

## APPLICATION FOR INDIVIDUAL COVERAGE

**Please note:** The underwriting process can take several weeks. Do not cancel your current health care coverage until you have received notice in writing that coverage has been approved.

**Instructions:**

1. Please complete all sections and print clearly in black ink.
2. Read carefully and sign the enclosed *Authorization for Release of Medical Information*.
3. Read carefully and sign the enclosed *Declarations and Conditions of Enrollment*.
4. Provide information about your spouse and dependents only if they are also applying for coverage. If you need additional space, attach a separate sheet with your signature and date.
5. Choose a payment option in Section A. Payment options are:
  - a. monthly billing (you must include a check for the first month's premium)
    - for HMO plans, make your check payable to Keystone Health Plan East
    - for PPO plans, make your check payable to Independence Blue Cross
  - b. monthly ACH — monthly automatic payment from your bank account
    - Complete the *Electronic Payments* form included in your packet and enclose it along with a voided check or savings deposit slip.

**Important:** Receipt of your initial payment does not constitute enrollment in this program. Your coverage will not begin until this application has been approved, an effective date assigned, and your payment received. Failure to provide all information requested may result in a delay in the processing of your application. If you are not approved for coverage, your check or voided check/savings deposit slip will be returned by mail.

6. Once your materials are complete, be sure to make a copy for your records. Mail your application and check or *Electronic Payments* form to:

Independence Blue Cross  
P.O. Box 41474  
Philadelphia, PA 19101-1474

7. If you are approved and enroll in an HSA-Qualified plan (PPO 5000 HSA or PPO 3000 HSA), you may be qualified to open a Health Savings Account (HSA) to help you save for future qualified medical expenses on a tax-free basis. Independence Blue Cross has a preferred relationship with The Bancorp Bank, an independent company, to provide HSA services. If you would like to open an HSA through Bancorp, in Section A, be sure to check “Yes, I’d like an HSA account set up through Bancorp, please send Bancorp my information.” Visit the Department of the Treasury website at <http://www.treas.gov/offices/public-affairs/hsa> to learn more about HSA accounts and eligibility.

**If you have any questions or need help completing this application, contact Independence Blue Cross at 1-800-263-1410 Monday through Friday, between 9 a.m. and 9 p.m.**



*Keep this page for your records.*

## Preexisting Condition Information

**Please note:** These plans exclude coverage for preexisting conditions for the first 12 months of coverage. However, if you meet the requirements for creditable coverage, you may be able to reduce or waive the waiting period for your preexisting condition.

### **What is a preexisting condition exclusion?**

A preexisting condition exclusion excludes coverage for a certain period of time for charges related to any medical condition or illness for which medical advice or treatment was recommended or received within a stated “look-back” period that precedes the effective date of coverage.

If you have prior creditable coverage, you may be eligible for a waiver of the preexisting condition exclusion.

### **What is creditable coverage?**

Creditable coverage refers to health coverage that you have now or that you have had previously that meets certain conditions. The previous health plan must have been in force for a specified time period (12 months for a Blue Cross® & Blue Shield® plan and 18 months for other carriers’ plans). If the prior coverage was with a Blue Cross & Blue Shield plan it must have been in force continuously without a break prior to your current application. For other carriers’ plans the prior coverage must have been in force continuously without a break of more than 63 days prior to your current application.

Prior creditable coverage does not guarantee acceptance into this medically underwritten program. All applications are subject to underwriting approval. For more information, go to [www.ibx.com](http://www.ibx.com) and visit the Individual & Family plans section.

### **What kind of plans qualify as creditable coverage?**

- group or individual health plans including governmental plans
- COBRA continuation coverage
- state high-risk pools
- Indian Health Service
- public health plans (such as a plan offered by a state)
- federal or state employee benefits
- Medicare
- Medicaid

### **Plans that do not count as creditable coverage include:**

- accident only
- dental or vision only
- disability or liability plans
- auto or homeowners plans
- hospital indemnity
- Workers’ compensation
- specified disease policies (e.g., cancer policies)

### **What is needed to be considered for a reduction or waiver of the preexisting condition exclusion period?**

- Be sure that you have fully completed all parts of Section G — Other Insurance.
- You must also submit a Certificate of Creditable Coverage for each applicant.



