BlueCross BlueShield of Texas

Applicant Name: _____

SSN#: _____

Member ID: _____

HOME OFFICE USE ONLY

2017 Individual Plan

New Application or Change in Coverage

To help us process your application promptly, follow the instructions.

1	Print all answers in **blue or black ink**. Pencil will not be accepted.
2	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.
3	If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information.
4	Please do not use correction fluid or tape.

Please submit your application via mail or fax or by calling an agent of Blue Cross and Blue Shield of Texas (BCBSTX), a division of Health Care Service Corporation, at 800-531-4456. Please complete the entire application including the selection of a Billing Method in Section D. Please note: If you are applying during a Special Enrollment Period (SEP), proof of a qualifying event must be included to complete your application. Failure to provide appropriate SEP documentation will delay processing of the application.

If you are working with a BCBSTX agent, please remember to include the name of your agent on the back of this application.

APPLY ONLINE	bcbstx.com (Only available during Open Enrollment.)
APPLY BY MAIL	Blue Cross and Blue Shield of Texas - Attn: Individual Enrollment, P.O. Box 3236, Naperville, IL 60566–7236
APPLY VIA FAX	888-697-0686

If you have any questions, please call your agent or call BCBSTX toll-free at 800-531-4456.

You have the option to choose a Consumer Choice health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

If you are applying for coverage during a Special Enrollment Period or "SEP" (an opportunity to enroll outside of Open Enrollment), you may request coverage if you have experienced one or more of the qualifying life events listed below during the last 60 days (check all that apply). You must provide acceptable proof of a qualifying event with this application. BCBSTX will review this proof to verify your eligibility for a SEP. Failure to provide acceptable proof of a qualifying event with this application will delay or prevent the processing of your application and enrollment in coverage. Please call 800-531-4456 for examples of acceptable proof of these qualifying events.

		DATE OF EVENT
☐	**1.** I and/or my dependent(s) lost Minimum Essential Coverage:[1] ☐ Involuntary loss due to reasons other than non-payment of premium or rescission on: ☐ Due to reaching the maximum age, legal separation, divorce, or death of the policyholder, as of: ☐ I am no longer eligible for my prior health insurance plan due to termination of employment, reduction in number of hours of employment, or loss of employer contribution toward my premiums, or I have exhausted my COBRA benefits as of: ☐ I am no longer residing or living in my prior health insurance plan's HMO service area as of: ☐ I have a claim that would meet or exceed a lifetime limit on all benefits as of: ☐ I have lost coverage because my plan no longer offers benefits to the class of similarly situated individuals as of: ☐ I have lost coverage through my group HMO because I no longer reside or work in the service area and no other package is available as of:	
☐	**2.** I gained or became a dependent due to marriage on:	
☐	**3.** I gained or became a dependent due to birth, adoption, or placement for adoption or foster care on:	
☐	**4.** An error occurred in my previous health plan enrollment, or I have adequately demonstrated that my previous health plan or issuer substantially violated a material provision of its contract with me, as of:	
☐	**5.** The Health Insurance Marketplace has determined that I or my dependents am/are newly eligible or ineligible for payments of the advanced premium tax credit, or have a change in cost-sharing eligibility, or misconduct by a non-Marketplace entity as of:	
☐	**6.** I gained access to new health plan options because of a permanent move on:	
☐	**7.** My current policy is ending on a date other than December 31st, which is:[1]	
☐	**8.** Other qualifying event. If you do not see your circumstance listed, please work with your agent or contact our sales center at 800-531-4456.	

[1]Can apply 60 days in advance.

Section A: Applicant(s)

Applicant Name: _____

SSN#: _____

PRIMARY APPLICANT

☐ NEW COVERAGE ☐ ADD DEPENDENT ☐ CHANGE IN COVERAGE

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

DO YOU HAVE A PREFERRED WRITTEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO?** 4 OR MORE TIMES PER WEEK ON AVERAGE, EXCLUDING RELIGIOUS OR CEREMONIAL USES Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY)
☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A ☐ PUERTO RICAN
☐ CUBAN ☐ OTHER _____

RACE (OPTIONAL—CHECK ALL THAT APPLY) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO
☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER_____

RESIDENTIAL ADDRESS - STREET, CITY, STATE, ZIP | **COUNTY**

MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)

