

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 818-987-5000 fax: 818-776-9865

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction) or quarterly (every three months).

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

Oleg Skurskiy  
18375 Ventura Blvd. # 226  
Tarzana, CA 91356

**Please make your check payable to: Blue Shield of California**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at: 818-987-5000**

Thank you for choosing...

blue  of california

# Application for Blue Shield Individual and Family Health Plans



## Blue Shield of California and Blue Shield of California Life & Health Insurance Company

APPLICATION MUST BE COMPLETED IN BLUE OR BLACK INK. Please make sure you answer all questions as completely and accurately as possible **and include first month's premium** to avoid a return of the application. Submit ALL pages, 1 through 25, as your complete application including any other supporting documentation to

**OLEG SKURSKIY 18375 Ventura Blvd. # 226 Tarzana , CA 91356  
BY FAX 818-776-9865 . CALL 818-654-4548**

**Please print using BLOCK CAPITAL LETTERS. Boxes should be marked as follows:**

**(PRODUCER USE ONLY)**

MARKET CODE

Reason for application:  New enrollment  Plan transfer  Add family member to existing coverage

### Part 1 – Primary applicant information –

Indicating the younger spouse/domestic partner as the primary applicant may reduce your monthly dues/premiums. You are eligible to apply for a Blue Shield individual and family health plan if you are: a California resident, under the age of 65 and not eligible for Medicare.

Applicant's Social Security number \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
Last name \_\_\_\_\_

Male Married:  Yes  No Date of birth (month/day/year) \_\_\_\_\_ Height (ft. in.)<sup>†</sup> \_\_\_\_\_ Weight (lbs.)<sup>†</sup> \_\_\_\_\_  
 Female Domestic partner:  Yes  No

Applicant's business phone \_\_\_\_\_ Applicant's home phone \_\_\_\_\_ Applicant's email address: \_\_\_\_\_  
Applicant's fax No. \_\_\_\_\_ Applicant's cell phone \_\_\_\_\_

If a current Blue Shield member, provide Subscriber number: \_\_\_\_\_

Home address (**NO** P.O. Box) \_\_\_\_\_ Apt. No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Billing address (if different from above) \_\_\_\_\_ Apt. No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Mailing address (if different from home address) \_\_\_\_\_ Apt. No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Applicant's occupation<sup>†</sup> \_\_\_\_\_ Applicant's employer's ZIP code \_\_\_\_\_  
Spouse/domestic partner's occupation<sup>†</sup> \_\_\_\_\_ Spouse/domestic partner's employer's ZIP code \_\_\_\_\_

List other name(s) used in past \_\_\_\_\_

### Health Plan option (check one box only):

<b>Shield Secure Plus:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000	<b>Shield Secure:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000	<b>Shield Wise:</b> <input type="checkbox"/> 2500 <input type="checkbox"/> 3500 <input type="checkbox"/> 4500	<b>Shield Saver:</b> <input type="checkbox"/> 4000 <input type="checkbox"/> 6000	<b>Shield Spectrum PPO:</b> <input type="checkbox"/> 5000* <input type="checkbox"/> 5500	<b>Access+:</b> <input type="checkbox"/> Value HMO <input type="checkbox"/> HMO package
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HMO only (visit [blueshieldca.com](http://blueshieldca.com) to find a provider, or for questions call **800-431-2809**)

Personal Physician name: \_\_\_\_\_ Provider No.: \_\_\_\_\_ Med Group/IPA No.: \_\_\_\_\_

Check if current patient Requested effective date (see Part 7(b), Item 4 for information)

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

† Do not complete if applying only for a HIPAA guaranteed issue plan (see below).

An Independent Member of the Blue Shield Association C12900-RD-PHX (7/12)

**Part 1 – Primary applicant information (continued):**

**HIPAA Guaranteed Issue Plans:** Please note that HIPAA guaranteed issue plan rates may be higher than those of Blue Shield's underwritten plans. If you are applying for both HIPAA guaranteed issue coverage and an underwritten plan, complete the entire application. If you are applying for HIPAA guaranteed issue coverage only, complete Parts 1-4, 6-8 and 10-11. See Part 8 for more information.

(a) Are all applicants currently residing in California?  Yes  No If no, which applicant(s) are not currently residing in California? \_\_\_\_\_

Where was the last residence? \_\_\_\_\_

(b) Have all applicants resided within the United States for the past six months?  Yes  No If no, which applicant(s) resided outside the United States during the past six months? \_\_\_\_\_

If residency was outside of the United States, current medical records documenting a complete physical exam by a California physician within the last six months may be required.

Indicate language preference:  English  Spanish  Chinese  Vietnamese  Other: \_\_\_\_\_

Preferred method of contact (check one):  Home phone  Work phone  Cell phone  Email  Standard mail Best time to contact: \_\_\_\_\_  AM  PM

Check here if you have previously had coverage with Blue Shield.  If prior coverage, indicate prior Blue Shield ID No., if known: \_\_\_\_\_

**Part 2 – Primary applicant supplemental plan choices**

You may also purchase a dental plan, or dental + vision package, and/or life insurance to supplement your medical coverage. Dental and dental + vision plans are also available without medical. Please note: If you enroll in any HIPAA guaranteed issue plans, you are not eligible for supplemental dental plan, dental + vision package, or life insurance coverage options.

Dental plan option (check one):  Dental HMO  Dental PPO  Value Smile  Specialty Duo (dental + vision) package\*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809** Dental Provider No. \_\_\_\_\_  
 Dental provider name: \_\_\_\_\_

Life insurance\* option (check one): Applicants under the age of 1 year are not eligible for life insurance. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below.

\$10,000 (ages 1-64)  \$30,000 (ages 1-64)  \$60,000 (ages 19-64)  \$90,000 (ages 19-49)  \$100,000 (ages 19-49)

If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.

Beneficiary: \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ City/State \_\_\_\_\_ (%) \_\_\_\_\_  
 Beneficiary: \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ City/State \_\_\_\_\_ (%) \_\_\_\_\_

**Part 3(a) – Spouse/domestic partner dependent applicant information** – If a dependent applies for a separate medical plan he/she is considered a primary applicant and is then eligible to select a life insurance plan.

Spouse  Domestic Partner Sex:  Male  Female Social Security number \_\_\_\_\_

First name \_\_\_\_\_ MI \_\_\_\_\_

Last name \_\_\_\_\_

Date of birth (Month/Day/Year) \_\_\_\_\_ Height (ft. in.)† ' ' Weight (lbs.)† \_\_\_\_\_

Is this dependent applying for the same plan as the primary applicant?  Yes  No If no, which plan? (check one):

**Shield Secure Plus:**  2000  4000  6000 **Shield Secure:**  2000  4000  6000 **Shield Wise:**  2500  3500  4500

**Shield Saver:**  4000  6000 **Shield Spectrum PPO:**  5000\*  5500 **Access+:**  Value HMO  HMO package

HMO only – visit **blueshieldca.com** to find a provider or for questions call **(800) 431-2809**.  Check if current patient  
 Personal Physician name: \_\_\_\_\_ Provider No.: \_\_\_\_\_ Med group/IPA No.: \_\_\_\_\_

Dental plan option (check one):  Dental HMO  Dental PPO  Value Smile  Specialty Duo (dental + vision) package\*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809**. Dental Provider No. \_\_\_\_\_  
 Dental provider name: \_\_\_\_\_

Life insurance\* option (check one only if applying for a separate medical plan):  
 \$10,000 (ages 1-64)  \$30,000 (ages 1-64)  \$60,000 (ages 19-64)  \$90,000 (ages 19-49)  \$100,000 (ages 19-49)

If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.