**For office use only**

Application ID: \_\_\_\_\_

Account ID: \_\_\_\_\_

**Application/Change Form for Individual Coverage**

Keystone Health Plan East (KHPE) HMO Plans and QCC Insurance Company PPO Plans\*

In order to be eligible for coverage, the following must be true:

- The primary applicant must be between the ages of 18 and 64.
- You, your spouse or dependents are not pregnant, an expectant parent, or in the process of adoption or surrogacy.
- Applicants are residents of Bucks, Chester, Delaware, Montgomery, or Philadelphia counties in Pennsylvania.
- Applicants are not eligible for Medicare or Medicare Disability.
- Dependents must be under 19 years old or a full-time student under age 23.

**SECTION A — Plan Selections**

Type of Coverage	Reason for Application	Payment Mode	For office use only
<input type="checkbox"/> Individual <input type="checkbox"/> Individual and spouse <input type="checkbox"/> Individual and child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> New enrollment <input type="checkbox"/> Add spouse <input type="checkbox"/> Add dependent child(ren) <input type="checkbox"/> Change benefit plan	<input type="checkbox"/> Monthly billing <input type="checkbox"/> Monthly ACH	Approved Effective Date _____

Choice of Plan	
Keystone Health Plan East plans: <input type="checkbox"/> HMO 5000 Deductible <input type="checkbox"/> HMO 20 Copay <input type="checkbox"/> HMO 2500 Deductible <input type="checkbox"/> HMO 15 Copay <input type="checkbox"/> HMO 1500 Deductible <input type="checkbox"/> HMO 10 Copay	QCC Insurance Company Personal Choice plans: <input type="checkbox"/> PPO 5000 Deductible <input type="checkbox"/> PPO 5000 HSA <input type="checkbox"/> Yes, I'd like an HSA account set <input type="checkbox"/> PPO 2500 Deductible <input type="checkbox"/> PPO 3000 HSA      up through Bancorp. Please <input type="checkbox"/> PPO 30 Copay                      send Bancorp my information.

**SECTION B — Primary Applicant Information (must be between the ages of 18 and 64)**

Primary applicant name: Last, First, M.I.		Social Security number			
Employer name	Birth date ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Height __ft. __in.	Weight ____lbs.
Primary care office name (HMO only) <sup>†</sup>	PCP office code (HMO ID#, HMO only) <sup>†</sup>			Current patient? (HMO only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No	

\* The Keystone Health Plan East HMO Plans are underwritten by Keystone Health Plan East and the QCC Insurance Company PPO Plans are underwritten by QCC Insurance Company.

<sup>†</sup> Required for all HMO plans. Use our website [www.ibx4you.com](http://www.ibx4you.com) to find a primary care physician (PCP) or call 215-241-3367 to request a PCP directory (HMO plans only).

**SECTION C — Family Information (if applying)**

Spouse name: Last, First, M.I.		Social Security number			
Employer name	Birth date ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Height __ft. __in.	Weight ____lbs.
Primary care office name (HMO only) <sup>†</sup>	PCP office code (HMO ID#, HMO only) <sup>†</sup>		Current patient? (HMO only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent name: Last, First, M.I.		Social Security number			
Relationship (e.g., son, stepdaughter)	Birth date ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Height __ft. __in.	Weight ____lbs.
Primary care office name (HMO only) <sup>†</sup>	PCP office code (HMO ID#, HMO only) <sup>†</sup>		Current patient? (HMO only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent name: Last, First, M.I.		Social Security number			
Relationship (e.g., son, stepdaughter)	Birth date ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Height __ft. __in.	Weight ____lbs.
Primary care office name (HMO only) <sup>†</sup>	PCP office code (HMO ID#, HMO only) <sup>†</sup>		Current patient? (HMO only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No		

Dependent name: Last, First, M.I.		Social Security number			
Relationship (e.g., son, stepdaughter)	Birth date ____/____/____	Age	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Height __ft. __in.	Weight ____lbs.
Primary care office name (HMO only) <sup>†</sup>	PCP office code (HMO ID#, HMO only) <sup>†</sup>		Current patient? (HMO only) <sup>†</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No		

<sup>†</sup>Required for all HMO plans. Use our website [www.ibx4you.com](http://www.ibx4you.com) to find a primary care physician (PCP) or call 215-241-3367 to request a PCP directory (HMO plans only).

