

Attention

The individual product which you are applying for is a medically underwritten product offered by Blue Care Network. If you are age 19 and over, you must provide evidence of good health in order to be eligible for this health plan.

If you have received treatment for certain medical conditions within the last five years, including taking prescription drugs, you may not be eligible for this product. If you apply and are not eligible for this health care plan, you should consider enrolling in one of our MyBlueSM health care plans offered by Blue Cross Blue Shield of Michigan.

Please note, medical underwriting does not apply during the Annual Open Enrollment Period which is January 1st – January 31st every year.

For more information, contact your Blues-contracted agent, call 1-877-4MY-BLUE (877-469-2583) or visit [bcbsm.com/myblue](https://www.bcbsm.com/myblue).



**Blue Care
Network**
of Michigan

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A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

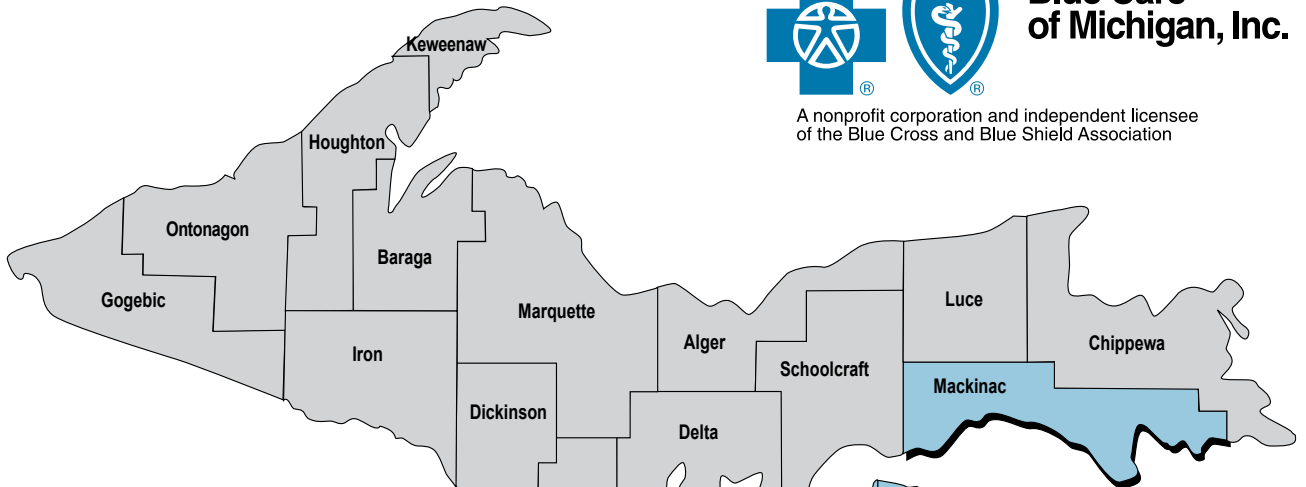
Enrollment Form Personal Plus

a health care plan for individuals

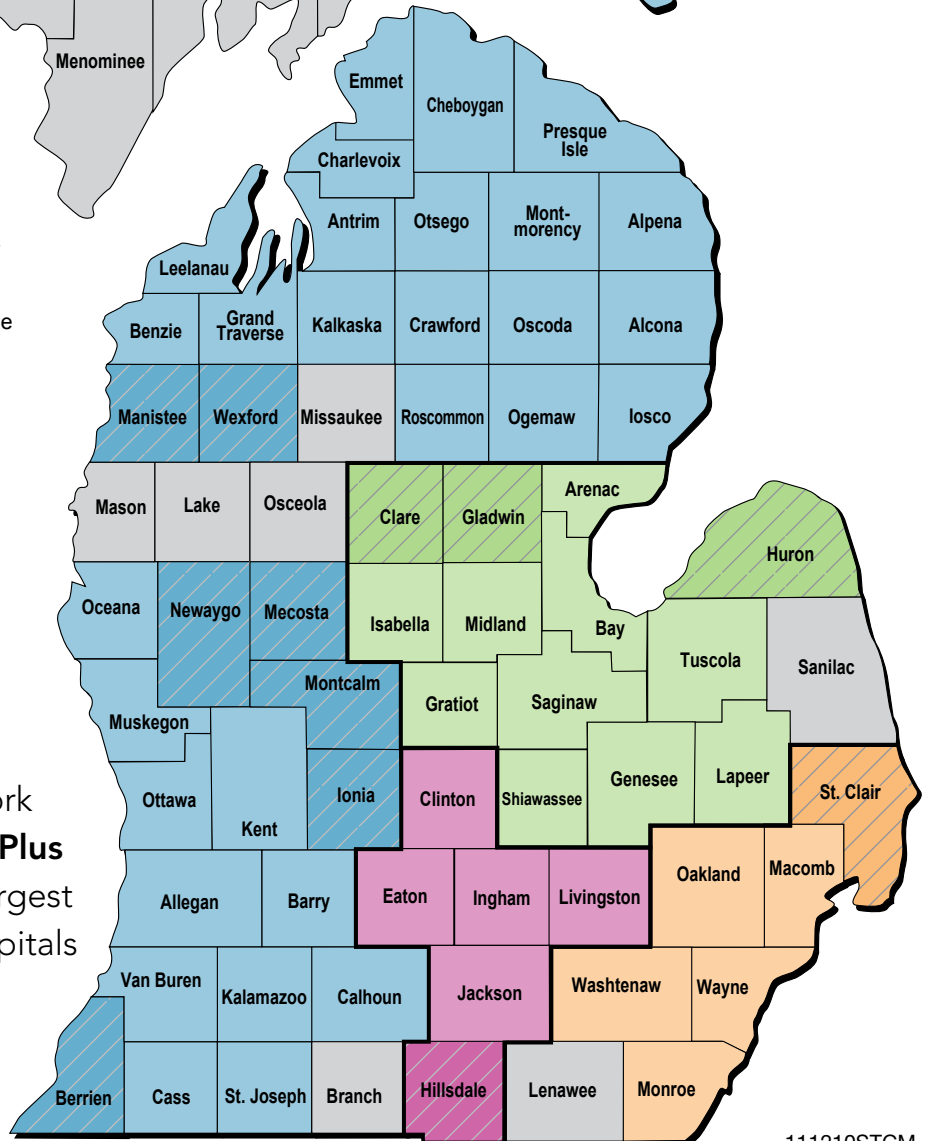
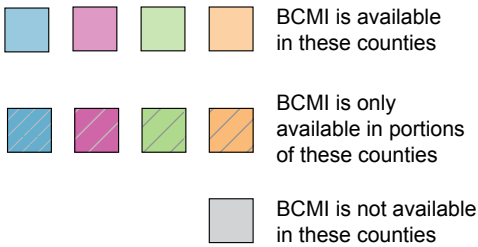


**Blue Care
of Michigan, Inc.**

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association



Service Map



Personal Plus is offered by Blue Care of Michigan Inc., an affiliate of Blue Care Network of Michigan. To find **Personal Plus** providers, search the state's largest network of physicians and hospitals at MiBCN.com/find.

Application for Individual Coverage Enrollment or Change of Status Form

Personal Plus

To be eligible for this coverage, you must live in the state of Michigan at least nine months of the year, be under age 65 and not be eligible for Medicare.

Personal Plus coverage begins the first day of the effective month. Requested effective first day of _____ (month).

Application deadline is the tenth of the previous month. Your application must be received by Blue Care of Michigan Inc. within 30 days of the signature date. Your requested effective date may not be more than 60 days after the signature date. Your requested effective date is subject to the Underwriting department's approval of your application and may change. Dependent children must be age 25 or younger to be eligible for coverage.

Do not send payment with your application. You will receive an invoice for your first payment.