Beneficiary: \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ City/State \_\_\_\_\_ (%) \_\_\_\_\_  
 Beneficiary: \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ City/State \_\_\_\_\_ (%) \_\_\_\_\_

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

† Do not complete if applying only for a HIPAA guaranteed issue plan.

**Part 3(b) – Child dependent applicant information** – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached.

<input type="checkbox"/> Son <input type="checkbox"/> Daughter		Social Security number _____	
First name _____			MI _____
Last name _____			
Date of birth (Month/Day/Year) _____		Height (ft. in.) <sup>†</sup> ' ____ " ____	Weight (lbs.) <sup>†</sup> _____
Is this dependent applying for the same plan as the primary applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, which plan? (check one):			
<b>Shield Secure Plus:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Secure:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Wise:</b> <input type="checkbox"/> 2500 <input type="checkbox"/> 3500 <input type="checkbox"/> 4500			
<b>Shield Saver:</b> <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Spectrum PPO:</b> <input type="checkbox"/> 5000* <input type="checkbox"/> 5500 <b>Access+:</b> <input type="checkbox"/> Value HMO <input type="checkbox"/> HMO package			
Consider my child for a separate plan <input type="checkbox"/>			
HMO only – visit <a href="http://blueshieldca.com">blueshieldca.com</a> to find a provider or for questions call <b>(800) 431-2809</b> .			<input type="checkbox"/> Check if current patient
Personal Physician name: _____		Provider No.: _____	Med group/IPA No.: _____
Dental plan option (check one): <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental PPO <input type="checkbox"/> Value Smile <input type="checkbox"/> Specialty Duo (dental + vision) package*			
Dental HMO only – visit <a href="http://blueshieldca.com">blueshieldca.com</a> to find a dental provider or for questions call <b>(800) 431-2809</b> .			Dental Provider No. _____
Dental provider name: _____			
Life insurance* option for child applicants age 1 year or older: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000			
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.			
Beneficiary: _____		Relationship _____	Age ____ City/State _____ (%) _____
Beneficiary: _____		Relationship _____	Age ____ City/State _____ (%) _____

**Part 3(c) – Child dependent applicant information** – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached.

<input type="checkbox"/> Son <input type="checkbox"/> Daughter		Social Security number _____	
First name _____			MI _____
Last name _____			
Date of birth (Month/Day/Year) _____		Height (ft. in.) <sup>†</sup> ' ____ " ____	Weight (lbs.) <sup>†</sup> _____
Is this dependent applying for the same plan as the primary applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, which plan? (check one):			
<b>Shield Secure Plus:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Secure:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Wise:</b> <input type="checkbox"/> 2500 <input type="checkbox"/> 3500 <input type="checkbox"/> 4500			
<b>Shield Saver:</b> <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Spectrum PPO:</b> <input type="checkbox"/> 5000* <input type="checkbox"/> 5500 <b>Access+:</b> <input type="checkbox"/> Value HMO <input type="checkbox"/> HMO package			
Consider my child for a separate plan <input type="checkbox"/>			
HMO only – visit <a href="http://blueshieldca.com">blueshieldca.com</a> to find a provider or for questions call <b>(800) 431-2809</b> .			<input type="checkbox"/> Check if current patient
Personal Physician name: _____		Provider No.: _____	Med group/IPA No.: _____
Dental plan option (check one): <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental PPO <input type="checkbox"/> Value Smile <input type="checkbox"/> Specialty Duo (dental + vision) package*			
Dental HMO only – visit <a href="http://blueshieldca.com">blueshieldca.com</a> to find a dental provider or for questions call <b>(800) 431-2809</b> .			Dental Provider No. _____
Dental provider name: _____			
Life insurance* option for child applicants age 1 year or older: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000			
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.			
Beneficiary: _____		Relationship _____	Age ____ City/State _____ (%) _____
Beneficiary: _____		Relationship _____	Age ____ City/State _____ (%) _____

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

† Do not complete if applying only for a HIPAA guaranteed issue plan.

**Part 3(d) – Child dependent applicant information** – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached.

<input type="checkbox"/> Son <input type="checkbox"/> Daughter		Social Security number	
First name			MI
Last name			
Date of birth (Month/Day/Year)		Height (ft. in.) <sup>†</sup>	Weight (lbs.) <sup>†</sup>
Is this dependent applying for the same plan as the primary applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, which plan? (check one):			
<b>Shield Secure Plus:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Secure:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Wise:</b> <input type="checkbox"/> 2500 <input type="checkbox"/> 3500 <input type="checkbox"/> 4500			
<b>Shield Saver:</b> <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Spectrum PPO:</b> <input type="checkbox"/> 5000* <input type="checkbox"/> 5500 <b>Access+:</b> <input type="checkbox"/> Value HMO <input type="checkbox"/> HMO package			
Consider my child for a separate plan <input type="checkbox"/>			
HMO only – visit <a href="http://blueshieldca.com">blueshieldca.com</a> to find a provider or for questions call <b>(800) 431-2809</b> .			<input type="checkbox"/> Check if current patient
Personal Physician name:		Provider No.:	Med group/IPA No.:
Dental plan option (check one): <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental PPO <input type="checkbox"/> Value Smile <input type="checkbox"/> Specialty Duo (dental + vision) package*			
Dental HMO only – visit <a href="http://blueshieldca.com">blueshieldca.com</a> to find a dental provider or for questions call <b>(800) 431-2809</b> .			Dental Provider No.
Dental provider name:			
Life insurance* option for child applicants age 1 year or older: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000			
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.			
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____

**Part 3(e) – Child dependent applicant information** – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached.

<input type="checkbox"/> Son <input type="checkbox"/> Daughter		Social Security number	
First name			MI
Last name			
Date of birth (Month/Day/Year)		Height (ft. in.) <sup>†</sup>	Weight (lbs.) <sup>†</sup>
Is this dependent applying for the same plan as the primary applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, which plan? (check one):			
<b>Shield Secure Plus:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Secure:</b> <input type="checkbox"/> 2000 <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Wise:</b> <input type="checkbox"/> 2500 <input type="checkbox"/> 3500 <input type="checkbox"/> 4500			
<b>Shield Saver:</b> <input type="checkbox"/> 4000 <input type="checkbox"/> 6000 <b>Shield Spectrum PPO:</b> <input type="checkbox"/> 5000* <input type="checkbox"/> 5500 <b>Access+:</b> <input type="checkbox"/> Value HMO <input type="checkbox"/> HMO package			
Consider my child for a separate plan <input type="checkbox"/>			
HMO only – visit <a href="http://blueshieldca.com">blueshieldca.com</a> to find a provider or for questions call <b>(800) 431-2809</b> .			<input type="checkbox"/> Check if current patient
Personal Physician name:		Provider No.:	Med group/IPA No.:
Dental plan option (check one): <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental PPO <input type="checkbox"/> Value Smile <input type="checkbox"/> Specialty Duo (dental + vision) package*			
Dental HMO only – visit <a href="http://blueshieldca.com">blueshieldca.com</a> to find a dental provider or for questions call <b>(800) 431-2809</b> .			Dental Provider No.
Dental provider name:			
Life insurance* option for child applicants age 1 year or older: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000			
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.			
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

† Do not complete if applying only for a HIPAA guaranteed issue plan.