PRIMARY PHONE CELL ☐ LANDLINE ☐ | **SECONDARY PHONE** CELL ☐ LANDLINE ☐

EMAIL ADDRESS | **PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" (REQUIRED) | **PCP#** (REQUIRED)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED (dependent children must be under age 26)†

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO?** 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY)
☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A
☐ PUERTO RICAN ☐ CUBAN ☐ OTHER _____

RACE (OPTIONAL—CHECK ALL THAT APPLY) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO
☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER_____

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE) | **COUNTY**

PRIMARY PHONE CELL ☐ LANDLINE ☐ | **EMAIL ADDRESS** | **PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" (REQUIRED) | **PCP#** (REQUIRED)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO?** 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY)
☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A
☐ PUERTO RICAN ☐ CUBAN ☐ OTHER _____

RACE (OPTIONAL—CHECK ALL THAT APPLY) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO
☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER_____

***MAILING ADDRESS - STREET, CITY, STATE, ZIP** (IF DIFFERENT THAN ABOVE) | **COUNTY**

PRIMARY PHONE CELL ☐ LANDLINE ☐ | **EMAIL ADDRESS** | **PREFERRED CONTACT METHOD** ☐ EMAIL ☐ POSTAL MAIL

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" (REQUIRED) | **PCP#** (REQUIRED)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

* Age 18 and over.
† The designation of spouse shall include domestic partners.

Section A: Applicant(s) (Continued)

Applicant Name: _____

SSN#: _____

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N IF YES, PLEASE SPECIFY:	*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:	IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) MEXICAN MEXICAN AMERICAN CHICANO/A PUERTO RICAN CUBAN OTHER_____

RACE (OPTIONAL—CHECK ALL THAT APPLY) WHITE BLACK OR AFRICAN AMERICAN AMERICAN INDIAN OR ALASKA NATIVE ASIAN INDIAN CHINESE FILIPINO JAPANESE KOREAN VIETNAMESE OTHER ASIAN NATIVE HAWAIIAN GUAMANIAN OR CHAMORRO SAMOAN OTHER PACIFIC ISLANDER OTHER_____

*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)	COUNTY

PRIMARY PHONE CELL LANDLINE	EMAIL ADDRESS	PREFERRED CONTACT METHOD EMAIL POSTAL MAIL

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" (REQUIRED)	PCP# (REQUIRED)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N IF YES, PLEASE SPECIFY:	*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:	IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) MEXICAN MEXICAN AMERICAN CHICANO/A PUERTO RICAN CUBAN OTHER_____

RACE (OPTIONAL—CHECK ALL THAT APPLY) WHITE BLACK OR AFRICAN AMERICAN AMERICAN INDIAN OR ALASKA NATIVE ASIAN INDIAN CHINESE FILIPINO JAPANESE KOREAN VIETNAMESE OTHER ASIAN NATIVE HAWAIIAN GUAMANIAN OR CHAMORRO SAMOAN OTHER PACIFIC ISLANDER OTHER_____

*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)	COUNTY

PRIMARY PHONE CELL LANDLINE	EMAIL ADDRESS	PREFERRED CONTACT METHOD EMAIL POSTAL MAIL

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" (REQUIRED)	PCP# (REQUIRED)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N IF YES, PLEASE SPECIFY:	*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:	IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) MEXICAN MEXICAN AMERICAN CHICANO/A PUERTO RICAN CUBAN OTHER_____

RACE (OPTIONAL—CHECK ALL THAT APPLY) WHITE BLACK OR AFRICAN AMERICAN AMERICAN INDIAN OR ALASKA NATIVE ASIAN INDIAN CHINESE FILIPINO JAPANESE KOREAN VIETNAMESE OTHER ASIAN NATIVE HAWAIIAN GUAMANIAN OR CHAMORRO SAMOAN OTHER PACIFIC ISLANDER OTHER_____

*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)	COUNTY

PRIMARY PHONE CELL LANDLINE	EMAIL ADDRESS	PREFERRED CONTACT METHOD EMAIL POSTAL MAIL

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" (REQUIRED)	PCP# (REQUIRED)

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) Y N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

* Age 18 and over.
† The designation of spouse shall include domestic partners.

