	State of Birth	Date of Birth	Hgt.	Wgt.
<input type="checkbox"/>	Husband									
<input type="checkbox"/>	Wife									
<input type="checkbox"/>	Son									
<input type="checkbox"/>	Daughter									
<input type="checkbox"/>	Son									
<input type="checkbox"/>	Daughter									
<input type="checkbox"/>	Son									
<input type="checkbox"/>	Daughter									

Section 3 PPO Select Basic Health Plan Selection (make selection below)

Add Dependents as indicated in Section 2 Change Health Deductible: (If changing to **lower** Deductible—complete pages 2 and 3.)

PPO SELECT BASIC

Options	Health Deductibles		Coinsurance Amounts		PDP			
	Network Individual/Family	Out-of-Network Individual/Family	Network	Out-of-Network	Generic	Preferred Brand Name	Non-Preferred Brand Name	Deductible does not apply to Generic Drugs
Plan I <input type="checkbox"/>	\$1,500/\$4,500	\$3,000/\$9,000	\$3,000/\$9,000	No Limit	\$10	\$50	\$65	\$500
Plan II <input type="checkbox"/>	\$2,500/\$7,500	\$5,000/\$15,000						
Plan III <input type="checkbox"/>	\$3,500/\$10,500	\$7,000/\$21,000						
Plan IV <input type="checkbox"/>	\$5,000/\$15,000	\$10,000/\$30,000						

Section 4 Cancel Coverage

Health and Dental (If covered 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 _____

HEALTH STATEMENT

Please Complete the Following Health Questions: For this insurance to be in force, you must answer the following health questions fully and truthfully and provide all of the health information asked for, including routine physical examinations, and Blue Cross and Blue Shield of Texas must approve this supplement to your application. No one may change this requirement for you in any way. If you commit fraud or intentionally misrepresent any information required on any enrollment form, your coverage may later be rescinded. Rescission voids your coverage from the effective date, and any premiums already paid (less any benefits paid) will be refunded. **Please do not mark over or strike out any signature, date or health question information. Important! Do not cancel any existing health coverage until notified of your acceptance.**

If you answer "Yes" to ANY questions on this page, please give details on the next page. Please note the timeframe reference for each question.

1. Has any person applying for coverage been advised to seek treatment for alcohol use or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism within the last **10 years**? Yes No
2. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use or dependency within the last **10 years**? Yes No
3. Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last **10 years** for the following: Please check Yes or No. If any boxes are checked "Yes" (Yes), also circle the condition, e.g. (**migraines**) and give details on the next page.

<p>A. Migraines; headaches; carpal tunnel syndrome; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" to HBP, provide 3 readings and their dates w/in the last year _____ and _____ and _____</p> <p>D. Varicose veins/spider veins/varicosities; elevated cholesterol or lipids; anemia; blood clot or any other blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; or any breathing difficulty, lung or respiratory disease, disorder or condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>F. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach or duodenum, or any other digestive disorder or condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>G. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? (indicate type of hepatitis _____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>H. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? (indicate diagnosis and location _____) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I. Acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other skin disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>J. Kidney stones; reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>K. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>L. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; bunions; joint replacement; or manipulation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>M. Thyroid disorder; goiter; Graves disease; diabetes; lupus; pituitary or adrenal disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>N. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>O. Has anyone applying for coverage ever been diagnosed as having or told by a medical doctor that you have AIDS, HIV, or ARC disorders? .. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>P. Have you or any person applying for coverage ever been tested positive for antibodies for the AIDS virus? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Q. Has any person applying been diagnosed by a member of the medical profession as having AIDS and/or has any proposed insured received treatment from a member of the medical profession for AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>R. Questions for Male Applicants and Dependents Only Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>S. Questions for Female Applicants and Dependents Only Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
--	---
4. During the last **5 years**, has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist? Yes No
5. Has any person applying for coverage been prescribed or taken any medications due to sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss in the last **12 months**? Yes No
6. Have you, your spouse (if to be insured), or any child (if to be insured) smoked or used any tobacco products – such as cigarettes, pipes, cigars, snuff or chewing tobacco – in the last **12 months**? YOU Yes No YOUR SPOUSE Yes No YOUR CHILD Yes No. If Yes,
 Name(s) _____
7. A. **Question for Female Applicants and Dependents Only:** Is any female applying for coverage now pregnant? Yes No
 B. **Question for Male Applicants and Dependents Only:** Is any male applying for coverage now an expectant parent? Yes No
 If "Yes" to either question, coverage cannot be offered.
8. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin or penile implant), internal fixation (e.g. pins, plates or screws), prosthesis, pacemaker, valve replacement, shunt or monitoring device? Yes No
9. Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery which has not yet been performed? Yes No
10. Has any person applying for coverage **ever** been hospitalized or been treated in the emergency room or had any physical impairment, deformity, congenital anomaly, sickness, operation, injury or hospitalization other than admitted to on this page? Yes No
11. Is each person applying for coverage a permanent resident of Texas, except for court-ordered Dependents? Yes No

Applicant's Name: _____ Subscriber No. _____

DETAILS OF MEDICAL HISTORY:

If you answered "Yes" to ANY questions on the previous page, please provide further information using the chart below.

Be sure to use the "correct" example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

	Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment, Advice Given, and Medications Prescribed	Name, Address and Phone Number of Doctors and Hospitals
			What is it?	Date that is Started	Date of Recovery (if applicable)			
Correct Example:	3C	Joe Smith	high blood pressure	6/95	none	no, ongoing	40mg Atenolol once	Dr. Jones St. Mary's Peoria, IL (309) 555-1212

Change Name/Address

New Name _____ Reason for Change Married 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: _____

Do Not Write in Spaces Below

Approved Preferred <input type="checkbox"/>	Underwriter _____	The following named Applicant(s) shall not be included for coverage under this Contract: _____
Approved Standard <input type="checkbox"/>	Decision Date _____	
Approved Preferred w/Rider <input type="checkbox"/>	Effective Date _____	
Approved Standard w/Rider <input type="checkbox"/>	Condition/Waiver _____	
Declined <input type="checkbox"/>	_____	
Incomplete <input type="checkbox"/>	Smoker/Tobacco User: <input type="checkbox"/>	_____
	Non-Smoker/Tobacco User: <input type="checkbox"/>	_____