Part I: Applicant information

Applicants	Applicant Social Security number		Applicant last name			Applicant first name		M.I.	Evening phone number (with area code)		Daytime phone number (with area code)	
	Street address (P.O. Box may not be entered)				City		State	ZIP code		County		Current marital status <input type="checkbox"/> Single <input type="checkbox"/> Married
	Applicant's driver's license or state ID number			Issue state	Expiration date		Spouse's driver's license or state ID number			Issue state	Expiration date	
	You may be contacted for a phone interview. What time and number are best for us to reach you for an interview? Time (between 8 a.m. and 4 p.m. Eastern Time)										Phone number	
	List all persons to be added or deleted from contract (attach additional sheet if necessary)						Primary care physician name		Check a physician, look up a provider code, check location and more at MiBCN.com/find .			
	Circle one	Last name	First name	M.I.	Gender M or F	Rel. code ¹	Last name	First name	Physician code (10 digit NPI number)		Physician city	
Applicant	Add Delete											<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse	Add Delete											<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent	Add Delete											<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent	Add Delete											<input type="checkbox"/> Yes <input type="checkbox"/> No

¹Relationship code			Type of application:		
N - Child (by birth or adoption)	P - Principal support ²	C - Court ordered coverage (QMCSO) ³	<input type="checkbox"/> New application		
S - Stepchild	A - Child adoption in progress ³	D - Disabled child (MCL 500.2264a) ⁴	<input type="checkbox"/> Add spouse or dependents to current contract # _____		
² Attach legal documentation	L - Legal guardianship	⁴ Attach physician statement	<input type="checkbox"/> Delete spouse or dependents from current contract # _____		
	³ Attach court order		<input type="checkbox"/> Change of address. (Provide address above.)		
			Effective date of change _____		
			Subscriber signature _____		

Part II: Eligibility information

- Do all individuals listed live in Michigan nine months or more each year? Yes No
 - Are any individuals listed above:
 - Eligible for Medicare? Yes No If yes, provide name: _____
 - Eligible for an employer-sponsored health plan? Yes No If yes, provide name of applicant and employer name: _____
 - Enrolled in an employer-sponsored health plan through the applicant's or spouse's employer? Yes No If yes, provide the following information: Name of applicant: _____
- Name of employer: _____ Name of carrier: _____ Contract number: _____ Date the coverage will end: _____

3. Under this individual health plan, for which you are applying, will your employer or your spouse's employer pay for or reimburse you for any portion of the premium? Yes No

For BCMI use only

MA Code	Agent number	Assoc./Chamber code	Contract number	Service code	Effective date
			Underwriter	Pre-existing date	De-identified ID number

Instructions for completing the *Application for Individual Coverage Enrollment or Change of Status Form*

All sections must be completed.

Part I: Applicant information

- The address should include apartment number if applicable. Do not enter a P.O. Box.
- List all persons that you wish to cover (including yourself) and identify their relationship to you (e.g., child, stepchild).
- In divorce or paternity cases, include appropriate relationship code. Legal documentation must be attached (e.g., divorce decree, custodial decree).
- Indicate the name of a Blue Care Network primary care physician selected for each person listed. In addition, include physician code (10-digit NPI number) and location (street and city).
- Check “Yes” or “No” whether each person has been seen by the physician within last 12 months or is current patient.
- Applicants may locate a primary care physician or the NPI# of their PCP online at **MiBCN.com**, or by calling Customer Service at 1-800-662-6667.
- Please indicate if this is a new application or a change to an existing contract (e.g., adding or removing a dependent or a change of address). If adding or removing dependents, please provide their information in Part I.

Part II: Eligibility information

If any person listed has other medical insurance coverage either through an employer or on an individual basis, indicate the person covered and complete the requested information.

Part III: Health questionnaire

All questions in Section 1, 2 and 3 must be answered or the application may be returned or rejected.

Part IV: Terms and conditions for coverage

Read the terms and conditions for coverage. Sign and date the form before submitting it to the address below.