IF ANY OF THE TELEPHONE NUMBERS ABOVE ARE CELL PHONES, THEN I AGREE TO THE FOLLOWING TYPES OF CONTACTS:
BCBSTX may call me or any one of my dependents with prerecorded or automated calls related to my health care coverage. Y N
BCBSTX may call me or any one of my dependents with information about new plans and benefits. Y N

IF ANY OF THE TELEPHONE NUMBERS ABOVE ARE FOR RESIDENTIAL (LANDLINE) PHONES, THEN I AGREE TO THE FOLLOWING TYPE OF CONTACT:
BCBSTX may call me or any one of my dependents with information about new plans and benefits. Y N

Section B: Applying for Coverage

Applicant Name: _____

SSN#: _____

NOTE: Effective dates are available on the first of the month only, unless otherwise required by law. Applications must be received by BCBSTX within the defined enrollment period to be accepted.
I acknowledge that I have reviewed the providers that are currently in the network for the plan I choose.

PLAN SELECTION	DEDUCTIBLE
☐ **Blue Advantage Bronze HMO℠ 006**	$6,500**
☐ **Blue Advantage Bronze HMO℠ 105 – Two $40 PCP visits**	$6,850**
☐ **Blue Advantage Silver HMO℠ 102**	$3,000**
☐ **Blue Advantage Silver HMO℠ 103**	$3,750**
☐ **Blue Advantage Silver HMO℠ 107**	$3,500**
☐ **Blue Advantage Gold HMO℠ 101**	$500**
☐ **Blue Advantage Gold HMO℠ 111**	$0

PLAN SELECTION	DEDUCTIBLE
☐ **Blue Advantage Plus Bronze℠ 103 – One $0 PCP visit**	$6,600
☐ **Blue Advantage Plus Bronze℠ 104**	$5,000
☐ **Blue Advantage Plus Silver℠ 102 – Three $0 PCP visits**	$3,250
☐ **Blue Advantage Plus Gold℠ 101**	$2,750

The plan below covers essential health benefits, but only after out-of-pocket cost sharing reaches the high deductible/out-of-pocket maximum required by law.

Select this plan only if you are under 30 before the plan year begins, or have received a certification from the marketplace that you are exempt from the individual mandate because you do not have an affordable coverage option or because you qualify for a hardship exemption. Please enclose a copy of your certificate of exemption with your application.

☐ **Blue Advantage Security HMO℠ 100**	$7,150

ATTENTION FEMALE MEMBERS: In selecting your PCP, remember that your PCP's network may affect your choice of OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, if your PCP is part of a limited provider network (LPN), the OB/GYN from who you receive services must belong to the same LPN as your PCP. This is another reason to make certain that your PCP's network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

** Section I: Disclosure must be completed.

Section C: Dental Coverage

The Affordable Care Act ("ACA") requires us to be reasonably assured that you and each member on this policy have or are seeking coverage for pediatric dental services that are essential health benefits. The Affordable Care Act requires these benefits even if there is no one on the policy who is eligible for these services.

Carriers can offer this required pediatric dental coverage to you through benefit plans called "Marketplace-certified stand-alone dental plans." These plans are also known as Dental Qualified Health Plans or Dental QHPs.

There are three ways to meet this requirement.

1. You can enroll in **BlueCare Dental℠**, our Full Dental QHP, which contains coverage for adults and pediatric dental essential health benefits; or
2. You can enroll in **BlueCare Dental 4 Kids℠**, our Limited Dental QHP, which only contains pediatric dental essential health benefits; or
3. You can confirm that you have obtained or are seeking coverage for pediatric dental essential health benefits somewhere else.

Please review your options below and select **one**:

If you do not select an option then you and each member on the policy will be enrolled in BlueCare Dental 4 Kids 1B, our Limited Dental QHP, in order to meet ACA's requirement that we provide you coverage with pediatric dental services that are essential health benefits.

BlueCare Dental (For All Applicants)	DEDUCTIBLE
☐ **1A**	$50
☐ **1B**	$75
☐ **2A**	$75

BlueCare Dental 4 Kids (For Child[ren] Applicants)	DEDUCTIBLE
☐ **1A**	$50
☐ **1B**	$75

NOTE: Dental plans include an additional premium. For premium information, please call 800-531-4456, or contact your authorized independent BCBSTX agent.

☐ **I/WE ALREADY HAVE THE NECESSARY COVERAGE (I AND EACH APPLICANT LISTED ON THIS APPLICATION, ETC.)** HAVE OBTAINED COVERAGE FOR PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS THROUGH ANOTHER POLICY.

