

IMPORTANT — COMPLETE ALL SECTIONS IN BLACK INK (PLEASE PRINT) AND SIGN ON BACK

LAST NAME <input type="checkbox"/> NEW OWNER <input type="checkbox"/> NEW NAME		FIRST NAME	M.I.	DATE OF BIRTH MO. DAY YEAR			SEX	SOCIAL SECURITY NO.
STREET		COUNTY	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED				CURRENT I.D. NO.	
CITY	STATE	ZIP CODE	DAYTIME PHONE () _____		EVENING PHONE NO. () _____		CURRENT GROUP NO.	

CHANGE COVERAGE AS INDICATED BELOW

1 CHANGE IN NAME OR COVERAGE OWNERSHIP

IMPORTANT: If changing name, please indicate new name above.

If changing ownership, both parties must sign the back of the form.

Change My Name From: _____ To: _____

Change Ownership From: _____ To: _____

2 CHANGE COVERAGE PLAN TYPE (COMPLETE MEDICAL QUESTIONNAIRE FOR BENEFIT CHANGES.)

PLAN TYPE: <input type="checkbox"/> Individual <input type="checkbox"/> Individual and Spouse <input type="checkbox"/> Individual and Children <input type="checkbox"/> Family	BENEFIT CHANGES TO: DEDUCTIBLE: I choose to pay the first <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 STOP LOSS AMOUNT: <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
REASON(S) FOR CHANGE: <input type="checkbox"/> Death — date _____ <input type="checkbox"/> Divorce — date _____ <input type="checkbox"/> Birth — date _____ <input type="checkbox"/> Marriage — date _____ Maiden Name (if applicable) _____ <input type="checkbox"/> Request for Reinstatement <input type="checkbox"/> Other — Explain _____ _____	OPTIONS: (Must be age 18 or older to add maternity coverage) ADD: <input type="checkbox"/> MATERNITY COVERAGE DELETE: <input type="checkbox"/> MATERNITY COVERAGE <input type="checkbox"/> TERM LIFE INSURANCE* *NOTE: Once BlueCare Term Life Insurance is deleted, it cannot be reinstated.

3 CHANGE IN DEPENDENT STATUS (COMPLETE MEDICAL QUESTIONNAIRE IF ADDING DEPENDENTS.) ADD DELETE

DO ALL PROPOSED APPLICANTS RESIDE IN THE SAME HOUSEHOLD? YES NO

IF NO, PROVIDE DETAILS: _____

LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH	S.S. NO.	RELATIONSHIP	HEIGHT	WEIGHT

A. Will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? Yes No

If yes, name of company _____, I.D. No. _____ Date of Termination ____/____/____
Address _____

B. Are you or any dependent to be covered by this policy also covered by Medicare? Yes No

If yes, effective date: ____/____/____
Persons covered by Medicare: (1) _____ (2) _____ (3) _____

4 MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE

I. Have you or any other persons to be insured

A. Ever been declined, rated, restricted or modified for the issuance of life, accident or health insurance? (A) Yes No

B. Ever had or been advised to have treatment, care or diagnosis for:

[Circle condition(s) for which "yes" answer applies.]

- (1) High blood pressure or disease or disorder of the heart or circulatory system? (1) Yes No
- (2) Allergies, asthma, sleep apnea, disease or disorder of the lungs or respiratory system? (2) Yes No
- (3) Disease or disorder of the kidneys, urinary tract, reproductive organs or breasts? (3) Yes No
- (4) Disease or disorder of the liver, gallbladder, intestines, rectum, stomach or other vital organs, including hepatitis? (4) Yes No
- (5) Diabetes or high blood sugar? If yes, date of onset _____ (5) Yes No

(Continued On Next Page)

FOR ABCBS OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)

<input type="checkbox"/> Approved <input type="checkbox"/> Approved with E.R. No. _____ <input type="checkbox"/> Approved without _____ <input type="checkbox"/> Approved with _____% <input type="checkbox"/> Approved with Benefit Change	<input type="checkbox"/> Denied <input type="checkbox"/> No Action Underwriter _____ Date _____	I.D. NO.	EFFECTIVE DATE	PLN.	PKG.	TOBACCO	NON-TOBACCO
		GROUP NO.					