Return completed enrollment form to:

Individual Business Underwriting/Personal Plus — Mail Code 1124
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226
313-983-2286 **Only** completed Personal Plus applications are accepted at this number

Customer Service inquiries:

1-800-662-6667 or 1-800-257-9980 (TTY)
8 a.m. to 5:30 p.m. Monday through Friday

Part III: Health questionnaire

Instructions: Please print clearly and answer all questions.

Applicant name		Last name	First name	Middle name
Home phone ()	Work phone ()	Mobile phone ()	Birth date	Month Day Year — — —
Social Security number	— — —	Marital status	<input type="checkbox"/> Single	<input type="checkbox"/> Married
Address		Number and street		
City	State		ZIP code	

List all persons to be covered. Attach additional sheets if necessary.

Member Letter	Full name	Sex	Relationship to applicant	Date of birth	Height ¹	Weight ¹	Social Security number (must include for all members age one or older)
A			Applicant				
B			Spouse				
C							
D							
E							
F							
G							
H							
I							

¹Height and weight are not required for dependents age 18 and under.

Section 1

All questions must be answered “Yes” or “No” or the application may be returned or rejected. If you answer “Yes” to any questions, provide details in Section 2.

In the last five years, has any person age 19 or older listed on this application been advised, counseled, tested, diagnosed, treated, hospitalized, taken any medication for, or had treatment recommended for any of the following conditions?

A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraines, headaches, seizure disorder, epilepsy, multiple sclerosis, paralysis, restless leg syndrome, any neurological disorder, or any disorder of the central nervous system?
B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Memory loss, dementia, narcolepsy, Alzheimer’s disease?
C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attention deficit disorder; anxiety; depression or chemical imbalance; any emotional, behavioral or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy, marital or any other form of counseling or therapy?
D	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chest pain, arrhythmia or palpitations, heart murmur, mitral valve prolapse, heart attack, bypass or angioplasty or stent, stroke or transient ischemic attack (TIA), any other heart or circulatory disorder or condition, hypertension or high blood pressure? If yes to high blood pressure give last three readings and dates:
E	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Elevated cholesterol or lipids, varicose veins, varicosities, anemia, blood clot, any other blood disorder?
F	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma, allergies, sinusitis, bronchitis, pneumonia, respiratory syncytial virus (RSV), tuberculosis, sleep apnea, chronic obstructive pulmonary disease (COPD), emphysema, any breathing difficulty, lung or respiratory disease, disorder or condition?
G	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia, colitis, chronic diarrhea or intestinal problems, hemorrhoids or rectal disorder, gastroesophageal reflux disease (GERD), any disorder of the esophagus, ulcer of the stomach, diverticular disease or any other digestive disorder or condition?
H	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any disease or disorder of the gallbladder, pancreas or liver, elevated liver function tests, cirrhosis, hepatitis? If yes to hepatitis, indicate type:
I	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer, tumor, growth, cyst, polyp, enlarged lymph nodes, leukemia? If yes indicate diagnosis and location:
J	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Acne, keratosis, psoriasis, basal cell carcinoma, skin lesions, eczema or any other skin disorder?
K	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney stones, kidney reflux, urinary incontinence, any infection or disorder of the urinary tract, bladder or kidney?
L	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breast cyst or nodule, gynecomastia, fibrocystic breast disease, breast implants, any other disease or disorder of the breast?
M	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis (osteo, rheumatoid or psoriatic), bursitis, herniated, bulging or slipped disk, gout, temporomandibular joint disorder (TMJ), any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles or joints, bunions, carpal tunnel syndrome, joint replacement, manipulation or subluxation therapy, spinal fusion?
N	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes, thyroid disorder, goiter, Graves disease, lupus, pituitary or adrenal disorder?
O	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cataracts, glaucoma, hearing loss, deviated nasal septum, any other eye, ear, nose or throat disorder?
P	<input type="checkbox"/> Yes	<input type="checkbox"/> No	AIDS, AIDS-related complex (ARC) or HIV positive, any other immune disorder?
Q	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Males only: Prostate disorder, elevated prostate specific antigen (PSA), sexually transmitted disease, genital warts, herpes, impotence, infertility, any other disease or disorder of the genital or reproductive system?
R	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Females only: Fibroid or uterine tumor, ovarian cyst, polycystic ovary syndrome (PCOS), endometriosis, cystocele/rectocele, infertility, sexually transmitted disease, genital warts, herpes, abnormal pap smear, any other disease or disorder of the genital or reproductive system?
S	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol use or abuse, alcoholism, substance abuse, drug addiction?
T	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is any person applying for coverage now pregnant or an expectant parent?
U	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage ever had an implant, internal fixation (pins, screws or plates), prosthesis, pacemaker, valve replacement, shunt or monitoring device?
V	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage had a physical examination (including check ups), diagnostic tests, consulted a physician, chiropractor or therapist? For each person applying for coverage, please provide details of their last physical in Section 3 .
W	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy or surgery which has not yet been performed?
X	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has any person applying for coverage ever been hospitalized or treated in the emergency room, or had any physical impairment, deformity, congenital anomaly, sickness, operation or injury other than those listed above?