**Student Information (Dependents age 19 and under 23 must be full-time students in an accredited school or university)**

Dependent name: Last, First	School attending	Semester hours	Expected graduation date

**SECTION D — Personal Information**

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Are any applicants 'non-U.S. citizen' residents? <input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes," provide the information below for 'non-U.S. citizen' residents:
Name(s) _____ Length of time in U.S. _____
Non-U.S. citizens must have resided within the United States for the past six (6) consecutive months and must provide a copy of their green card or student/work visa.

**SECTION D, continued**

Residence address			Mailing address (if different from residence address)		
Street (P.O. Box not acceptable)			Street		
City	State	ZIP code	City	State	ZIP code
County			Note: Confidential medical information may be mailed to the mailing address.		

**SECTION E — Contact Information**

Home phone # (      )	Business phone # (      )	Best time to call: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon
Mobile phone # (      )	Email address	Best location to call: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Mobile

**SECTION F — Household Information**

A. Do all applicants reside in the same household?    Yes    No  
 If no, provide reason: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

B. Do all applicants reside in one of the following counties: Bucks, Chester, Delaware, Montgomery, or Philadelphia?    Yes    No  
 If no, provide reason: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SECTION G — Other Insurance**

A. Are you or any applicants currently insured with Independence Blue Cross or an affiliate of Independence Blue Cross, or another Blue Cross & Blue Shield plan?    Yes    No

B. Have you or any applicants been insured under any other group or individual health plan for the last 18 months without a break of more than 63 days?    Yes    No

C. Do you have any other accident and health insurance in force?    Yes    No

D. Are you replacing the accident and health insurance plan listed in A, B, or C above?    Yes    No

If “yes,” termination date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Important: Do not cancel any existing coverage until you have received notification that your application has been approved. Attach a Certificate of Creditable Coverage for each applicant (if applicable). If approved, you may be eligible for preexisting credit.*

If you answered “yes” to question A,B, and/or C provide the following information for each applicant.

Name	Health care carrier	Policy number	Term/ Renewal date

**SECTION G, continued**

Have any applicants been rejected for life or health insurance?  Yes  No

If "yes," provide the following:

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason: \_\_\_\_\_

Are you or any applicants enrolling or eligible for Medicare or Medicaid due to age and/or disability?  Yes  No

If "yes," provide the following:

Name: \_\_\_\_\_

Eligibility Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Any person eligible for Medicare or Medicare disability benefits is not eligible for this coverage.

**SECTION H — Travel and Residence Outside the U.S.A.**

A. Have you or any applicants resided or traveled outside of the U.S.A. for the past six consecutive months?  Yes  No

If "yes," please provide name, country and explain: \_\_\_\_\_

B. Is any applicant planning to travel or work outside the U.S.A. within the next two years?  Yes  No

If "yes," name of person: \_\_\_\_\_ Country: \_\_\_\_\_

Reason: \_\_\_\_\_ Length of stay: \_\_\_\_\_

**SECTION I — Expectant Parent Information (including adoption and surrogacy)**

**Females:** Have you or any dependents (whether applying for coverage or not) been diagnosed and/or are currently under the care of a licensed health care practitioner for an existing pregnancy?  Yes  No

If "yes," name of person: \_\_\_\_\_ Expected delivery date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Males:** Are you expecting a child with anyone, even if the birth mother with a diagnosed pregnancy is not listed on the application?  Yes  No

