CUSTOMER INFORMATION FORM

Your agent will submit an application for Blue Care based on the information that you provide below. Please answer every question.

Applicant's Residential Address:

Name: ______________________ Social Security No. ______________

Street (No P.O. Boxes): ______________________ Apt. #: ________

Telephone No. ______________ County: ______________

City: ______________________ State: ______ Zip Code: ________

Mailing Address (if different than residence):

P.O. Box: ______________________ Apt. #: ________

City: ______________________ State: ______ Zip Code: ________

Applicant's Sex: ☐ M ☐ F Date of Birth: ____________ Height: ________ Weight: ________

If you are applying on behalf of a minor, please complete the following:

Relationship (check one): ❑ Parent ❑ Guardian / Legal Representative

Name: ______________________

Address: ______________________

City: ______________________ State: ______ Zip Code: ________

Deductible Amount (choose one): ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

Maternity is an optional coverage. If you choose maternity coverage, you should understand that nothing related to maternity would be covered for the first 12 months after the policy is effective and the rates will be significantly higher. Do you want maternity coverage? ☐ Yes ☐ No

Are any of these people currently covered by other health insurance? ☐ Yes ☐ No

If yes, check type: ☐ Blue Cross and Blue Shield (BCBS) ☐ Medicare ☐ Other Company

If the other coverage is Blue Cross and Blue Shield, location of the BCBS Plan:

City ______________________ State ______

Current BCBS Identification Number: ______________________

Are all of the people mentioned above covered by this policy? ☐ Yes ☐ No

If no, list the full names of all of the people NOT covered: ______________________

If Carrier other than Medicare, complete the following:

Carrier Name ______________________________

Identification Number ______________________ Effective Date of Coverage ______________

Are all of the people mentioned above covered by this policy? ☐ Yes ☐ No

If no, list the full names of all of the people NOT covered: ______________________________

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Please provide the following information for every person that will be covered under the policy. Make sure that the height and weight are accurate.

Name	Social Security #	Date of Birth	Sex	Height	Weight

RESIDENTIAL AND HEALTH INFORMATION

Check Yes or No:

Is the Applicant and each listed family member a resident of the state of Mississippi, living in Mississippi for at least six (6) months of each calendar year? ☐ Yes ☐ No

Has the applicant or any listed family member ever been refused health or life insurance? ☐ Yes ☐ No

Is the applicant or any listed family member currently receiving or contemplating medical attention or surgery? ☐ Yes ☐ No

Are you or any members of your family now pregnant? (This information must be provided even if the pregnant family member will not be covered.) ☐ Yes ☐ No

Has the applicant or any family member sought treatment for infertility at any time during the past five (5) years? (This information must be provided even if the family member who received the infertility treatment will not be covered.) ☐ Yes ☐ No

Has the applicant, or any listed family member, or any other individuals living in applicant's household, including those not applying for coverage, used tobacco products within the past twelve (12) months? ☐ Yes ☐ No

Has the applicant or any listed family member used smokeless tobacco products within the past twelve (12) months? ☐ Yes ☐ No

Has the applicant or any listed family member ever been diagnosed with any of the following health conditions?

CARDIAC
- Hypertension ☐ Yes ☐ No
- High Cholesterol ☐ Yes ☐ No

DIABETES ☐ Yes ☐ No

GASTROINTESTINAL
- Ulcers ☐ Yes ☐ No

CANCER ☐ Yes ☐ No

NEUROLOGICAL
- Neck / Back Injury ☐ Yes ☐ No

NERVOUS / MENTAL
- Alcohol Abuse ☐ Yes ☐ No
- Drug Abuse ☐ Yes ☐ No
- Depression ☐ Yes ☐ No

JOINT REPLACEMENT ☐ Yes ☐ No
- Left Elbow ☐ Yes ☐ No
- Right Elbow ☐ Yes ☐ No
- Left Hip ☐ Yes ☐ No
- Right Hip ☐ Yes ☐ No
- Left Knee ☐ Yes ☐ No
- Right Knee ☐ Yes ☐ No
- Other Joint ☐ Yes ☐ No