Note: Answers given for dependents under age 19 will not be used to determine if the dependent is eligible for the plan.

In the last five years has any person age 19 years or older¹ applying for coverage been prescribed any medications?

Yes No If yes, provide details below.

Family member	Medication and dosage	Illness for which medication is prescribed	Date prescribed	Date discontinued

Section 2 If you answered yes to any of the medical questions in **Section 1**, provide details (attach additional sheet if necessary):

Letter of question	Family member	Illness or condition	Date illness began	Date of recovery (if applicable)	Complete recovery? Yes or No	Type of treatment	Name, address and phone of doctors and hospitals

Section 3 Details of the last physical exam of each family member age 19 or older¹:

Family member	Date of last physical exam	Tests done	Test results

Section 4 Additional information:

Have you ever been or are you now a member of Blue Care Network or Blue Cross Blue Shield of Michigan? Yes No

If yes, date of coverage: _____ Contract number: _____ Contract holder's name: _____

Has anyone applying for coverage age 19 or older¹ used tobacco products in the past 12 months? Yes No

If yes, applicant's name: _____ Date last used tobacco: _____

Note: You may be asked to complete and have your primary care physician sign a Personal Plus Smoking Status Form. We will mail it to you. If you answered no, you may be required to take a nicotine screening.

¹ Answers provided for dependents under age 19 will not be used to determine if the dependent is eligible for the plan.

Part IV: Terms and conditions for coverage

- I understand that acceptance of my application will be subject to medical underwriting.
- I understand that approval of this application and coverage effective date will be determined by Blue Care of Michigan Inc. and shall be subject to requirements by BCMI for additional information and payment of bills.
- I understand that I am applying for myself and eligible members of my family for health coverage in the individual health plan offered by BCMI. The coverage shall not exceed those benefits and services contained on the certificates and riders.
- I may enroll my legal spouse and eligible dependents who reside in BCMI's service area. Eligible dependents are defined as children of mine or my spouse, by birth, legal adoption, foster parenthood or legal guardianship. Eligible dependents must be 25 years of age or younger to enroll. I may not enroll myself, my spouse or any dependents who are eligible for, beneficiaries of, or recipients of Medicare or who are eligible for any employer sponsored-health benefit plan.
- I understand that coverage for my dependent children will end on the last day of the year in which they reach age 26. These dependent children may apply for their own Personal Plus coverage.
- On behalf of myself and my enrolled family members, I agree that all our medical services must be performed, prescribed, directed or authorized by our designated BCMI primary care physicians except in the case of an immediate and unforeseen medical emergency as those terms are defined in the coverage documents.
- I request that payment of insurance company or HMO benefits be made payable to BCMI on my behalf for any services furnished to me by BCMI.
- With regard to costs of hospital and medical services delivered by or paid for by BCMI, I agree to assign to BCMI, my entire right to recovery of those costs against any person or organization as a result of accident or disease including injuries or disease claimed under workers compensation laws or acts whether by redemption award or voluntary payment or otherwise.
- I understand that I may protest a proposed amendment in this contract or rate changed within 30 days of receipt of notice, and that my continued payment, while an appeal is in progress, shall not be deemed to constitute acceptance of the proposed amendment or rate change.
- I understand that I may cancel this contract within 10 days of signing this form. If I or any eligible members of my family incur any claims during this 10 days time frame, I will be responsible for payment of these claims. BCMI will have no liability.