**Females and males:** Is any applicant in the process of adoption or surrogacy with anyone whether or not that person is applying for coverage on this application?  Yes  No

If "yes," name of person: \_\_\_\_\_ Expected adoption/delivery date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**SECTION J — Health Related Questions**

1. Does any applicant use medical equipment (such as a walker, cane, hospital bed)?  Yes  No

2. Is any applicant currently receiving home health care?  Yes  No

3. Has any applicant received occupational, physical, or speech therapy, or chiropractic treatments in the past 5 years?  Yes  No

4. In the past five years, has any applicant been advised by a licensed health care practitioner of any abnormal lab results, X-rays, MRI, or physical exams results?  Yes  No

5. In the past five years, has any applicant been medically advised to undergo further medical testing, treatment, or surgery which has not yet been completed?  Yes  No

6. Has any applicant consulted any physician or other health care provider, been a patient in a hospital, surgical center, or other medical facility in the last five years?  Yes  No

7. Has any applicant taken prescription medications or been advised to take prescription medications in the past 2 years?  Yes  No

8. Has any applicant been medically treated or diagnosed for alcohol, chemical, or substance abuse or been advised to reduce alcohol intake at any time during the last five years?  Yes  No

## SECTION J, continued

Below provide dates and details for "yes" responses in Section "J" questions 1 – 8. Attach a separate sheet if needed, and sign and date.

Question #	Name of person	Start and end dates MM/YY to MM/YY	Explanation
		___/___ to ___/___	
		___/___ to ___/___	
		___/___ to ___/___	
		___/___ to ___/___	
		___/___ to ___/___	

9. Has any applicant used controlled substances including but not limited to cocaine, heroin, LSD, marijuana, or methamphetamines at any time during the last 5 years?  Yes  No

If "yes," provide the following:

Name of person: \_\_\_\_\_ Name of drug/substance: \_\_\_\_\_ Date last used: \_\_\_/\_\_\_/\_\_\_

10. Has any applicant smoked or used any form of tobacco within the last five years?  Yes  No

If "yes," list below the name of person(s) and type and amount of tobacco used per day.

Name of person: \_\_\_\_\_ Type and amount: \_\_\_\_\_ Date last smoked or used tobacco: \_\_\_/\_\_\_/\_\_\_

Name of person: \_\_\_\_\_ Type and amount: \_\_\_\_\_ Date last smoked or used tobacco: \_\_\_/\_\_\_/\_\_\_

## SECTION K — Health History Questionnaire

Answer all questions and provide complete details to all "yes" answers in Section L1 — Additional Detailed Medical Information.

In the last 10 years, has any applicant consulted a health care provider, been diagnosed, received treatment, or been hospitalized for any of the following conditions or diseases?

1. Birth Defects/Congenital Abnormalities <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Skull or facial deformities
<input type="checkbox"/> Cleft palate/lip	<input type="checkbox"/> Down's syndrome	<input type="checkbox"/> Lung disorder	<input type="checkbox"/> Webbed fingers/toes
<input type="checkbox"/> Club foot	<input type="checkbox"/> Heart disorder	<input type="checkbox"/> Mental retardation	<input type="checkbox"/> Other _____
2. Brain/Nervous System Conditions/Disorders <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Alzheimers	<input type="checkbox"/> Head injury	<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Convulsions	<input type="checkbox"/> Headaches – chronic	<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Seizures
<input type="checkbox"/> Dementia	<input type="checkbox"/> Headaches – migraine	<input type="checkbox"/> Nervous disorder	<input type="checkbox"/> Stroke
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Neuritis	<input type="checkbox"/> Tremors
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> Vertigo
<input type="checkbox"/> Fainting	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Other _____
3. Cancer/Tumors <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Abnormal growth/neoplasm	<input type="checkbox"/> Hodgkin's disease	<input type="checkbox"/> Tumors	
<input type="checkbox"/> Cysts	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Other cancer _____	

