

Important Information About the Application for Alliance Coverage, the Authorization for Use of Protected Health Information and the Premium Payment Form

Note to Applicant: Blue Cross Blue Shield of Missouri requires that the “Authorization for Use of Protected Health Information” be completed and submitted with your completed Application. In addition, we require completion of the Premium Payment Form and payment of your first month’s premium with the Application. If we do not receive your completed Authorization and Premium Payment Form, we cannot process your Application. ***Except:** If you are applying **only** for the HIPAA Alliance plan, you are not required to complete the Authorization or the Premium Payment Form.*

Please print the all of the attached forms (a total of eight pages) and complete them by hand.

1. Application

- A) If you completed Section 7 (Health History), circle all health conditions that apply to any family member, including yourself.
- B) If necessary, attach additional sheet(s) to complete the information requested in sections 5, 6 and/or 7. Be sure to mark clearly which section(s) you are completing.
- C) On page 6 of the application, provide all required signatures in the Signature Section.

2. Authorization for Use of Protected Health Information

Complete your name, address and phone number information and provide all the required signatures. If you and/or any family members are unable to sign, you may have a personal representative sign for that person.

3. Premium Payment Form

Complete your name, address and phone number information and select the payment method for your first premium payment. Be sure to provide complete information, and any required signature(s), for the payment method you choose.

After completing the Application, Authorization and Premium Payment forms, mail them to us at:

Blue Cross Blue Shield of Missouri
100 N. 1st St. Ste. 301
Burbank, CA 91502-1845

Or, if you have chosen to pay your first premium by Credit Card or Automatic Bank Account Withdrawal, you may *fax* all the forms to us at 1-877-901-5522.

Important: Be sure to submit all forms together.

For more information, call our Direct Sales Department at: **1-800-497-4010** or e-mail us at: **moreinfo@bcbsmo.com**

Section 1: HIPAA Eligibility and Program Selection (You must complete this section – even if you only want to apply for a regular Alliance program.)

Please read #5 on the front page before you complete this section.

To be eligible for the HIPAA Alliance program, you and any dependents listed on this application must meet all of the following requirements. (For more information, please refer to the enclosed sheet titled "HIPAA Information.") Complete the next 5 statements. Any time you check "Yes," write the name of each family member, including yourself, who meets that requirement.

- 1. I and any dependents listed have had at least 18 months of creditable coverage without a break in continuous coverage of more than 63 consecutive days.
[] No, this is not true. [] Yes, this is true for:
2. The most recent coverage that I and any listed dependents had was through a group, church or government health plan (other than Medicare, Medicaid or a state Health Insurance Pool) and it was not canceled due to fraud or failure to pay premiums. [] No, this is not true.
[] Yes, this is true for:
3. If I and any dependents listed were eligible for COBRA and/or state Continuation Coverage, we elected that coverage. In addition, we will have used up all of that coverage as of the date our HIPAA Alliance coverage becomes effective. [] No, this is not true.
[] Yes, this is true for:
If you and/or any dependents listed were not offered COBRA and/or advised of state Continuation Coverage, check "Yes" above and write the names here:
4. Neither I nor any dependents listed are eligible for coverage under a group plan, Medicare or Medicaid. [] No, this is not true.
[] Yes, this is true for:
5. Neither I nor any dependents listed have any other health coverage. [] No, this is not true.
[] Yes, this is true for:

Not eligible: Any persons for whom you checked "No" in one or more of the 5 statements above are not eligible for the HIPAA Alliance program. For those persons, please continue to Section 2.

Eligible: Any persons for whom you checked "Yes" for all 5 statements above are eligible for the HIPAA Alliance program. They will be guaranteed acceptance and will not have any exclusions or any waiting periods for coverage of any preexisting conditions. But the premium will be higher than for a regular Alliance program. (If maternity coverage is purchased, it may not begin until after one year.) Please complete either A or B, below:

A. [] I and any eligible dependents listed are applying only for the HIPAA Alliance program, with the options checked below:

- Deductible options: [] \$1,000 or [] \$2,500
Effective date options: [] Date application was received by the Companies or
[] Requested effective date: (mo/day/yr)

*The date you request must be the same as, or later than, the date your other coverage ended, but cannot be prior to our receipt of this application. If you completed

A., in 1st column, please continue to Sections 3, 4, 5 and 6. In Section 4, do not select a regular program. In Section 5, you do not need to complete the height and weight information. Along with this application, submit your certification or a completed Attestation Form (provided on the enclosed "HIPAA Information" sheet).

