BlueCross BlueShield of Texas

Employee/Retired Employee Name_____ **SSN or Benefits ID** _____

Additional explanation of "Yes" answers in Section D - Please provide details of "Yes" answers below and please remember to sign and date it.

Q#	Person	Medical Condition	Dates From / To	Hospitalized Yes / No	Surgery Yes / No	Treatment / Medication	Current Medication / Remaining Problems	Names and Addresses of Physicians and Hospitals

X_____ _____ (____)_____ (____)_____

Signature of Employee/Retired Employee **Date Signed** **Daytime Phone** **Evening Phone**

X_____ _____ (____)_____ (____)_____

Signature of Spouse (if requesting insurance) **Date Signed** **Daytime Phone** **Evening Phone**

***Remember*: You must complete this application in its entirety to be considered for coverage. Return this application to: Blue Cross and Blue Shield of Texas Administrative Offices, Attn: Medical Underwriting Dept. P.O. Box 7072 Downers Grove, IL 60515**

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