**SECTION K, continued**

<b>4. Digestive Conditions/Disorders</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Acid or gastric reflux (GERD)	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Hernia	<input type="checkbox"/> Rectal disorder
<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/> Gastric bypass/banding	<input type="checkbox"/> Intestines disorder	<input type="checkbox"/> Stomach disorder
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Esophagus disorder	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Colitis	<input type="checkbox"/> Heartburn/Indigestion	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Unexplained weight gain or loss
<input type="checkbox"/> Colon polyps	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Jaw or chewing problems	<input type="checkbox"/> Other _____
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Hepatitis (type _____)	<input type="checkbox"/> Liver disease	
<b>5. Eyes, Ears, Nose, and Throat Conditions/Disorders</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<b>Eyes/Sight:</b>	<b>Ears/Hearing:</b>	<b>Nose/Breathing:</b>	<b>Throat/Swallowing:</b>
<input type="checkbox"/> Blindness	<input type="checkbox"/> Deafness	<input type="checkbox"/> Adenoiditis	<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Eustachian tube dysfunction	<input type="checkbox"/> Deviated septum	<input type="checkbox"/> Strep throat
<input type="checkbox"/> Crossed eyes	<input type="checkbox"/> Infections	<input type="checkbox"/> Polyps	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Detached retina	<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other _____		
<input type="checkbox"/> Infections			
<input type="checkbox"/> Other _____			
<b>6. Heart and Circulatory Conditions/Disorders</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Chest pain	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Raynauds disease/Phenomenon
<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Angina	<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Lymphadenitis	<input type="checkbox"/> Thrombosis
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Pacemaker or defibrillator	<input type="checkbox"/> Valve replacement
<input type="checkbox"/> Bleeding/Clotting disorder	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Bypass surgery/angioplasty	<input type="checkbox"/> High cholesterol/lipids	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Other _____
<b>7. Metabolic and Endocrine Conditions/Disorders</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Adrenal/Pituitary disorder	<input type="checkbox"/> Epstein-Barr	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Other glandular disorder
<input type="checkbox"/> AIDS/ARC/HIV positive	<input type="checkbox"/> Goiter	<input type="checkbox"/> Pancreatic disorder	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chronic fatigue syndrome	<input type="checkbox"/> Immune disorder	<input type="checkbox"/> Scleroderma	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lupus	<input type="checkbox"/> Thyroid disorder	
<b>8. Musculoskeletal Conditions/Disorders</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fracture	<input type="checkbox"/> Joint or bone disorder	<input type="checkbox"/> Tendon injury
<input type="checkbox"/> Back disorder	<input type="checkbox"/> Gout	<input type="checkbox"/> Paraplegic/Quadriplegic	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dislocations	<input type="checkbox"/> Herniated disc	<input type="checkbox"/> Spinal curvature	
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Internal fixation/hardware	<input type="checkbox"/> Strain/Sprain	
<b>9. Nervous, Mental and Behavioral Conditions/Disorders</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Anxiety/Panic disorders	<input type="checkbox"/> Chemical imbalance	<input type="checkbox"/> Manic depressive disorder	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Attention deficit hyperactivity disorder	<input type="checkbox"/> Counseling/Support group	<input type="checkbox"/> Mental disease	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> Obsessive-compulsive disorder	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Eating disorders	<input type="checkbox"/> Psychosis	
<b>10. Female Reproductive Conditions/Disorders</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Abnormal menstrual bleeding	<input type="checkbox"/> Breast disorders/implants	<input type="checkbox"/> Miscarriage/abortion	<input type="checkbox"/> Polycystic ovary syndrome
<input type="checkbox"/> Abnormal Pap smear	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> Absence of menstruation	<input type="checkbox"/> Genital warts/herpes	<input type="checkbox"/> Pelvic pain/pelvic inflammatory disease	<input type="checkbox"/> Uterine fibroids
<input type="checkbox"/> Breast cysts/lumps/adenomas	<input type="checkbox"/> Infertility		<input type="checkbox"/> Other _____
<b>11. Male Reproductive Conditions/Disorders</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Genital herpes/warts	<input type="checkbox"/> Low sperm count	<input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Undescended testes
<input type="checkbox"/> Infertility	<input type="checkbox"/> Prostate disorder	<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> Other _____
<b>12. Respiratory Conditions/Disorders</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Allergies	<input type="checkbox"/> COPD	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pneumothorax	<input type="checkbox"/> Other _____
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Fungal infections	<input type="checkbox"/> Sarcoidosis	