**Part 4 – Prior medical coverage: must be completed.**

1a. Did you or any applying family member have other health coverage (insurance) within the last 63 days?  Yes  No

1b. Was any applying child under age 19 covered continuously by other health coverage(s) within the last 90 days?  Yes  No

If you answered NO to question 1a or 1b, skip to question 3.

If you answered **YES** to question 1a or 1b, submit evidence of prior coverage, such as certificate(s) of creditable coverage from your previous health carrier and complete the following:

2. Name(s)	Type of coverage	Effective date	Cancel date	Health plan carrier and/or COBRA administrator
Primary applicant	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other			
Spouse/domestic partner dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other			
Child dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other			
Child dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other			
Child dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other			
Child dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other			

3. If you or any applying family member currently has coverage, it will need to be cancelled if this application for coverage is approved by Blue Shield. Will you cancel your other coverage if this coverage is approved by Blue Shield?  Yes  No

4. If you or any applying family member are applying for a plan other than an HMO and had other health coverage within the last 63 days, submit a certificate of creditable coverage from your previous health carrier (this document is sent to you by your previous carrier and discloses when your coverage ended and how long you were covered). You can obtain a copy of your certificate of creditable coverage by contacting your previous health carrier. If this application is approved, Blue Shield will apply the individual's creditable coverage to reduce any waiting period on their pre-existing condition exclusion with this plan. The pre-existing condition exclusion does not apply to dependents under the age of 19 unless you are adding an applicant under 19 to a grandfathered plan (coverage issued prior to March 23, 2010). See the EOC /Policy booklet for more on pre-existing conditions. You can obtain a copy of the EOC /Policy by contacting Blue Shield at **(800) 431-2809**.

**Part 5 – Health questionnaire.**

Answer all questions accurately and completely for each applicant. Blue Shield relies upon the information you provide in your application to determine whether you are eligible for coverage. While we may review your medical records in certain instances, do not assume we will review your medical records before issuing coverage. Blue Shield has the right to rescind your coverage if your answers are intentionally and materially inaccurate or incomplete. If coverage is rescinded, this means that you may lose coverage back to the original effective date. If your coverage is lawfully rescinded, Blue Shield may have the right to seek repayment from you for medical expenses that we already paid. You should be aware that we can and do review medical records in certain situations after a health services contract/policy has been issued to determine whether material facts were misrepresented or omitted on the application. It is therefore very important that you make every effort to answer all questions accurately and completely. Please note that even if you currently have coverage, or had prior coverage, with Blue Shield you must answer all questions in this health questionnaire. Your obligation to disclose medical information includes the obligation to disclose to Blue Shield any new or changed medical information arising after submission of this Application but before your enrollment date. Any failure to disclose new or changed information may result in rescission of your contract/policy, if that information would have been material to the issuance of coverage.

**HIPAA Guaranteed Issue Plans:** If you are applying for both HIPAA guaranteed issue coverage and an underwritten plan, complete the entire application. If you are applying for HIPAA guaranteed issue coverage only, complete parts 1-4, 6-8, and 10-11 (do not complete this Part 5). See Part 8 for more information.

**Part 5(a) – Medical history**

All questions must be answered. Mark  "Yes" or "No." Complete details of any "Yes" answer must be given in Part 5(b). **Where indicated below for questions 1 through 16, please print the first name of each individual applying for coverage.** Initial and date any changes/corrections you may make. If you do not understand a medical term being used, or are not sure whether you have or had a medical condition listed on this application, do not answer "No." Speak to your doctor or otherwise take steps to understand what the question means before answering. If you otherwise need help filling out the application, call Blue Shield at **(800) 431-2809**, or contact your agent. If you still aren't sure or don't recall if you have or had a listed medical condition, answer "Don't know" and then explain the answer in Part 5(b).

**NOTE** – Each "Yes" or "Don't know" answer must be explained in Part 5(b) or the application will be deemed to be incomplete. If more than four child dependents are applying for coverage, please attach supplemental pages providing all information listed below for Section 5(a) and Sections 5(b), 5(c) and 5(d) if applicable, your signature and date. Mark here if a supplemental page is attached.

1. In the past 10 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
(a) Aortic or Mitral Valve Regurgitation or Stenosis, other Heart Valve condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Abnormality of the Veins or Arteries of the Brain, such as Aneurysm, AV Malformation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Acquired Immune Deficiency Syndrome (AIDS) or AIDS – Related Complex (ARC), Kaposi's Sarcoma (KS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Alzheimer's Disease or Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(e) Bi-polar Disorder, Manic Depression, Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(f) Cancer, Malignant Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(g) Connective Tissue Disorder, Scleroderma, Systemic Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(h) Coronary Artery Disease (CAD), Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(i) Disorder(s) of the blood vessels or heart, Heart Enlargement, Heart Failure, Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(j) Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(k) Hepatitis If yes, please specify Type (A, B, C, D, other?) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(l) Joint Replacement (such as hip, knee, shoulder), Amputation, Prosthetic Limb	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(m) Leukemia, Hodgkin's Disease, Lymphoma, Organ or bone marrow transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(n) Stroke or Transient Ischemic Attack (TIA), Bruit, or Carotid Stenosis (narrowing or stiffness of the arteries)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

2. In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
(a) Alcohol Abuse, Dependence or Addiction; Drug Use or Abuse, Dependence or Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Angina, Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Anorexia, Bulimia or other eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Arthritis, Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(e) Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(f) Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma, other Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(g) Bleeding or Blood Disorder (except HIV test)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(h) Bone, Ligament, Tendon, Joint Injury or Disorder, Carpal Tunnel Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

**Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).**

2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
(i) Bronchitis, Pneumonia, Breathing or other Lung Disorder(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(j) Cataracts, Glaucoma, Strabismus (crossed eyes), other Eye Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(k) Cerebral Palsy, Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(l) Chronic (or recurrent) Muscle/Limb Weakness, Fatigue, or Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(m) Chronic (or recurrent) Pain, including back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(n) Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(o) Cleft Lip, Cleft Palate or other Congenital (Birth) Defect or Abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(p) Crohn's Disease, Inflammatory Bowel Disease (IBD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(q) Curvature of the Spine, Scoliosis, other Spine Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(r) Depression, Anxiety, Panic Attack(s), Obsessive Compulsive Disorder (OCD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(s) Deviated Nasal Septum, Sinusitis, Excessive Snoring or other Sinus Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(t) Diabetes or other Endocrine (Glandular) Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(u) Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(v) Epilepsy, Convulsions, Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(w) Fibrocystic Breasts, Micro-Calcifications, other Breast Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(x) Fractures, Retained Hardware (pins, screws, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(y) Gastric Bypass, Stapling, Banding or other weight loss surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(z) Heartburn or Reflux (recurrent), other Digestive Tract Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(aa) Heart Murmur, Palpitations, Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(bb) Herniated or Bulging Disk, Sciatica	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(cc) Hormone or Growth Hormone Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(dd) Infertility, male or female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ee) In-vitro Fertilization ( <i>females only</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ff) Kidney Infection, Bladder Infection, Kidney or Bladder Stones, Interstitial Cystitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(gg) Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(hh) Multiple Sclerosis, Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ii) Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(jj) Osteoporosis or Osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(kk) Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ll) Phlebitis, Blood Clots, Embolism, Varicose Veins, Peripheral Artery Disease (PAD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(mm) Premature Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(nn) Prostatitis, Enlarged Prostate (BPH), other Disorder of the male Reproductive (sex) Organs ( <i>males only</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(oo) Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(pp) Severe Burns	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(qq) Syphilis, Gonorrhea, Chlamydia, Genital Warts, Herpes, other Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(rr) Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ss) Tumor, Mass, Polyp, Cyst (other than ovarian)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(tt) Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(uu) Ulcerative Colitis, other Bowel or Rectal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(vv) Uterine Fibroid(s), Endometriosis, other Disorders of the Female Reproductive (sex) Organs ( <i>females only</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

3. In the past 5 years, have you:	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
(a) Been an inpatient or outpatient in a hospital, surgical center, emergency room, or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Had any kind of surgery, including biopsy, angioplasty, bypass or cosmetic/reconstructive surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Had any application for health or life insurance rescinded, declined, deferred, postponed, or restricted in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Had abnormal test results (Blood Test (except HIV test), X-Ray, CT Scan, MRI)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

4. In the past 2 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
(a) Abnormal or Irregular Menstrual/Uterine Bleeding ( <i>females only</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Allergies, Asthma, Reactive Airway Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Apnea or Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(e) Birth Marks (Hemangioma)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(f) Bladder Disorder, Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(g) Ear Infections, other Ear or Hearing Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(h) Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(i) Headaches or Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(j) Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(k) High Blood Pressure (Hypertension)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(l) High Cholesterol and/or high Triglycerides	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(m) Hyperactivity, Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(n) Hypothyroidism, other Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(o) Implant(s), Prosthesis (other than breast)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(p) Miscarriage (Spontaneous Abortion) ( <i>females only</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(q) Ovarian Cyst(s), Polycystic Ovaries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(r) Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(s) Psoriasis, Keratosis, Acne, Herpes, Shingles, other Skin Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(t) Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(u) Temporal Mandibular Joint Disorder (TMJ)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

5. In the past 12 months have you had, or do you currently have:	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
(a) Any illness or infection lasting more than a week, not mentioned elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) A physical injury requiring medical attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Any medical diagnosis by a licensed health practitioner, not mentioned elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
6. (a) In the past 12 months have you been advised or referred by a licensed health practitioner to have a medical exam, further testing, treatment, or surgery which has not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) In the past 12 months have you been recommended for, or have you been planning to have any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
7. Have you taken prescription medication(s) or been written a prescription for medication(s) in the past 12 months? If Yes or Don't know, please complete Part 5(c) below.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
<b>8. Are you currently receiving scheduled doses of medication administered by self-injection or through IV therapy in a physician's office or hospital setting?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>9. Are you currently receiving insurance or workers' compensation benefits due to a disability?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>10. Do/did you regularly smoke cigarettes?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Average number of packs per day?	_____	_____	_____
(b) How many years?	_____	_____	_____
(c) Have you stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If yes, when?	_____	_____	_____
<b>11. Do/did you regularly drink alcoholic beverages? (one drink equals 1 oz. liquor, 4 oz. wine, or 12 oz. beer)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Average number of drinks per week?	_____	_____	_____
(b) How many years?	_____	_____	_____
(c) Have you stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If yes, when?	_____	_____	_____
<b>12. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of alcohol or substance use (including if court ordered)? If Yes, please complete (a) and (b) below.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Type?	_____	_____	_____
(b) How long?	_____	_____	_____
<b>13. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of mental, emotional, or behavioral disorder(s)? If Yes, please complete (a) and (b) below.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Type?	_____	_____	_____
(b) How long?	_____	_____	_____
<b>14. Are you expecting a child with anyone, even if the expecting mother is not listed on the application?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>15. Male and females:</b>			
(a) Are you, or your spouse, domestic partner or dependent (whether or not listed on the application), in the process of adoption or surrogate pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Within the last 90 days have you, or your spouse, domestic partner or dependent performed a home pregnancy test, or had a pregnancy test performed at a clinic or a lab, which was positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>16. Females only:</b>			
(a) Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) If you are between the ages of 14-55, do you menstruate (have monthly periods)? (If no, please explain).	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
(c) If yes to (b) above, has it been more than 40 days since your last menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If you are 18 years of age or older, have you had a Pap test? (If yes, please provide date of last test & results in Part 5(b))	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) If you are 18 years of age or older, do you have breast implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type? (check one) Implant Surgery Date:	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline _____	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline _____	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline _____

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

**Part 5 – Health questionnaire.**

Answer all questions accurately and completely for each applicant. Blue Shield relies upon the information you provide in your application to determine whether you are eligible for coverage. While we may review your medical records in certain instances, do not assume we will review your medical records before issuing coverage. Blue Shield has the right to rescind your coverage if your answers are intentionally and materially inaccurate or incomplete. If coverage is rescinded, this means that you may lose coverage back to the original effective date. If your coverage is lawfully rescinded, Blue Shield may have the right to seek repayment from you for medical expenses that we already paid. You should be aware that we can and do review medical records in certain situations after a health services contract/policy has been issued to determine whether material facts were misrepresented or omitted on the application. It is therefore very important that you make every effort to answer all questions accurately and completely. Please note that even if you currently have coverage, or had prior coverage, with Blue Shield you must answer all questions in this health questionnaire. Your obligation to disclose medical information includes the obligation to disclose to Blue Shield any new or changed medical information arising after submission of this Application but before your enrollment date. Any failure to disclose new or changed information may result in rescission of your contract/policy, if that information would have been material to the issuance of coverage.

**HIPAA Guaranteed Issue Plans:** If you are applying for both HIPAA guaranteed issue coverage and an underwritten plan, complete the entire application. If you are applying for HIPAA guaranteed issue coverage only, complete parts 1-4, 6-8, and 10-11 (do not complete this Part 5). See Part 8 for more information.

**Part 5(a) – Medical history**

All questions must be answered. Mark  "Yes" or "No." Complete details of any "Yes" answer must be given in Part 5(b). **Where indicated below for questions 1 through 16, please print the first name of each individual applying for coverage.** Initial and date any changes/corrections you may make. If you do not understand a medical term being used, or are not sure whether you have or had a medical condition listed on this application, do not answer "No." Speak to your doctor or otherwise take steps to understand what the question means before answering. If you otherwise need help filling out the application, call Blue Shield at **(800) 431-2809**, or contact your agent. If you still aren't sure or don't recall if you have or had a listed medical condition, answer "Don't know" and then explain the answer in Part 5(b).