DATE	SIGNATURE

Section D: Billing Information

Applicant Name: _____

SSN#: _____

Note: Do not cancel any current coverage you may have until your application is approved and your new plan is effective.
Please select one of the following options to make arrangements for paying your premium.

☐ BANK DRAFT

Bank Draft includes initial and ongoing payments. Payment will be drafted upon receipt of this application. You must complete the following Authorization Agreement.

☐ 1-MONTH BANK DRAFT (12 Payments Per Year)

AUTHORIZATION AGREEMENT

Required for Bank Draft Payments Only
I request and authorize BCBSTX and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer–sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future. I also understand that both the Financial Institution and BCBSTX reserve the right to terminate this payment program and/or my participation therein. To make changes to my Financial Institution I understand that I will need to provide at least 10 days advance notice to BCBSTX by telephone prior to a scheduled withdrawal date.

Please complete the following – print or type information
I authorize BCBSTX to deduct the premium payments from my checking or savings account. If the draft date falls on a non–business day or a holiday, the premium payment will be deducted from my account on the next business day.

Please ensure adequate funds are available at the time of application. BCBSTX is not responsible for fees incurred due to insufficient funds.

PLEASE CHECK ONE ☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT	**NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT**	
BANK TRANSIT NUMBER	**DEPOSITOR'S ACCOUNT NUMBER**	
☐ I HAVE READ AND ACCEPT THE ABOVE AGREEMENT		
DEPOSITOR'S SIGNATURE	**DATE**	**RELATIONSHIP TO APPLICANT**

☐ DIRECT BILLING

FIRST MONTH PREMIUM AMOUNT OF $ _____ **ENCLOSED**

☐ SEND ME A PAPER BILL

☐ 1-MONTH DIRECT BILL (12 Payments Per Year)

NOTE: Cashing of the Premium Deposit does not constitute approval of this Application. If this Application is not approved, the Premium Deposit will be returned to the Primary Applicant and neither the Primary Applicant nor any other person applying for coverage under this Application shall be entitled to benefits or coverage.

Policy on third-party payments. BCBSTX only accepts premium and cost-sharing payments from: (1) the Applicant; (2) the Applicant's family; (3) Required Entities (the entities the law requires BCBSTX to accept premium and cost-sharing payments from, which currently are Ryan White HIV/AIDS programs, under title XXVI of the Public Health Service Act, Indian tribes, tribal organizations and urban Indian organizations; and State and Federal government programs, as described in 45 C.F.R. § 156.1250); and (4) private non-profit foundations that make premium or cost-sharing assistance available to the Applicant: (a) for the entire coverage period of the Applicant's Contract, (b) regardless of the Applicant's health status, and (c) cannot condition assistance on enrollment with a particular issuer or in a particular benefit plan. BCBSTX does not accept premium and cost-sharing payments from any other third party. Cost-sharing payments from any party, other than those listed above, will not be applied to your account. Premium payments from any party, other than those listed above, will not be credited to your account which may result in termination or cancellation of coverage in accordance with the Termination provisions of the Evidence of Coverage.

Section E: Proxy Statement (Optional)

Applicant Name: _____

SSN#: _____

PROXY STATEMENT

PROXY STATEMENT

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

PRIMARY APPLICANT'S PROXY SIGNATURE: **NOTE: WHETHER YOU SIGN FOR PROXY OR NOT, YOU MUST SIGN IN "SECTION G" BELOW TO COMPLETE THIS APPLICATION.**	**DATE**
PRINT YOUR NAME AS YOU SIGNED IT:	

Section F: Other Coverage Information

OTHER COVERAGE INFORMATION

DOES ANY PERSON APPLYING FOR COVERAGE CURRENTLY HAVE, OR DID THEY PREVIOUSLY HAVE **WITHIN THE LAST 5 YEARS**, BCBSTX COVERAGE, OR HEALTH OR MAJOR MEDICAL INSURANCE COVERAGE WITH ANY OTHER INSURER, OR COVERAGE UNDER A TAX SUPPORTED OR GOVERNMENT PROGRAM, INCLUDING MEDICARE, TO THE EXTENT PERMITTED BY LAW, EITHER AS A PRIMARY INSURED, SPOUSE OR AS A DEPENDENT? Y N

IF "YES," PLEASE COMPLETE THE FOLLOWING:

APPLICANT NAME	NAME ON PREVIOUS POLICY (IF APPLICABLE)	MEMBER/GROUP NUMBER (OPTIONAL)
APPLICANT NAME	NAME ON PREVIOUS POLICY (IF APPLICABLE)	MEMBER/GROUP NUMBER (OPTIONAL)

REPLACEMENT OF COVERAGE

WILL THIS INSURANCE REPLACE ANY HEALTH INSURANCE CURRENTLY IN FORCE? Y N **IF "YES," READ THE STATEMENT BELOW AND COMPLETE THE FOLLOWING:**

LIST ALL COVERAGE THAT WILL BE REPLACED

INSURED	NAME OF COMPANY	POLICY NUMBER	TERMINATION DATE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by BCBSTX. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning any person applying for coverage. Failure to include all material information on any application may provide a basis for BCBSTX to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
3. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by BCBSTX.

Section G: Required Signatures

Applicant Name: _____

SSN#: _____

ACKNOWLEDGMENTS

The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows:

1. This application is the first step in applying for Medical Expense Coverage. You do not have Medical Expense Coverage until the effective date of the policy and the first month's premium is paid.
2. If you use an agent or broker, they cannot accept risks or modify policies or requirements of BCBSTX.
3. If a spouse and/or dependent(s) is/are included for medical expense coverage, the premium will be calculated based on the age of each individual covered, subject to applicable law and regulations.
4. I understand that if any person makes a fraudulent misstatement of a material fact on the application, the fraudulent misstatement may be used to void the policy. Rescission (voiding the policy) is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage.
5. If an Agent, Producer or Broker was working with me to purchase an Individual Policy, then BCBSTX may pay the broker a commission and/or other compensation. I understand that if I want additional information about any commissions or other compensation paid the agent or broker I should contact the agent or broker.

Agreement: I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following payment in full of the first month's premium. The undersigned Applicant and broker acknowledge that the Applicant has read the completed application which will become a part of the contract between BCBSTX and the applicant.

Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency, pharmacy benefit manager, retail pharmacy, pharmacy clearinghouse or other person or firm, to disclose to BCBSTX 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 prescription and use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize BCBSTX to review and research its own records for information.

I understand that BCBSTX will only disclose collected information as needed to medical entities related to my care.

I understand information obtained with my authorization may be re-disclosed by BCBSTX as permitted or required by law. If such a disclosure is required, the person or agency receiving the information will become responsible for its protection.

This Authorization is valid for two years from today, or until I terminate coverage. I understand that I have the right to revoke the Authorization at any time, in writing, by contacting BCBSTX. I further understand that I or any authorized representative will receive a copy of this authorization upon request. Any revocation will not affect the activities of BCBSTX prior to the date such revocation is received by BCBSTX.

Signatures: I acknowledge receipt of the required Outline of Coverage and I agree that Individual Insurance is intended to be paid as my personal expense and that this policy is offered on my representation that only I, a family member, or permissible third party as outlined below will pay BCBSTX directly. I understand that BCBSTX does not accept payments of premium or cost-sharing payments directly from third parties except from those identified in Section D (family members, Required Entities, certain private non-profit foundations). I understand that a violation of this policy may result in premium and cost-sharing payments paid by a third party not being credited to my account or coverage or being refunded to me, which may result in the cancellation of my coverage.

Special Enrollment Period Attestation and Acknowledgement. I understand that if I am applying for coverage outside of Open Enrollment, I must qualify for a Special Enrollment Period ("SEP"). I understand that in order to qualify for a SEP I must have experienced one of the qualifying events identified on page 1 of the application during the last 60 days, and I must provide acceptable proof of any qualifying event(s) with this application in order for BCBSTX to verify my eligibility.

I represent that the proof I am providing is valid and I understand that failure to provide proof of a qualifying event will delay or prevent the processing of my application and enrollment in coverage.

In addition I acknowledge that this coverage is intended to be individual coverage and nothing in this document creates a group health plan as defined under state and federal laws.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

At any time when BCBSTX is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Policy, BCBSTX may at its option make an offer to reform the policy already in force and/or change the rating category/level. In the event of reformation, the Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

I understand that written communications that are required by law may be delivered to me electronically, with my consent. I understand that if I consent to receiving my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.