**SECTION K, continued**

<b>13. Skin Conditions/Disorders</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Acne	<input type="checkbox"/> Fungal infections	<input type="checkbox"/> Pre-cancerous lesions	<input type="checkbox"/> Skin cancer or melanoma	
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Keratosis	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Eczema	<input type="checkbox"/> Moles/warts			
<b>14. Urinary Conditions/Disorders</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Kidney/bladder stones	<input type="checkbox"/> Sugar in urine		
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Kidney infections/nephritis	<input type="checkbox"/> Urinary tract disorder		
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Protein in urine	<input type="checkbox"/> Other _____		
<b>15. Has any applicant been diagnosed or treated for any other condition or disorder not listed in questions 1 through 14?</b>				<input type="checkbox"/> Yes <input type="checkbox"/> No
If "yes," write the condition below.				
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	

**SECTION L1 — Additional Detailed Medical Information**

Provide full details to *all* questions answered "yes" in Section K. Attach a separate sheet if needed, and sign and date it.

Question #	Person treated: _____	Start and end dates: ___/___ to ___/___	Degree of recovery: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Full
Explain nature of illness/condition:		Physician or hospital	
_____		Name: _____	
_____		Specialty: _____	
Describe treatment received/recommended:		Phone: ( _____ ) _____	
_____		_____	
_____		_____	

Question #	Person treated: _____	Start and end dates: ___/___ to ___/___	Degree of recovery: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Full
Explain nature of illness/condition:		Physician or hospital	
_____		Name: _____	
_____		Specialty: _____	
Describe treatment received/recommended:		Phone: ( _____ ) _____	
_____		_____	
_____		_____	

Question #	Person treated: _____	Start and end dates: ___/___ to ___/___	Degree of recovery: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Full
Explain nature of illness/condition:		Physician or hospital	
_____		Name: _____	
_____		Specialty: _____	
Describe treatment received/recommended:		Phone: ( _____ ) _____	
_____		_____	
_____		_____	

**SECTION L1, continued**

Question # _____	Person treated: _____	Start and end dates: ___/___ to ___/___	Degree of recovery: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Full
Explain nature of illness/condition: _____ _____			Physician or hospital Name: _____
Describe treatment received/recommended: _____ _____			Specialty: _____ Phone: ( _____ ) _____

Question # _____	Person treated: _____	Start and end dates: ___/___ to ___/___	Degree of recovery: <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Full
Explain nature of illness/condition: _____ _____			Physician or hospital Name: _____
Describe treatment received/recommended: _____ _____			Specialty: _____ Phone: ( _____ ) _____

**SECTION L2 — Additional Detailed Medical Information**

Have any applicants taken any prescription drugs or medications within the last 12 months?  Yes  No

If “yes,” list all below. Attach a separate sheet if needed, and sign and date it.

Name of person	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Reason/Condition for which medication is prescribed	Date prescribed to date discontinued ____/____ to ____/____	Physician or hospital Name: _____ Phone: ( _____ ) _____
			____/____ to ____/____	Name: _____ Phone: ( _____ ) _____
			____/____ to ____/____	Name: _____ Phone: ( _____ ) _____
			____/____ to ____/____	Name: _____ Phone: ( _____ ) _____
			____/____ to ____/____	Name: _____ Phone: ( _____ ) _____
			____/____ to ____/____	Name: _____ Phone: ( _____ ) _____

### SECTION L3 — Last Doctor Visit

List the last doctor visit for all applicants, including routine check-ups. Attach a second sheet if needed, and sign and date it.