4 MEDICAL QUESTIONNAIRE (Continued)

- (6) Seizures, nervous system disease or disorder including epilepsy, Parkinsonism, convulsions, or headaches? (6) Yes No
- (7) Mental disease, nervous disorder, emotional problems, anxiety, depression, any eating disorder, psychiatric treatment, counseling, drug overdose, or attempted suicide? (7) Yes No
- (8) Stroke, paralysis or physical incapacitation? (8) Yes No
- (9) AIDS/AIDS-related complex or immune deficiency disorder? (9) Yes No
- (10) Cancer or malignancy? (10) Yes No
- (11) Disease or disorder of blood, glands, skin or lymphatic system? (11) Yes No
- (12) Epstein-Barr or chronic fatigue syndrome? (12) Yes No
- (13) Back pain, arthritis, paralysis, disease or disorder of the muscles, bones or joints? (13) Yes No
- (14) Disease or disorder of eyes, ears, nose, throat or esophagus? (14) Yes No
- (15) Chronic pain, abnormal growths, chronic infections? (15) Yes No
- C. Ever had or been advised to have treatment or counseling for alcoholism or other drug dependency? (C) Yes No
- D. Consulted a physician or received hospital (inpatient or outpatient care) or rehabilitation services during the past five years? (D) Yes No
- E. Been in an automobile, boating, airplane, etc., accident within the last 5 years? (E) Yes No
- F. Received occupational therapy, physical therapy, speech therapy or chiropractic treatments? (F) Yes No
- G. Used sedatives, tranquilizers, cocaine or other hallucinogenic or narcotic drugs or received treatment for drug abuse or chemical dependency in the past 10 years? (G) Yes No
- H. Ever had or been advised to have treatment for any condition not listed? (H) Yes No
- II. In the past three years has any applicant had prescribed or taken any prescription drugs?**
If yes, please list medication and the prescribing physician and address below. II. Yes No
- III. Is any person to be covered, or a dependent (whether applying for coverage or not) of an applicant, now pregnant or an expectant parent?**
Name _____ Expected Delivery Date _____ III. Yes No
- IV. Have you or any of the persons to be insured used any form of tobacco within the last 12 months?**
If yes, list name of person(s) below and type and amount of tobacco used per day: IV. Yes No
- Name(s) (1) _____ (2) _____ (3) _____
Type: _____ Type: _____ Type: _____
- V. Is any applicant listed planning to travel or work outside the USA within the next two years?**
If yes, give details: _____ V. Yes No

List below full details to questions answered "yes" and provide information on all previous surgeries including C-Sections. If separate sheet is needed, please date and sign.

Question No.	Person Treated	Condition – Type of Treatment Medication & Dosage	Date Occurred	Degree Recovery			Complete Name and Address of Physician
				None	Partial	Full	

5 PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application may be rejected. (2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card, and the initial premium is paid in full, but in no event will insurance become effective earlier than 10 days after the date of this application. (3) In addition to other exclusions and limitations, NO ARKANSAS BLUE CROSS AND BLUE SHIELD BENEFITS WILL BE AVAILABLE FOR 12 MONTHS FOR THE TREATMENT OF ANY CONDITION WHICH EXISTED BEFORE THE EFFECTIVE DATE OF MY COVERAGE. (4) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (5) I agree any provider of medical services or supplies is authorized and directed to furnish Arkansas Blue Cross and Blue Shield, its agents or any of its subsidiaries, all records or copies thereof, relating to such services or supplies. (6) My signature authorizes Arkansas Blue Cross and Blue Shield to coordinate benefits under this policy with other insurance I have which is subject to coordination. (7) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded to the best of my knowledge and belief; (b) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility; insurance or reinsurance company or any third party engaged by Arkansas Blue Cross and Blue Shield to secure medical or non-medical information having information with respect to any physical or mental condition, treatment or any non-medical information on me, or any member of my family (if applicable), to give Arkansas Blue Cross and Blue Shield, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (d) agree that this authorization shall be valid without time limit; (e) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request; (f) and authorize the Office of Driver Services to release my traffic violation record to Arkansas Blue Cross and Blue Shield.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

List below the name, driver's license number and state of issue for all licensed applicants:

Applicant: _____ Dependent: _____
Spouse: _____ Dependent: _____

Has any person to be covered had their driver's license suspended or revoked, or had two or more moving traffic violations in the past two years?

Yes No If yes, please explain: _____

Does any person to be covered intend to pilot a private aircraft or participate in sky or scuba diving; ballooning; motor vehicle, boat or snowmobile racing; mountain climbing; hang gliding, or any other hazardous sport, hobby or activity?

Yes No If yes, please explain: _____

Note: This application must be signed in the state of Arkansas.

SIGNATURE OF APPLICANT	X	DATE SIGNED	
------------------------	----------	-------------	--

SIGNATURE OF SPOUSE	X	DATE SIGNED	
---------------------	----------	-------------	--

PARENT/GUARDIAN SIGNATURE (if policy for a minor)	X	DATE SIGNED	
---------------------------------------------------	----------	-------------	--

THIS SECTION TO BE COMPLETED BY SALES REPRESENTATIVE

To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical or major medical insurance if this coverage is approved by Arkansas Blue Cross and Blue Shield and accepted by the applicant? Yes No

SALES REP. S.S. #	SALES REPRESENTATIVE'S SIGNATURE	DATE SIGNED
	X	

AGENCY FEDERAL TAX ID # (If applicable)	SALES REPRESENTATIVE'S NAME (Please print)
	X

COMMENTS:

FOR HOME OFFICE USE ONLY

HOME OFFICE ENDORSEMENTS

THIS APPLICATION IS VALID ONLY WHEN COMPLETED AND SIGNED.