Pre-existing conditions

- I understand that during the six month period following the effective date, neither I nor my enrolled family members age 19 or older will be covered for any and all conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before my enrollment. The term "conditions" includes, but is not limited to, maternity care, obstetrical care and termination of pregnancy. I understand that my enrollment date begins on the effective date of coverage as determined by BCMI.

Authorization for use and disclosure of Protected Health Information

- I understand that BCMI may collect personal and protected health information about me in order to complete my application for coverage. BCMI will use and disclose this information only in accordance with their *Notice of Privacy Practices* which is available on **MiBCN.com** or by calling 313-225-9000.

I authorize:

- Use and disclosure of my PHI, including membership, eligibility and claims data stored on BCMI, Blue Care Network of Michigan, Blue Cross Blue Shield of Michigan and its subsidiaries' or affiliates' computer systems.
- Physicians, health care professionals, hospitals, clinics, laboratories, pharmacies or pharmacy benefits managers, or other health care providers that have provided treatment or services to me or any of my dependents age 19 years or older who are also applying for coverage to disclose medical records, prescription history, medications prescribed and other PHI as requested to BCMI.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or who have knowledge of my medical information or the medical information of any of my dependents age 19 years or older who are also applying for coverage, to disclose medical records information, prescription history, medication prescribed and other PHI as requested to BCMI.

My authorizations include disclosure of information on the diagnosis and treatment of human immunodeficiency virus infection and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes disclosure of psychotherapy notes. (As applicable, any applicant age 18 years or older must sign below to indicate authorization to disclose such information to BCMI.)

This authorization includes and applies to any and all protected health information related to treatment or services where I have requested a restriction, or for any health care item or service for which the health care provider has been paid out of pocket in full.

This PHI is to be disclosed so that BCMI may: (1) perform case, care and disease management, (2) administer claims and determine or fulfill responsibility for coverage and provision of benefits, and (3) for other legally permissible purposes, including but not limited to, health care operations. If PHI is disclosed under your authorization to persons or organizations that are not subject to federal privacy laws, it may be redisclosed and no longer protected.

I understand that my enrollment with BCMI is conditioned upon my authorization to release PHI for the purposes stated above and that if I do not provide authorization I may not be eligible for enrollment. My signature on this form indicates my approval for the release of PHI from BCMI and from any of the parties listed above to BCMI. A photographic copy of this authorization shall be valid as the original.

This authorization will expire after 30 months from the signature date. I understand that I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request on a standard form available online at **MiBCN.com** or by contacting my agent. I understand that revocation will not affect actions taken before BCMI or any of the parties identified above receive my request.

I certify that the above information is true, correct, and complete to the best of my knowledge. I authorize Blue Care of Michigan to obtain any and all records from providers of service, including but not limited to, records regarding the above conditions, treatment, surgeries, tests, prescriptions and other information that BCMI deems necessary. I understand that the information will be used in reviewing my application and administering coverage, and that my failure to provide complete and accurate answers or my submission of false or misleading information may result in voiding of coverage for myself, denial of claims or cancellation of coverage.

Signature of applicant

Date

Signature of applicant's spouse

Date

Signature of dependent age 18 or older

Date

Agent name

Agent number

Managing agent or general agent name

Managing agent or general agent number

Agent signature

Date