Primary applicant name	Date of last doctor visit ____/____/____
Purpose of last visit: _____ _____	Physician information Name: _____ Phone: (____) _____
Findings <input type="checkbox"/> normal <input type="checkbox"/> abnormal (if abnormal, provide details): _____ _____	Address: _____ _____ _____

Spouse name	Date of last doctor visit ____/____/____
Purpose of last visit: _____ _____	Physician information Name: _____ Phone: (____) _____
Findings <input type="checkbox"/> normal <input type="checkbox"/> abnormal (if abnormal, provide details): _____ _____	Address: _____ _____ _____

Dependent name	Date of last doctor visit ____/____/____
Purpose of last visit: _____ _____	Physician information Name: _____ Phone: (____) _____
Findings <input type="checkbox"/> normal <input type="checkbox"/> abnormal (if abnormal, provide details): _____ _____	Address: _____ _____ _____

Dependent name	Date of last doctor visit ____/____/____
Purpose of last visit: _____ _____	Physician information Name: _____ Phone: (____) _____
Findings <input type="checkbox"/> normal <input type="checkbox"/> abnormal (if abnormal, provide details): _____ _____	Address: _____ _____ _____

Dependent name	Date of last doctor visit ____/____/____
Purpose of last visit: _____ _____	Physician information Name: _____ Phone: (____) _____
Findings <input type="checkbox"/> normal <input type="checkbox"/> abnormal (if abnormal, provide details): _____ _____	Address: _____ _____ _____



Application ID: \_\_\_\_\_

Account ID: \_\_\_\_\_

**Authorization for Release of Medical Information**

Keystone Health Plan East (KHPE) HMO Plans

QCC Insurance Company PPO Plans

As part of the process of determining eligibility, and for the purpose of underwriting this insurance application, I authorize the release of my protected health information (PHI) and that of my dependent children under the age of 18. This includes information and/or medical records relating to past, present, and future health care examinations, prescription drugs, treatment and diagnosis, including those involving mental health (excluding psychotherapy notes, unless specifically and separately authorized), substance abuse, and HIV/AIDS. I do authorize any physician, medical practitioner, hospital, medical or medically related facility, insurer, pharmacy benefits manager, or any other health care organization to release the information as described above to Keystone Health Plan East or QCC Insurance Company (“the companies”) and their subsidiaries.

This authorization shall remain in force for 18 months following the date of the signature(s) below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notice to Independence Blue Cross, Medical Underwriting Department, 1901 Market Street, Philadelphia, PA 19103-1480. I understand that a revocation is not effective to the extent that the companies or any other person have already relied on this authorization to disclose or collect information, or to the extent the companies and their subsidiaries have a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that the PHI disclosed based on this authorization may be subject to re-disclosure and may then be no longer protected by the federal privacy rule. However, the companies are required to comply with the HIPAA Privacy Rules and any re-disclosure of information will be done under the privacy rule. I understand that I will receive a copy of this signed authorization. A copy of this authorization is as valid as the original. I understand that if I refuse to sign this authorization the companies may refuse to enroll me or may determine that I am not eligible for benefits.

**SIGN HERE**  \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of proposed primary insured Date

**SIGN HERE**  \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of spouse (if applying for coverage) Date

**SIGN HERE**  \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of adult dependent child, age 18-22 (if applying for coverage) Date

**SIGN HERE**  \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature of adult dependent child, age 18-22 (if applying for coverage) Date

## SECTION M — Declarations and Conditions of Enrollment

Please read carefully before signing below.

By applying to Keystone Health Plan East or QCC Insurance Company ("the companies") for coverage for myself and the dependents listed in Section C, I understand and agree as follows:

**\*Coverage may be denied, or a premium adjustment made, based on information provided to the companies during the underwriting process.**