B. [] I and any eligible dependents listed qualify for the HIPAA Alliance program, but I am also applying for one of the regular programs (in Section 4), which I understand may have exclusions or waiting periods for coverage of preexisting medical conditions. I understand that, if not accepted for the regular program, I/we will be enrolled in the HIPAA Alliance program, with the deductible option I have checked here: [] \$1,000 or [] \$2,500. Also, if the Companies require additional medical information, I/we will be enrolled in the HIPAA program while eligibility for a regular program is determined. If I am accepted in a regular program, but any health conditions and/or family member(s) are excluded, I understand that I and/or my family member(s) have the option of remaining in the HIPAA Alliance program. My/our effective date of coverage will be either the end date of my other coverage or the date the Companies received my completed application, whichever is later.

If you completed B., above, please complete Sections 3, 4, 5, 6 and 7.

Section 2: Other Coverage (Attach second sheet, if necessary.)

Do you and/or your spouse and/or children who are listed on this application form have any other health coverage? [] Yes [] No If "Yes," please provide name(s):

Also, provide the policyholder's Identification No.: and Group No.: and the name of the insurance company:*

Are you continuing that coverage? [] Yes [] No If "No," provide: a) Date the coverage will end (month / day / year): / / and

(b) Reason the coverage will end: [] leaving employment [] spouse or child no longer eligible [] other

*If the other coverage was provided through a Blue Cross and/or Blue Shield plan (including ours), provide the plan location:

City and State

Section 3: General Information

Type of membership wanted (check one): [] Applicant only [] Applicant & spouse [] Applicant & unmarried child(ren) [] Applicant, spouse & unmarried child(ren)
[] Child only (through age 18) If checked, be sure to write child's name in "Application Information" on cover page.

How do you want to be billed? (check one): [] Monthly [] Quarterly [] Annually Note: Billing schedule chosen will apply to all coverages selected on this form.

Please check your preferred effective date of coverage (regular programs only):

- 1. [] Same date we approve this application. (If application is accepted, premium will be charged starting on this date, but you will not receive your identification card until after this date.)
2. [] Requested future date: mo / day / yr (Date must be within 90 days after your signature date.)
Note: If requested future date cannot be granted, date application is approved will be the effective date.

Tobacco Use* Designation and Declaration (not required for HIPAA-only applicants):

- 1. I [] have [] have not used tobacco products during the past 12 months.
2. My spouse (if included on this application) [] has [] has not used tobacco products during the past 12 months.

*Premium for all covered family members is higher if subscriber and/or spouse have used tobacco products in the past 12 months.

Section 4: Medical/Drug/Dental Coverage Selection

Medical Coverage: Unless you want only HIPAA medical coverage or only Term Life Coverage, check one of the six regular (non-HIPAA) plans below. Be sure to check the appropriate box or boxes for the plan's options. **Important:** The AllianceChoice plan and provider network are available only in certain counties.