PRIMARY APPLICANT'S SIGNATURE	**DATE**
SPOUSE'S SIGNATURE (IF APPLYING)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
PARENT OR LEGAL GUARDIAN OF A MINOR CHILD	**DATE**
IF THIS AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF AN INDIVIDUAL (OTHER THAN A PARENT FOR A MINOR CHILD), COMPLETE THE FOLLOWING:	
PERSONAL REPRESENTATIVE'S NAME (PLEASE PRINT)	**RELATIONSHIP:**

Section H: Agent Information

Applicant Name: _____

SSN#: _____

AGENT'S CERTIFICATION

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the required Outline of Coverage, and if requested, the Disclosure Statement.

AGENT INFORMATION (if applicable)

AGENT'S SIGNATURE	DATE	AGENT ID	P&C CROSS REFERENCE
PRINT AGENT'S NAME	AGENT'S PHONE		AGENT'S FAX

Section I: Disclosure

TEXAS DEPARTMENT OF INSURANCE REQUIRED DISCLOSURE NOTICE FOR ALL INDIVIDUAL HMO CONSUMER CHOICE BENEFIT PLANS ISSUED IN TEXAS

As required by 28 TAC §21.3530, I have been informed that the Consumer Choice Health Benefit Plan that I am purchasing does not include all state mandated health insurance benefits. I understand that the following benefits are provided at a reduced level from what is mandated, or excluded completely from the plan.

MANDATED BENEFIT DESCRIPTION	BENEFIT REDUCED	BENEFIT EXCLUDED
COPAYMENTS Section 11.506(2)(A), Subchapter F, Title 28 Texas Insurance Code: A reasonable copayment option may not exceed 50 percent of the total cost of services provided. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrolled in that calendar year total two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee.	For some services and supplies, this plan may include cost-sharing that exceeds the limits imposed by the mandated.	
DEDUCTIBLES Section 11.506(2)(B), Subchapter F, Title 28 Texas Insurance Code: A deductible shall be for specific dollar amount of the cost of the basic, limited or single health care service. An HMO shall change a deductible only for services performed out of the HMO's service area or for services performed by a physician or provider who is not in the HMO's delivery network.	Deductibles may apply to some services provided by HMO Participating Providers in the HMO service area. Deductibles may apply to Professional Services, Inpatient Hospital Services, Outpatient Facility Services, Outpatient Lab and X-Ray Services, Rehabilitation Services, Maternity Care and Family Planning, Behavioral Health Services, Emergency and Ambulance Services, Extended Care Services, some Preventive Care Services, Dental Surgical Procedures, Cosmetic, Reconstructive or Plastic Surgery, Allergy Care, Diabetes Care, Prosthetic Appliances, Orthotic Devices, Durable Medical Equipment, Hearing Aids and Prescription Drugs.	
LIMITATIONS Section 11.508 (d) Subchapter F, Title 28 Texas Insurance Code: A state-mandated health benefit plan defined in §11.2(b) of this title (relating to Definitions) shall provide coverage for the basic health care services as described in subsection (a) of this section, as well as all state-mandated benefits as described in §§21.3516 - 21.3518 of this title (relating to State-mandated Health Benefits in Individual HMO Plans, State-mandated Health Benefits in Small Employer HMO Plans, and State-mandated Health Benefits in Large Employer HMO Plans), and must provide the services without limitation as to time and cost, other than those limitations specifically prescribed in this subchapter.	Benefit limits will apply to coverage for Home Health Services. Benefit limits will also apply to Rehabilitation Services except for treatment of Acquired Brain Injury and Autism Spectrum Disorder.	
Coverage for Telehealth and Telemedicine Services: Chapter 1455 (b), Texas Insurance Code		Not Covered

I also understand that if I purchase a health plan that excludes or reduces coverage for a certain condition, I may be limiting my ability to obtain individual insurance coverage for that condition, in the event the health of any individual covered under the plan changes. I understand that I may obtain addition information on Consumer Choice Health Benefit Plans, either by visiting the TDI website at www.tdi.texas.gov/consumer/index.html, or by calling 1-800-252-3439.

SIGNATURE OF APPLICANT	NAME OF APPLICANT (PRINT NAME)	DATE
ADDRESS - STREET, CITY STATE, ZIP		

Note: This form must be retained by the carrier issuing the policy and must be provided to the Commissioner of Insurance upon request. **You have the right to a copy of this written disclosure free of charge.** A new form must be completed upon each subsequent renewal of this policy.

THANK YOU FOR APPLYING.

Please include all necessary materials when submitting this application.
If legal guardian, please enclose signed court decree.