**NOTE** – Each "Yes" or "Don't know" answer must be explained in Part 5(b) or the application will be deemed to be incomplete. If more than four child dependents are applying for coverage, please attach supplemental pages providing all information listed below for Section 5(a) and Sections 5(b), 5(c) and 5(d) if applicable, your signature and date. Mark here if a supplemental page is attached.

1. In the past 10 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Child dependent	Child dependent	Child dependent
(a) Aortic or Mitral Valve Regurgitation or Stenosis, other Heart Valve condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Abnormality of the Veins or Arteries of the Brain, such as Aneurysm, AV Malformation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Acquired Immune Deficiency Syndrome (AIDS) or AIDS – Related Complex (ARC), Kaposi's Sarcoma (KS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Alzheimer's Disease or Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(e) Bi-polar Disorder, Manic Depression, Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(f) Cancer, Malignant Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(g) Connective Tissue Disorder, Scleroderma, Systemic Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(h) Coronary Artery Disease (CAD), Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(i) Disorder(s) of the blood vessels or heart, Heart Enlargement, Heart Failure, Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(j) Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(k) Hepatitis If yes, please specify Type (A, B, C, D, other?)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(l) Joint Replacement (such as hip, knee, shoulder), Amputation, Prosthetic Limb	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(m) Leukemia, Hodgkin's Disease, Lymphoma, Organ or bone marrow transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(n) Stroke or Transient Ischemic Attack (TIA), Bruit, or Carotid Stenosis (narrowing or stiffness of the arteries)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

2. In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Child dependent	Child dependent	Child dependent
(a) Alcohol Abuse, Dependence or Addiction; Drug Use or Abuse, Dependence or Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Angina, Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Anorexia, Bulimia or other eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Arthritis, Osteoarthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(e) Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(f) Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma, other Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(g) Bleeding or Blood Disorder (except HIV test)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(h) Bone, Ligament, Tendon, Joint Injury or Disorder, Carpal Tunnel Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

**Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).**

2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Child dependent	Child dependent	Child dependent
(i) Bronchitis, Pneumonia, Breathing or other Lung Disorder(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(j) Cataracts, Glaucoma, Strabismus (crossed eyes), other Eye Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(k) Cerebral Palsy, Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(l) Chronic (or recurrent) Muscle/Limb Weakness, Fatigue, or Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(m) Chronic (or recurrent) Pain, including back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(n) Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(o) Cleft Lip, Cleft Palate or other Congenital (Birth) Defect or Abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(p) Crohn's Disease, Inflammatory Bowel Disease (IBD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(q) Curvature of the Spine, Scoliosis, other Spine Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(r) Depression, Anxiety, Panic Attack(s), Obsessive Compulsive Disorder (OCD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(s) Deviated Nasal Septum, Sinusitis, Excessive Snoring or other Sinus Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(t) Diabetes or other Endocrine (Glandular) Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(u) Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(v) Epilepsy, Convulsions, Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(w) Fibrocystic Breasts, Micro-Calcifications, other Breast Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(x) Fractures, Retained Hardware (pins, screws, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(y) Gastric Bypass, Stapling, Banding or other weight loss surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(z) Heartburn or Reflux (recurrent), other Digestive Tract Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(aa) Heart Murmur, Palpitations, Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(bb) Herniated or Bulging Disk, Sciatica	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(cc) Hormone or Growth Hormone Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(dd) Infertility, male or female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ee) In-vitro Fertilization (females only)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ff) Kidney Infection, Bladder Infection, Kidney or Bladder Stones, Interstitial Cystitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(gg) Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(hh) Multiple Sclerosis, Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ii) Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(jj) Osteoporosis or Osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(kk) Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ll) Phlebitis, Blood Clots, Embolism, Varicose Veins, Peripheral Artery Disease (PAD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(mm) Premature Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(nn) Prostatitis, Enlarged Prostate (BPH), other Disorder of the male Reproductive (sex) Organs (males only)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(oo) Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(pp) Severe Burns	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(qq) Syphilis, Gonorrhea, Chlamydia, Genital Warts, Herpes, other Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(rr) Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(ss) Tumor, Mass, Polyp, Cyst (other than ovarian)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(tt) Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(uu) Ulcerative Colitis, other Bowel or Rectal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(vv) Uterine Fibroid(s), Endometriosis, other Disorders of the Female Reproductive (sex) Organs (females only)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

3. In the past 5 years, have you:	Write in name of:		
	Child dependent	Child dependent	Child dependent
(a) Been an inpatient or outpatient in a hospital, surgical center, emergency room, or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Had any kind of surgery, including biopsy, angioplasty, bypass or cosmetic/reconstructive surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Had any application for health or life insurance rescinded, declined, deferred, postponed, or restricted in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Had abnormal test results (Blood Test (except HIV test), X-Ray, CT Scan, MRI)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

4. In the past 2 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Child dependent	Child dependent	Child dependent
(a) Abnormal or Irregular Menstrual/Uterine Bleeding ( <i>females only</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Allergies, Asthma, Reactive Airway Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Apnea or Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(e) Birth Marks (Hemangioma)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(f) Bladder Disorder, Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(g) Ear Infections, other Ear or Hearing Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(h) Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(i) Headaches or Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(j) Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(k) High Blood Pressure (Hypertension)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(l) High Cholesterol and/or high Triglycerides	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(m) Hyperactivity, Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(n) Hypothyroidism, other Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(o) Implant(s), Prosthesis (other than breast)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(p) Miscarriage (Spontaneous Abortion) ( <i>females only</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(q) Ovarian Cyst(s), Polycystic Ovaries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(r) Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(s) Psoriasis, Keratosis, Acne, Herpes, Shingles, other Skin Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(t) Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(u) Temporal Mandibular Joint Disorder (TMJ)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

5. In the past 12 months have you had, or do you currently have:	Write in name of:		
	Child dependent	Child dependent	Child dependent
(a) Any illness or infection lasting more than a week, not mentioned elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) A physical injury requiring medical attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Any medical diagnosis by a licensed health practitioner, not mentioned elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
6. (a) In the past 12 months have you been advised or referred by a licensed health practitioner to have a medical exam, further testing, treatment, or surgery which has not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) In the past 12 months have you been recommended for, or have you been planning to have any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
7. Have you taken prescription medication(s) or been written a prescription for medication(s) in the past 12 months? If Yes or Don't know, please complete Part 5(c) below.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