<p>1. <input type="checkbox"/> Alliance</p> <p>Coinsurance — Network/Non-Network (check one):</p> <p><input type="checkbox"/> \$100% / 70%</p> <p><input type="checkbox"/> \$ 90% / 70%</p> <p>Deductible* (check one):</p> <p><input type="checkbox"/> \$ 300</p> <p><input type="checkbox"/> \$ 600</p> <p><input type="checkbox"/> \$ 1,000</p> <p><input type="checkbox"/> \$ 1,500</p> <p><input type="checkbox"/> \$ 2,500</p> <p><input type="checkbox"/> \$ 5,000</p> <p><input type="checkbox"/> \$10,000</p>	<p>2. <input type="checkbox"/> AllianceChoice</p> <p>Coinsurance — Network/Non-Network (check one):</p> <p><input type="checkbox"/> 100% / 70%</p> <p><input type="checkbox"/> 90% / 70%</p> <p><input type="checkbox"/> 80% / 60%</p> <p>Deductible* (check one):</p> <p><input type="checkbox"/> \$0 / \$500†</p> <p><input type="checkbox"/> \$ 500</p> <p><input type="checkbox"/> \$ 1,000</p> <p><input type="checkbox"/> \$ 1,500</p> <p><input type="checkbox"/> \$ 2,500</p> <p><input type="checkbox"/> \$ 5,000</p> <p><input type="checkbox"/> \$10,000</p> <p>†Network/Non-Network</p>	<p>3. <input type="checkbox"/> RateSaver</p> <p>Coinsurance — Network/Non-Network (check one):</p> <p><input type="checkbox"/> 100% / 70%</p> <p><input type="checkbox"/> 80% / 50%</p> <p>Deductible* (check one):</p> <p><input type="checkbox"/> \$ 1,000</p> <p><input type="checkbox"/> \$ 1,500</p> <p><input type="checkbox"/> \$ 2,500</p> <p><input type="checkbox"/> \$ 5,000</p> <p><input type="checkbox"/> \$10,000</p> <p>Provider Network (check one):</p> <p><input type="checkbox"/> Alliance Network</p> <p><input type="checkbox"/> AllianceChoice Network</p>	<p>4. <input type="checkbox"/> HSA-Compatible Medical Plan</p> <p>Coinsurance — Network/Non-Network (check one):</p> <p><input type="checkbox"/> 100% / 70%</p> <p><input type="checkbox"/> 90% / 60%</p> <p><input type="checkbox"/> 80% / 50%</p> <p>Deductible* (check one):</p> <p>If coverage is for Applicant only:</p> <p><input type="checkbox"/> \$1,050 <input type="checkbox"/> \$2,000</p> <p><input type="checkbox"/> \$3,000 <input type="checkbox"/> \$5,000**</p> <p>If coverage is for Applicant and other family members:</p> <p><input type="checkbox"/> \$2,100 <input type="checkbox"/> \$ 4,000</p> <p><input type="checkbox"/> \$6,000 <input type="checkbox"/> \$10,000**</p> <p>**Available only with 100% / 70% coinsurance.</p> <p>Provider Network (check one):</p> <p><input type="checkbox"/> Alliance Network</p> <p><input type="checkbox"/> AllianceChoice Network</p>	<p>5. <input type="checkbox"/> Hospital/Surgical Plan †</p> <p>Provider Network (check one):</p> <p><input type="checkbox"/> Alliance Network</p> <p><input type="checkbox"/> AllianceChoice Network</p> <p>† For extra premium, do you wish to add optional Mental Health & Substance Abuse benefits for yourself and any covered family members?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If added, these benefits replace the substance abuse benefits included in plan.</p>	<p>6. <input type="checkbox"/> HSA-Compatible Hospital/Surgical Plan †</p> <p>(available for effective dates 4-01-05 and after)</p> <p>Deductible* (check one):</p> <p>If coverage is for Applicant only:</p> <p><input type="checkbox"/> \$1,050</p> <p><input type="checkbox"/> \$2,000</p> <p><input type="checkbox"/> \$3,000</p> <p>If coverage is for Applicant and other family members:</p> <p><input type="checkbox"/> \$ 2,100</p> <p><input type="checkbox"/> \$ 4,000</p> <p><input type="checkbox"/> \$ 6,000</p> <p>Provider Network (check one):</p> <p><input type="checkbox"/> Alliance Network</p> <p><input type="checkbox"/> AllianceChoice Network</p>
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*Deductible amounts are for charges in and out of network, except as noted.

Medical/Drug Coverage Options* – If I am accepted for coverage, please add the option(s) checked below if available with my plan:

- 1. Maternity Coverage** – Add (at extra cost): Yes No
If added, maternity benefits will apply only to subscriber or covered spouse, and may not begin until one year after the date added.
 - 2. 3-Tier Prescription Drug Deductible** – Add a \$1,000 deductible to my coverage for Tier 2 and Tier 3 prescription drugs: Yes No
 - 3. Generic Drugs** – Replace the regular prescription drug coverage of my plan with generic drug benefits: Yes No
Except: With the Hospital/Surgical Plan and the HSA-Compatible Hospital/Surgical Plan, generic drug benefits will be in addition to benefits for chemotherapy drugs.
- *Options 1 and 2 are not available with the RateSaver plan, the Hospital/Surgical Plan or the HSA-Compatible Hospital/Surgical Plan. Options 2 and 3 are not available with the HSA-Compatible Medical Plan or with the HIPAA Alliance Plan.