RESPIRATORY
- Asthma ☐ Yes ☐ No
- Cystic Fibrosis ☐ Yes ☐ No
- Emphysema ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No

CARDIAC
- Angina ☐ Yes ☐ No
- Congestive Heart Failure (Heart Attack) ☐ Yes ☐ No
- Coronary Heart Disease ☐ Yes ☐ No
- Heart Surgery of any type ☐ Yes ☐ No

GASTROINTESTINAL
- Crohn's Disease ☐ Yes ☐ No
- Pancreatitis ☐ Yes ☐ No
- Diverticulitis ☐ Yes ☐ No
- Ulcerative Cholitis ☐ Yes ☐ No

HEPTOBILIARY / RENAL
- Hepatitis A ☐ Yes ☐ No
- Hepatitis B ☐ Yes ☐ No
- Hepatitis C ☐ Yes ☐ No
- Liver Disease ☐ Yes ☐ No
- Kidney Disease ☐ Yes ☐ No

NEUROLOGICAL
- Cardiovascular Accident (CVA) / Stroke / Transient Ischemic Accident (TIA) ☐ Yes ☐ No
- Paralysis ☐ Yes ☐ No
- Spina Bifida ☐ Yes ☐ No
- Cognitive Disorder / Dementia ☐ Yes ☐ No
- Multiple Sclerosis ☐ Yes ☐ No
- Lou Gehrig's Disease (ALS) ☐ Yes ☐ No
- Epilepsy / Seizures ☐ Yes ☐ No
- Cerebral Palsy ☐ Yes ☐ No

NERVOUS / MENTAL
- Eating Disorder ☐ Yes ☐ No

ORTHOPAEDIC
- Osteoarthritis ☐ Yes ☐ No
- Rheumatoid Arthritis ☐ Yes ☐ No
- Fibromyalgia ☐ Yes ☐ No

DISEASES OF THE IMMUNE SYSTEM
- Acquired Immune Deficiency Syndrome (AIDS) ☐ Yes ☐ No
- Antibodies to AIDS Virus ☐ Yes ☐ No
- Lupus ☐ Yes ☐ No
- Sickle Cell Anemia ☐ Yes ☐ No
- Blood Disorder / Hemophilia ☐ Yes ☐ No

Has the applicant or any listed family member ever had any other health conditions not listed above? ☐ Yes ☐ No

Has the applicant or any listed family member taken any prescribed medication during the past twenty-four (24) months at the advice of a physician or other professional? ☐ Yes ☐ No

Explain any yes answer, include the name of the patient, names and dates of the doctors that treated you, medications prescribed (including strength), and current status of the condition (i.e. On Going, Complete Recovery, No Longer Requiring Treatment, etc.).

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METHOD OF PAYMENT

Do you wish to have a Bankdraft? ☐ Yes ☐ No (If no, bill me ☐ monthly ☐ quarterly.)
(If yes, attach a voided check.)

EFFECTIVE DATE

I want my coverage to be effective on the *(check one)* ☐ 1st or ☐ 15th of the month.

NOTE: Blue Care is a preferred risk product. While you have a right to access all protected health information upon which a rejection of the application is based, Blue Cross & Blue Shield of Mississippi is not required to and will not provide any specific explanation regarding a rejection of coverage.

PRE-EXISTING CONDITIONS

The applicant agrees that no benefits will be provided under the policy for any pre-existing condition until the policy has been in effect for a period of 12 months. A pre-existing condition means any injury, illness, congenital defect, or pregnancy; or condition related to injury, illness, congenital defect or pregnancy for which a person received medical care, treatment, consultation, or prescribed drugs during the 12-month period immediately preceding an individual's effective date of coverage under the policy.

The applicant or person applying on behalf of the applicant declares that all statements made on this customer information form are true, correct and complete.

Applicant's Signature: ______________________________ Date: ____________________