	Write in name of:		
	Child dependent	Child dependent	Child dependent
<b>8. Are you currently receiving scheduled doses of medication administered by self-injection or through IV therapy in a physician's office or hospital setting?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>9. Are you currently receiving insurance or workers' compensation benefits due to a disability?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>10. Do/did you regularly smoke cigarettes?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Average number of packs per day?	_____	_____	_____
(b) How many years?	_____	_____	_____
(c) Have you stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If yes, when?	_____	_____	_____
<b>11. Do/did you regularly drink alcoholic beverages? (one drink equals 1 oz. liquor, 4 oz. wine, or 12 oz. beer)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Average number of drinks per week?	_____	_____	_____
(b) How many years?	_____	_____	_____
(c) Have you stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If yes, when?	_____	_____	_____
<b>12. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of alcohol or substance use (including if court ordered)? If Yes, please complete (a) and (b) below.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Type?	_____	_____	_____
(b) How long?	_____	_____	_____
<b>13. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of mental, emotional, or behavioral disorder(s)? If Yes, please complete (a) and (b) below.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Type?	_____	_____	_____
(b) How long?	_____	_____	_____
<b>14. Are you expecting a child with anyone, even if the expecting mother is not listed on the application?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
<b>15. Male and females:</b>			
(a) Are you, or your spouse, domestic partner or dependent (whether or not listed on the application), in the process of adoption or surrogate pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Within the last 90 days have you, or your spouse, domestic partner or dependent performed a home pregnancy test, or had a pregnancy test performed at a clinic or a lab, which was positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>16. Females only:</b>			
(a) Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) If you are between the ages of 14-55, do you menstruate (have monthly periods)? (If no, please explain).	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
(c) If yes to (b) above, has it been more than 40 days since your last menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If you are 18 years of age or older, have you had a Pap test? (If yes, please provide date of last test & results in Part 5(b))	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) If you are 18 years of age or older, do you have breast implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type? (check one) Implant Surgery Date:	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline _____	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline _____	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline _____

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

**Part 5(b) – Medical history and condition details**

**If you or any family member applying for coverage answered Yes or Don't Know to any question in Part 5(a), please provide complete details below. If you do not recall dates, specify "unknown."** If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached.

Name of applicant		
<b>List Part 5(a) question number and letter:</b> _____		
<b>If you answered "Don't Know", please explain:</b> _____		
Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: _____ (month/year) Ended: _____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____, _____, _____
Other comments/details:		
Full name of physician, clinic or hospital:		Specialty:
Phone number:	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name of applicant		
<b>List Part 5(a) question number and letter:</b> _____		
<b>If you answered "Don't Know", please explain:</b> _____		
Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: _____ (month/year) Ended: _____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s) _____, _____, _____
Other comments/details:		
Full name of physician, clinic or hospital:		Specialty:
Phone number:	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name of applicant		
<b>List Part 5(a) question number and letter:</b> _____		
<b>If you answered "Don't Know", please explain:</b> _____		
Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: _____ (month/year) Ended: _____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____, _____, _____
Other comments/details:		
Full name of physician, clinic or hospital:		Specialty:
Phone number:	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

**Part 5(b) – Medical history and condition details**

**If you or any family member applying for coverage answered Yes or Don't Know to any question in Part 5(a), please provide complete details below. If you do not recall dates, specify "unknown."** If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached.

Name of applicant \_\_\_\_\_

**List Part 5(a) question number and letter:** \_\_\_\_\_  
**If you answered "Don't Know", please explain:** \_\_\_\_\_

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: (month/year) Ended: (month/year)
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Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?
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Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____
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Other comments/details: \_\_\_\_\_

Full name of physician, clinic or hospital:	Specialty:
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Phone number:	Medical group (if applicable):
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Address:	Suite
City	State ZIP code

Name of applicant \_\_\_\_\_

**List Part 5(a) question number and letter:** \_\_\_\_\_  
**If you answered "Don't Know", please explain:** \_\_\_\_\_

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: (month/year) Ended: (month/year)
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Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?
--	-----------------

Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____
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Other comments/details: \_\_\_\_\_

Full name of physician, clinic or hospital:	Specialty:
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Phone number:	Medical group (if applicable):
---------------	--------------------------------

Address:	Suite
City	State ZIP code

Name of applicant \_\_\_\_\_

**List Part 5(a) question number and letter:** \_\_\_\_\_  
**If you answered "Don't Know", please explain:** \_\_\_\_\_

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: (month/year) Ended: (month/year)
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Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?
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Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____
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Other comments/details: \_\_\_\_\_

Full name of physician, clinic or hospital:	Specialty:
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Phone number:	Medical group (if applicable):
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Address:	Suite
City	State ZIP code

**Part 5(c) – Current or recent prescription medications**

**If you or any family member applying for coverage answered Yes or Don't know to question 7 in Part 5(a) regarding prescription medications, please provide complete details below. If you do not recall dates specify "unknown."** If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached.

Name of applicant			
Medication	Dates from: _____ to: _____		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number	
Address			Suite
City		State	ZIP code
Name of applicant			
Medication	Dates from: _____ to: _____		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number	
Address			Suite
City		State	ZIP code
Name of applicant			
Medication	Dates from: _____ to: _____		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number	
Address			Suite
City		State	ZIP code
Name of applicant			
Medication	Dates from: _____ to: _____		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number	
Address			Suite
City		State	ZIP code
Name of applicant			
Medication	Dates from: _____ to: _____		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name		Specialty	
Medical group (if applicable)		Phone number	
Address			Suite
City		State	ZIP code

**Part 5(d) – Recent health practitioner visit(s)**

**Have you or any family member applying for coverage visited a physician, mental health practitioner, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health practitioner in the past 2 years?**  Yes  No **If Yes, please provide complete details below.**

Medical records may be requested for all children up to 7 months of age. For children under 6 years of age, be sure to include the date and results of the most recent well child exam. If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached.

Name of applicant		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____ (month/year) Ended: _____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____, _____, _____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number:	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name of applicant		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____ (month/year) Ended: _____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____, _____, _____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number:	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name of applicant		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____ (month/year) Ended: _____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____, _____, _____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number:	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

**Part 5(d) – Recent health practitioner visit(s) (continued)**

Name of applicant		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____ (month/year) Ended: _____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____, _____, _____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number:	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code
Name of applicant		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____ (month/year) Ended: _____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____, _____, _____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number:	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code
Name of applicant		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: _____ (month/year) Ended: _____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: _____ to: _____ Dates from: _____ to: _____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): _____, _____, _____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number:	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

**Part 6 – Authorization for release of information**

By signing this form you are authorizing the release of your and/or your dependents' healthcare information by a healthcare provider, insurer, insurance support organization (which includes consumer reporting agencies, MIB Group Inc and Milliman Inc), health plan, or your insurance agent, to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, Blue Shield) for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing this form you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization (which includes consumer reporting agencies, MIB Group Inc and Milliman Inc), health plan, or your insurance agent for the purpose of investigating or evaluating any claim for benefits. In addition, Blue Shield may make a brief report to MIB Group Inc regarding information received in the underwriting process. The healthcare information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under the federal health information privacy laws.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your and/or your dependents' eligibility for coverage and enrollment determinations upon receipt of this signed authorization.

You are entitled to a copy of this authorization after you sign it.

**Expiration:** This authorization will remain valid: 1) for thirty (30) months from the date of this authorization for the purposes of processing your application and reporting information, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

**Right to revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

_____ Applicant/parent or legal guardian	_____ Today's date
_____ Applicant's spouse/domestic partner	_____ Today's date
_____ Applicant age 18 or over	_____ Today's date
_____ Applicant age 18 or over	_____ Today's date
_____ Applicant age 18 or over	_____ Today's date
_____ Applicant age 18 or over	_____ Today's date

**Continue to Part 7 - your signature and today's date are required in that section.**

**Part 7(a) - Applicant verification of accuracy**

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature. Keep a copy of this application for your records.