Dental Coverage: Do you wish to add DentaBlue coverage (at extra cost)? Yes* No

*If you and/or any listed family members are declined for medical coverage, would you still want to be enrolled in this dental coverage? Yes No

Note: If added on this form, the dental coverage applies to the same family members, billing schedule and effective date as indicated for the medical plan. To enroll in dental coverage for certain family members only, please complete the separate DentaBlue Application instead.

Section 5: Term Life Insurance Coverage Selection

Term Life Insurance Coverage – Do you wish to purchase this coverage? Yes No If “Yes,” complete this section and Health History Section for each family member that you want to have Healthy Alliance Life Insurance Company term life insurance.

Family Member Name	Amount of Benefit			Primary Beneficiary(ies)		Contingent Beneficiary(ies)	
	\$15,000	\$30,000	\$50,000	Name	Relationship	Name	Relationship

Note: The \$50,000 amount is not available to applicants/dependents under age 19. If selected by an approved applicant/dependent under age 19, the selection will default to \$30,000. If a beneficiary is not listed and Policy is issued, death benefits will be paid according to the Beneficiary Provision in the Policy.

Section 6: Applicant and Family Information (complete as appropriate)

Complete for yourself (the applicant), your spouse, if applicable, and any other eligible family members you want covered on your membership. Your children must be under age 23 and unmarried to be covered on your membership. (Attach a separate sheet if necessary.) **Please print.**

First	middle	last	Check appropriate box:			Sex M / F	Height		Weight		Relationship to Applicant	Date of Birth (mo/day/yr)
			Medical	Life	Both		Ft.	In.	Now	1 Yr. Ago		
Applicant												Self

Section 7: Health History — Most applicants must complete this Health History section. However, **you are not required to complete this section if:** 1) you are transferring directly from another nongroup program through our Companies into the same or a lesser program; 2) you are applying only for the HIPAA Alliance program; or 3) you did not qualify for our BlueCHOICE Individual program and this application is received by us within 90 days after the signature date on your original BlueCHOICE application (see *Application Agreement, page 6*). **If you are required to complete this section, each item must be checked either “Yes” or “No” before we can process your application.**

Within the past 10 years, have you or a listed family member been advised of, diagnosed with or treated for any of the following conditions by a medical professional? Please CIRCLE ALL CONDITIONS THAT APPLY (such as Allergies).