1. a) The requested Effective Date of Coverage is the \_\_\_\_\_ 1st or the \_\_\_\_\_ 15th day of \_\_\_\_\_ (month).  
b) There is no guarantee that your requested Effective Date can be met.  
c) Coverage does not begin until this application is approved by the companies with an Effective Date of coverage assigned and payment has been received.  
d) If selecting monthly payment, a check for the first monthly premium must be submitted with your paper application. If selecting automatic monthly bank withdrawal through Automatic Clearing House (ACH), a completed authorization form and a voided check or savings deposit slip must be submitted with the application.  
e) Receipt of the initial payment (check or ACH) does not constitute enrollment under any program.  
f) This coverage is provided only to residents of the geographical area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, Pennsylvania, served by the companies. The companies reserve the right to investigate and confirm your residence.
2. a) The companies may require me and/or my family member(s) applying to provide additional medical history. The companies may also require a medical examination, blood test or other applicable medical test prior to acceptance of the application.  
b) The companies may telephone me or my dependents for additional information that may help with timely application processing.  
c) The companies may deny this application, in which case any premium submitted will be returned to me.  
d) The companies may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by supplying materially incorrect or misleading enrollment eligibility information, except in the case of fraudulent statements or omissions, for which there is no time limit for voiding the policy.
3. **HMO:** I understand that benefits will not be payable during the 12-month period following the Effective Date on which I and my covered dependents become enrolled under the non-group benefit policy for any condition, illness, or injury for which medical advice or treatment was recommended by or received from a physician or other professional provider within a 90-day period prior to the Effective Date of the policy.
4. **PPO:** I understand that benefits will not be payable during the 12-month period following the Effective Date on which I and my covered dependents become enrolled under the non-group benefit policy for any condition, illness, or injury for which medical advice or treatment was recommended by or received from a physician or other professional provider within a 12-month period prior to the Effective Date of the policy.
5. I understand that I and any dependents may be eligible for insurance coverage without a preexisting condition exclusion if I (we) have been enrolled in a Blue Cross and Blue Shield plan, or an affiliate of Independence Blue Cross during the 12 months immediately preceding without a break in coverage.
6. The terms and conditions of the coverage will be controlled by the written agreement with the companies, and the companies may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.
7. **HMO Plans Only:**
  - a) As a condition of coverage, each applicant must select a participating primary care physician.
  - b) As a condition of coverage, (with the exception of emergency procedures and certain direct access services as defined in the Subscriber Agreement) all services, in order to be covered by KHPE, must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy (if applicable), or other provider as authorized by a referral, or pre-certification, from a participating primary care physician or KHPE.
8. I understand that benefits under this policy will be coordinated with other coverage any covered person may have which is subject to coordination.
9. By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-Group policy, the companies will use and disclose PHI (protected health information) for purposes of Treatment, Payment and Operations (TPO) as this term is defined by federal law.
10. I understand that any medical condition or treatment that occurs after the signature date and before the effective date of any approved coverage will be considered in the final underwriting decision. I agree to advise the companies of any condition or treatment occurring during such period.
11. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

### Signature(s) Required

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

SIGN HERE

X

Applicant/Parent or Legal Guardian signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

SIGN HERE

X

Applicant spouse signature (if applying for coverage)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**SECTION N — Statement of Accountability (if applicable)**

To be completed if the applicant cannot complete or has not completed the application:

I, \_\_\_\_\_, have read and completed the application form for the primary applicant for the following reason(s):

- Applicant does not speak English
- Applicant does not write in English

- Applicant does not read English
- Other (explain) \_\_\_\_\_

I translated and fully explained the "Declarations and Conditions of Enrollment." I also translated the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by: \_\_\_\_\_

 X \_\_\_\_\_ / /  
Signature of translator (required) Date (required)

Relationship to applicant: \_\_\_\_\_

**SECTION O — Broker Information (if applicable)**

Primary broker code PA06853A	Producer broker code
Primary broker name Savoy Associates	Producer name
Telephone number 973 377 2220 ext 123	Telephone number

**IBC Sale Representative (if applicable)**

Sales representative code	Name of sales representative
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Mail your application and check or *Electronic Payments* form to:  
**Independence Blue Cross**  
**P.O. Box 41474**  
**Philadelphia, PA 19101-1474**

If you have any questions, contact Independence Blue Cross at **1-800-263-1410** between 9 a.m. and 9 p.m.