**I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application, including all information provided in the medical history section of this application, is accurate, true and complete. If Blue Shield determines that information on this application is materially inaccurate, not true or incomplete, I understand that coverage may be cancelled or, if the inaccuracy, untruthfulness, or incompleteness was intentional, coverage may be rescinded. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.**

**For applicants with a language preference other than English: If I indicated in Part 1 that I have a language preference other than English and have completed the English-version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.**

\_\_\_\_\_  
Signature of applicant/parent or legal guardian      Today's date      Print name (and relationship if applicant is a minor)

Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

\_\_\_\_\_  
Signature of applicant's spouse/domestic partner (if applying)      Today's date      Print name

Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

\_\_\_\_\_  
Signature of family member age 18 and over (if applying)      Today's date      Print name

Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

\_\_\_\_\_  
Signature of family member age 18 and over (if applying)      Today's date      Print name

Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

\_\_\_\_\_  
Signature of family member age 18 and over (if applying)      Today's date      Print name

Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

\_\_\_\_\_  
Signature of family member age 18 and over (if applying)      Today's date      Print name

Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

**Continued on the next page**

### Part 7(b) – Authorizations, terms and conditions

Please read the following terms and conditions carefully. Each applicant age 18 and older is required to review the completed application and provide their own authorization and signature. Keep a copy of this application for your records.

1. **Application for coverage:** It is important to know that Blue Shield of California or Blue Shield of California Life & Health Insurance Company (as applicable) has the right to decline your application for coverage. Note: I understand that Blue Shield may use any medical information in reviewing my application, including any medical condition which occurs after the signature and submission of the application, and before a decision by Blue Shield is communicated. I understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.
2. **First month's dues/premiums:** Blue Shield requires first month's dues/premium at the time of application submission. Find your estimated monthly dues/premiums in the rate book provided to you. Refer to Parts 10 and 11 for details on payment options. Failure to submit full payment of dues/premiums will result in a return of your application. Please note that processing of your payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If your application is not approved, the dues/premium you submit with your application will not be processed. If you include a check, it will be destroyed. If you complete the payment authorization form for your credit card or checking account, your card or account will not be debited.
3. **Dues/premiums:** Dues/premiums are to be paid by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the *Health Service Agreement/Policy*.
4. **Effective date of coverage:** If your application is approved, Blue Shield will notify you of your effective date of coverage. If Blue Shield cannot honor your requested effective date, or is unable to issue coverage before your requested date, coverage will begin as soon as possible. If additional dues/premiums are owed, payment must be received within the time specified in the notice from Blue Shield to be enrolled. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Acceptance of Application:** You understand that only Blue Shield can accept your application and approve coverage. Your agent or broker cannot approve this application for coverage or change any terms or conditions of coverage.
6. **Parents/guardians:** If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 7. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach the court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):
  - Parent or legal guardian only: \_\_\_\_\_ (include name and relationship) or,
  - My designee \_\_\_\_\_ (include name and relationship) or,
  - Qualified medical child support order designee \_\_\_\_\_ (include name and relationship).
  - Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.
7. **Authorization for spouse/domestic partner to make changes:** If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield.  Yes  No
8. **Authorization for your agent to provide/obtain information:** Check here if you do **not** authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application, including medical information.
9. **Process to authorize Blue Shield to release personal and health information to a third party:** If you would like to authorize your spouse, domestic partner or a third party to access your personal health information, please complete the form titled Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party. To obtain this form go to [blueshieldca.com](http://blueshieldca.com) and click on the Privacy link at the bottom of the page, or call **(800) 431-2809**.
10. **Response to requested information:** You agree to cooperate with Blue Shield (or Blue Shield Life, as applicable) by providing, or by providing access to, documents and other information requested to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or information may be cause to rescind or cancel your coverage.
11. **HIV or genetic testing prohibited:** No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits an HIV test from being required or used by a health insurance company or health care service plan as a condition of obtaining health coverage.

**I have reviewed all responses pertaining to me in this application. I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature.)**

Signature of applicant/parent or legal guardian	Today's date	Print name (and your relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name

**Important: Return the application within 30 days of your date(s) and signature(s).**

**Part 8 – Statement of Guaranteed Issue Eligibility if applying for a HIPAA guaranteed issue plan**

If you do not qualify for an underwritten plan, Blue Shield offers an alternative that you may want to consider.

The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people in certain instances to maintain coverage if they lose existing group health plan coverage. Depending on your responses to the statements below, you may be eligible for guaranteed issue in accordance with HIPAA, and Blue Shield will automatically accept your application for one of its HIPAA guaranteed issue plans without medical underwriting. Each person on the application must meet HIPAA eligibility requirements to qualify for a HIPAA guaranteed issue plan. Please note that HIPAA guaranteed issue rates may be higher than those of Blue Shield's underwritten plans.

If you are applying individually for coverage on behalf of any dependents who are not eligible for a HIPAA guaranteed issue plan, their coverage will be subject to medical underwriting, except for children who were enrolled under any prior creditable coverage within 30 days of the birth or placement for adoption. A dependent child who is 25 years of age or younger or a dependent spouse applying for HIPAA guaranteed issue must complete a separate Statement of HIPAA Guaranteed Issue Eligibility (Blue Shield will accept copies of the Statement of Guaranteed Issue Eligibility). For additional applications or current HIPAA guaranteed issue plan rates, please contact your insurance agent, or call Blue Shield at **(800) 431-2809**.

Note: Children under the age of 19 are only eligible for a HIPAA guaranteed issue plan if applying as a dependent for family coverage because they are otherwise eligible for guaranteed issue coverage under CA state law.

**Statement of Guaranteed Issue Eligibility and checklist if applying for a HIPAA guaranteed issue plan**

Name of applicant(s) requesting HIPAA guaranteed issue coverage: \_\_\_\_\_

Please complete the following questionnaire if you are interested in a HIPAA guaranteed issue policy so that your eligibility for HIPAA guaranteed issue coverage may be verified.

<input type="checkbox"/> Yes	<input type="checkbox"/> No	1. I have had a total of at least 18 months of healthcare coverage (including COBRA or Cal-COBRA, if applicable) without a lapse in coverage of more than 63 days (excluding employer-imposed waiting periods).
<input type="checkbox"/> Yes	<input type="checkbox"/> No	2. My most recent coverage was through an employer-sponsored health plan (COBRA and Cal-COBRA are considered employer-sponsored coverage).
<input type="checkbox"/> Yes	<input type="checkbox"/> No	3. I accepted and exhausted any available COBRA and/or Cal-COBRA coverage (if COBRA/Cal-COBRA were not available, check "yes"). COBRA/Cal-COBRA coverage dates _____ through _____ COBRA administrator _____ Telephone _____ Insurance carrier _____ Telephone _____ If your most recent coverage was employer-sponsored and you were not eligible for COBRA and/or Cal-COBRA coverage, please explain: _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	4. I am currently eligible for coverage under a group or employer-sponsored health plan, Medicare, or Medicaid.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	5. My most recent coverage terminated because of nonpayment of dues/premium or fraud.