- | | | | |
|--|--|------|------------------------|
| <p>1. Allergies, hay fever, asthma, allergic reaction . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Anemia, other blood disease or disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Arthritis, lupus, gout or any inflammation, recurrent pain or diminished range of motion in the joints, including knees or hips (please indicate the involved joint — see the following page) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Back, neck or spinal column disorders, including back adjustments, recurrent back pain or immobility <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Bladder infections, kidney infections, kidney stones; other bladder, urinary or kidney disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Breast disorder (male or female), fibrocystic disease, breast implant* or reduction. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>*6a. Was breast implant necessary because of cancer?. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Cancer, cysts, tumors, polyps or other growths <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Congenital disease or birth defect. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Crossed eyes, detached retina, cataract, glaucoma or any other eye injury or disorder (except corrective lenses) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Cystic acne, actinic keratosis, severe burns, severe scars or any other skin disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Diabetes, goiter or thyroid disorder or disorder of the glands <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Diseases related to the immune system, <i>other than</i> Human Immunodeficiency Virus (HIV) infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Disorder of the male or female reproductive organs, including enlarged prostate, prostatitis, menstrual irregularity or disorder, fibroid uterus, abnormal Pap smear or ovarian cyst <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Ear infections, hearing impairment, nasal malformation, deviated nasal septum, sinus trouble, or any other disorder of the ear, nose or throat . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Eating disorder, such as anorexia or bulimia . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Emphysema, bronchitis or any chest, lung or respiratory problem or disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Epilepsy, seizures, migraines or recurrent headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Fractures, dislocations, polio, loss of limb(s), bone disorders. On the following page, please indicate the involved limb(s) — left or right, arm or leg — and if screws, pins or plates are now in place? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Gallstones, gallbladder disorder, hernia (except hiatal) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>20. Heart murmur, irregular heartbeat, rheumatic fever, chest pain, heart valve problem, heart attack or any other heart condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Hepatitis, cirrhosis or any other liver disorder. . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Muscular or neurological disorder, such as muscular dystrophy, multiple sclerosis, cerebral palsy or Parkinson's <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Nervous, mental or emotional condition; attempted suicide, depression or mental retardation; ADD (Attention Deficit Disorder); ADHD (Attention Deficit Hyperactivity Disorder) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Paralysis, stroke, TIA (Transient Ischemic Attack), or high blood pressure (provide most current blood pressure reading — see the following page) . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Sexually-transmitted diseases, such as genital herpes, syphilis, gonorrhea, chlamydia or venereal warts <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Ulcers, colitis, hemorrhoids, ulcerative colitis, Crohn's, hiatal hernia or any other stomach, intestine, bowel or rectal disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Varicose veins, clots, poor circulation or any other vein or artery disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Have you or any other family member listed on page 3:</i></p> <p>28. Had an operation or been hospitalized in the past 10 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>29. In the past 10 years had, or been diagnosed with or treated for, HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>30. In the past 10 years, been treated or counseled for alcoholism, the use of alcohol, drug abuse or the use of drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Within the past five years, ever had any other condition, disorder, ailment or injury not listed above for which you have had or plan to seek advice, diagnosis or treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Consulted a doctor, chiropractor, therapist or other health care provider within the past 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>33. Are you or any family member listed on page 3 now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
 <input type="checkbox"/> Not applicable</p> <p>If YES, please provide:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 5px;">Name</td> <td style="width: 30%; padding: 5px;">Expected Delivery Date</td> </tr> </table> | Name | Expected Delivery Date |
| Name | Expected Delivery Date | | |

Section 7: Health History (continued)

34. If you answered "yes" to any of the questions numbered 1-33, complete this section. Give complete details, including the number of each item that you answered "yes." Attach additional sheet if necessary.

Item No.	Patient's Name (Include maiden name, if appropriate.)	Dates of Illness or Conditions/ Symptoms	Diagnosis, Treatment, Medication, Reason for Visit	Is further treatment needed?	Were you hospitalized?	Name and Address of Doctor and/or Hospital
		From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
		To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address
		From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
		To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address
		From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
		To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address
		From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
		To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address
		From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
		To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address

35. Are you or any family member listed on page 3 currently taking any prescribed medications? Yes No
If YES, complete below. (Use an extra sheet if necessary.)

Name	Medicine	Reason	Name and address of prescribing doctor

36A. Have you or any family member listed on page 3 had a physical exam in the last two years Yes No
If YES, provide:

Person's Name	Physician's Name and Address	Date of exam (mo-day-yr)

36B. Have you or any female over age 18 listed on page 3 had a Pap smear in the last two years? Yes No Not applicable
If YES, provide:

Person's Name	Physician's Name and Address	Date of exam

37. Has future surgery, diagnostic testing or medical treatment been recommended or discussed for you or any family member listed on page 3? Yes No

Person's Name	Date	Diagnosis	Type of operation or treatment

(End Section 7)

(Continue to page 6. Be sure to read Application Agreement before signing this form.)



Section 8: Application Agreement (Please read carefully.)

Applicant (the person completing and signing this form) hereby requests the coverage that is applied for on this form and that will be set forth in the Certificate issued to him or her by the Companies after acceptance. (See page 1 for a description of the Companies.)

The Application Process:

This is an application only. I understand that I should not cancel any existing coverage unless I am notified in writing by the Companies of my acceptance.

I understand that sending my initial premium with this application, and the receipt of my payment by the Companies, does not mean that coverage has been approved. I understand that my full payment will be refunded to me if my application is denied.

If I am using this form to request a change in my current Individual/Family plan provided through the Companies, I understand that if my request is accepted, my membership will be canceled once the new coverage is in effect.

If my request is being handled by a producer, the producer is not authorized to bind or commit the Companies in any manner.

If I, my spouse (if listed) or any of my listed dependents have not had a physical examination in the past two years, an examination may be required at my expense during the application process. In addition, I understand that I must sign and return with my Application the enclosed separate authorization form. This authorization permits the Companies to request from health care providers any additional medical information needed to determine my eligibility for coverage and/or the eligibility of any family members listed on this form.

(This paragraph does not apply to the HIPAA Alliance program.)

If I am submitting this application because I did not qualify for the BlueCHOICE Individual program, I understand that this document becomes part of my original application and I agree that, except for the sections revised by this form, the information provided and statements agreed to on my original application still remain the same.

HALIC Term Life Insurance:

If I or any family members are applying for Term Life Insurance underwritten by Healthy Alliance Insurance Company (HALIC), I agree that all the information I have provided on this form, including health information for myself and any family members, will also be submitted to HALIC. If I am declining this coverage, I have discussed my decision with my producer, if any.

Limitations and Exclusions:

I understand that if I and any listed family members are accepted for coverage, any preexisting medical condition(s) disclosed during the application process will be covered as of my effective date, unless I am notified in an Application Amendment that any condition(s) will be permanently excluded from coverage. I also understand that I will be notified in an Application Amendment if any listed family member is permanently excluded from coverage. I understand that if I or any listed family member(s) receive medical care between the time I complete this Application Form and the time my Application is accepted or declined, I must notify the Companies.*

I understand that, for any preexisting medical condition(s) not disclosed

during the application process, medical and drug benefits will not be provided for 12 months.*

I understand that if I am transferring directly from a prior membership through the Companies, and if any health conditions affecting me and/or my covered dependents were excluded from coverage under that membership, those exclusions will also apply under this membership.*

**These paragraphs do not apply to the HIPAA Alliance program.*

If the plan I purchase offers maternity coverage, and I purchase that coverage, I understand that 1) these benefits apply only to me or my covered spouse and not to any dependent child and 2) these benefits will not begin until after my membership has been in effect for one year. **Note:** *If a female applicant/spouse is approved for coverage, this waiting period will be waived if she is transferring directly from group coverage through the Companies that was in effect for 12 months or more with no break in coverage.*

If I purchase optional dental coverage, I understand that I will have a six-month waiting period for coverage of Basic services and a 12-month waiting period for coverage of Major services. *(For a description of Basic and Major services, please refer to your Marketing materials.)* I understand that these waiting periods will be eliminated if I am transferring directly from a comparable dental benefits plan that was in effect for 12 months or more with no break in coverage.

Payment of Premiums:

I understand that, if my premiums are not paid within the time specified on my billing statement, all coverage will end as of the date to which my last premium was paid. I also understand that if a premium payment I issue to the Companies is returned for insufficient funds, the Companies will charge me a fee.

Completeness and Accuracy:

I understand and agree that if I have omitted or overlooked any information needed to process my Application Form, an employee of the Companies may contact me by phone to obtain the information. Then they may add or correct it directly on my Application Form. All changes or additions made during the phone call will be detailed in a verification letter that will be mailed to me with a copy of my updated Application Form. I understand that if, within 10 business days after the letter is mailed, I have not contacted the Companies with any further clarifications, the letter will become part of my Application Form.

I understand that the Companies rely upon the information provided on this form, plus any information obtained from my family physician(s), in issuing my coverage. If I omit any information or provide any false or incomplete information that is considered fraud or material misrepresentation, this can result in the cancellation of my coverage based on the terms of my Certificate. I agree to repay promptly any benefit payment to which I or my dependents were not entitled.

Required Signatures: Please read the Application Agreement above before signing. Your spouse and any dependents age 18 or over must also sign, if they are listed on the form. *Note to parents/guardians: If your child is under age 18 and is applying for his/her own membership, please sign as indicated below to show your consent. If date of signature is left blank, we will use the date we receive your application.*

By signing below, I/we attest that I/we have read and understood the Application Agreement and the HIPAA Eligibility and Program Selection Section, and agree to all of the statements listed therein.