If your answers to statements 1, 2, and 3 are "yes," and your answers to statements 4 and 5 are "no," please complete the remaining sections below to apply for a HIPAA guaranteed issue plan. Note: Submit evidence of prior coverage with your application, such as a certificate of creditable coverage from your previous health carrier and/or verification from your previous COBRA/CalCOBRA administrator to avoid processing delays.

**HIPAA guaranteed issue coverage options (please select one)**

A. If you know that you will not qualify, or do not want to apply for an underwritten plan, check this box:

Issue the HIPAA guaranteed issue plan only. Since I have chosen this option, I understand that I will not be considered for an underwritten plan.

B. If you are applying for both HIPAA guaranteed issue and an underwritten plan, select one of the following:

Issue the HIPAA guaranteed issue plan at the earliest effective date, so that I am covered during the underwriting process of the individual plan. (I understand that if my application for the underwritten plan is approved, I will automatically be transferred to the underwritten plan. If it is not approved, I will continue to receive HIPAA guaranteed issue coverage.)

Issue the HIPAA guaranteed issue plan only if I am not approved for the underwritten plan. (I understand that I will not have any individual Blue Shield coverage until my application for the underwritten plan is processed and either approved or declined.)

**HIPAA guaranteed issue plan options (please select one)**

Access+ HMO package                       Access+ Value HMO  
 Shield Spectrum PPO 5500                 Shield Spectrum PPO 5000\*

By signing this statement, I verify that I have read and understood the eligibility conditions for HIPAA guaranteed issue listed above, and that all of the information I have provided is true and correct.

\_\_\_\_\_  
Signature of applicant or legal guardian                      Today's date (required)                      Print name

\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

**Part 9 – Producer information: to be completed by an authorized Blue Shield agent**

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely. This attestation must be completed by the producer and submitted with each Blue Shield IFP application.

1. Are you aware of any information not disclosed in this application, which may have a bearing on this risk?  Yes (if yes, attach explanation)  No
2. Review and select one of the following:
  - I did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice of any kind from me.
  - I assisted the applicant in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to \$10,000.
3. Did you see any of the following applicants sign the application?
  - a. Primary Applicant:  Yes  No
  - b. Spouse/Domestic Partner:  Yes  No  Not applying
  - c. Family member age 18 or above:  Yes  No  Not applying
 If no to (a), (b), or (c) above, provide details: \_\_\_\_\_

4. Do you want the health service agreement/policy sent directly to the subscriber?  Yes  No

Producer name **Oleg Skurskiy**  
 E-mail address **oleg@findppo.com**  Update e-mail | Producer number **██████████0570S**  
 Telephone number **818-987-5000**  Update phone | Fax number **818-776-9865**  Update fax  
 Producer address **18375 Ventura Blvd. # 226**  Update address  
 City **Tarzana** State **CA** ZIP code **91356**  
 Super producer name \_\_\_\_\_ Super producer number \_\_\_\_\_

\_\_\_\_\_ **Oleg Skurskiy**  
 Producer signature (required) Today's date (required) Print name

**Producers:** Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information. IFP applications can be faxed toll-free 24 hours a day, 7 days a week, to **(888) 386-3420**.

**Part 10 – Billing and payment information**

**Calculate estimated monthly dues/premiums**

- Using the rate book provided to you, calculate your estimated rates or talk to your agent to get estimated rates. You may receive rates higher than your agent quoted you based on Underwriting determination.
- First month's dues/premium are required at the time of application submission. You can enroll in Easy\$Pay where automatic payments are handled via electronic transfer through your checking or savings account for the first month's dues/premium and for ongoing payments. If paying first month's dues/premium by credit card, please fill out section B of the Payment Authorization Form.

**Easy\$Pay automatic payment option**

To sign up for automatic payments, complete section A of the payment authorization form on the next page and return it with your application. You must provide the routing/transit number of your financial institution or staple a deposit slip or blank check marked "VOID CHECK" to your authorization form.

**Submit completed applications to:**

PO Box 3008  
Lodi, CA 95241-9969

<b>Mary Jane Blue</b>	<b>3025</b>
<b>123 First St.</b>	
<b>Anytown, CA 99999</b>	
Pay to _____	20 ____
Order of _____	Dollars
<b>VOID CHECK</b>	
Any Bank	
San Francisco Main Office	
P.O. Box 8944	
San Francisco, CA 94126	
Memo _____	
032056884 9 8707228001 0233	
_____ Bank account number	
_____ Bank routing/transit number	

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## Part 11 – Payment authorization form

**(Dues/premium payment is required with your application. Please select Option 1 or 2)**

**Option 1:** Automatic payment through checking or savings account – Easy\$Pay for **initial and ongoing payments** (complete section A below)

**Option 2:** Please choose one of the options below for both: 1) your initial payment, and 2) for ongoing payments

**Initial payment with application:**

by credit card (complete section B)

**Ongoing payments:**

by automatic payment through checking or savings account – Easy\$Pay (complete section A)     Monthly billing     Quarterly billing

### Applicant information

Applicant name

Mailing address

Apt. No.

City

State

ZIP code

Applicant's daytime phone number

### Method of payment

**A. Easy\$Pay debit:**  Checking account     Savings account

Payment date:  1<sup>st</sup> of month     15<sup>th</sup> of month    (Note: If you do not select a payment date, the default will be 1<sup>st</sup> of the month. HMO and Dental HMO must use 1<sup>st</sup> of the month.)

Payment frequency: Monthly

Bank routing/transfer number

Bank account number

Name(s) on bank account

Name of financial institution

Branch address

City

State

ZIP code

Branch telephone number

**B. Credit Card** (Visa or MasterCard only)

For initial payment only

Cardholder name

Cardholder billing address

Apt. No.

City

State

ZIP code

Credit card number

Card type:  Visa     MasterCard

Expiration date (mm/yyyy) \_\_\_\_\_

**If paying first month's dues/premium by credit card, the estimated first month's payment is:\* \$ \_\_\_\_\_**

\* This is only an estimate of monthly dues/premium. Blue Shield will provide notice of actual monthly dues/premium if my application for coverage is accepted. All dues/premium must be received prior to the original effective date for coverage to be in effect.

**Authorization and Signature(s)**

**Automatic Payment by debit from checking/savings account:**

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date (or within 2 to 3 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record and I will be responsible for making my payment by check or money order, along with a return item service charge.

**Additional information if paying initial dues/premium only by credit card:**

If only the first month's dues/premium box is checked, this authorization is only valid to charge the first month's dues/premium owed to Blue Shield. I understand my credit card will be charged for the estimated first month's dues/premium immediately upon receipt of my application; however, this payment does not constitute approval of my application, and if my application is accepted, a different rate may apply. If I am accepted at a different rate, the difference in dues/premium must be paid prior to the original effective date of coverage. Blue Shield will not automatically charge the difference in rate owed to the credit card without a separate authorization from the applicant.

**Notice to Change/Cancel Required:**

I will continue to be debited/charged the amount of dues/premium owed until I cancel this Automatic Payment authorization upon at least 10 calendar days notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 431-2809**. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form (if the bank account is a joint account, all accountholders must sign) and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

\_\_\_\_\_  
Cardholder/Accountholder Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Social Security number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Cardholder/Accountholder Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Social Security number

\_\_\_\_\_  
Date