X _____ <i>(Applicant's signature if age 18 or older or Parent's or guardian's signature if applicant is under age 18)</i>	X _____ <i>(Date)</i>	X _____ <i>(Spouse's signature)</i>	X _____ <i>(Date)</i>
X _____ <i>(Printed name of person signing above.)</i>		X _____ <i>(Signature of dependent age 18 or over)</i>	X _____ <i>(Date)</i>
X _____ <i>(Relationship to applicant)</i>		X _____ <i>(Signature of dependent age 18 or over)</i>	X _____ <i>(Date)</i>

No action will be taken without required signature(s) above. Please do not cancel your present coverage, if any, until you receive documentation from the Companies, such as an ID card or written notification, showing that your Application has been approved.

If submitting a personal check or a money order, please attach it here, using either a paper clip or a stapler. Do not use tape.

Premium Payment Form

(Please Print Clearly)



Your first month's* premium must be submitted with your application, unless you are applying only for HIPAA coverage. For speedier handling, make your first payment by credit card or automatic withdrawal from your bank account and fax this form, along with your application and other required documents, to 314-923-5002. If your application is not accepted, your payment will be refunded (see "Note," at end of this form).

Applicant's name: _____ Date of application: _____ Phone number: () _____

Address: _____

Section 1. Amount of Premium: I understand that the first month's* premium for the coverage I have selected for myself and any family members is: \$_____.
(please complete)

(If your application is accepted and the amount you indicated above is less than or more than the actual amount needed, the difference will be reflected as a debit or a credit on the first bill you receive from BCBSMo — provided that the amount is within our payment guidelines. If the amount is **not** within our guidelines, we will notify you.)

Section 2. Payment Method: I am paying this amount by (check only one):

- Credit card
- Automatic bank account withdrawal
- Check or money order

A. If Paying by Credit Card:

A credit card can be used only for this initial premium payment. If your application is accepted, you will be billed for future payments or you can call us to change to automatic bank withdrawal. Complete below:

Authorization: I authorize BCBSMo to charge the credit card indicated below for the amount specified in Section 1.

Applicant's Signature: _____

X _____

Following is my credit card information —

Cardholder's Name (as shown on the credit card): _____

If applicant is using the credit card of another cardholder: By signing this form, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.

Type of Credit Card: VISA MasterCard Discover

Credit Card Number: _____

Expiration Date (month/year): _____/_____

3-Digit Verification Code: _____ (See signature area on back of credit card.)

BCBSMo will use the billing address indicated on the application form as the cardholder's billing address.

***Except: For Short Term Medical coverage, please submit full payment for the benefit period selected on your application.**

Note: If your application is not accepted and you chose to pay by credit card or automatic bank withdrawal, we will not process the payment transaction. If you chose to pay by check or money order, it will be returned to you.

Blue Cross Blue Shield of Missouri is the name RightCHOICE® Managed Care, Inc. (RIT) uses to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by Healthy Alliance® Life Insurance Company (HALIC) and HMO benefits underwritten by HMO Missouri, Inc. HMO Missouri, Inc. does business as BlueCHOICE. RIT, HMO Missouri, Inc. and HALIC are independent licensees of the Blue Cross and Blue Shield Association.

B. If Paying by Automatic Withdrawal:

Deduct money from my/our account for (check one):

- My first payment only (amount specified in Section 1)
- My first and ongoing payments*
- My ongoing payments only* (I am making my first payment by another method.)

Contact us if you later want to change your payment method.

Authorization and Signature(s): I/we authorize BCBSMo to deduct my premium payment(s) from my/our checking account at the bank (or other financial institution) named below.

Each person listed on checking account must sign here:

X _____

X _____

Provide the following bank account information —**

Name(s) on Checking Account: _____

Name of Bank (or other Financial Institution): _____

Bank Address: _____

City: _____ State: _____ Zip Code: _____

Financial Institution Routing No.: _____

Checking Account No.: _____

** or you may attach a sample check from your bank account, marked "VOID" in ink.

C. If Paying by Personal Check or Money Order:

Be sure to attach your check or money order to this form, in the upper left-hand corner. A separate check or money order is required for each application submitted.