BlueCross BlueShield of Oklahoma

SimplyBlue HealthCheck

Application or Change in Coverage

To help us process your application promptly, please remember to:

1. Print all answers in **blue or black ink**. Pencil will not be accepted.
2. Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.
3. If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information.
4. Please do not use correction fluid or tape.

Please submit an application via one of the following methods. If submitting by mail or fax, please complete the entire application and select a premium mode in Section H.

IF YOU ARE WORKING WITH A BLUE CROSS AGENT, PLEASE REMEMBER TO INCLUDE THE NAME OF YOUR AGENT ON THE BACK OF THIS APPLICATION OR SELECT YOUR AGENT'S NAME FROM THE ONLINE DROP DOWN BOX

APPLY ONLINE (via Internet): bcbsok.com

APPLY BY MAIL: Blue Cross and Blue Shield of Oklahoma
Attn: Underwriting & Individual Enrollment
P.O. Box 3236; Naperville, IL 60566–7236

APPLY VIA FAX: 1–888–223–1988

If you have any questions, please call your agent or our Customer Service Department toll–free at 1–866–520–2507.

Applicant Name ____________________

CHECK ALL THAT APPLY: ☐ New Policy ☐ Add Spouse and/or Dependent(s) ☐ Upgrade (increase of benefits)

SECTION A – PERSON(S) APPLYING FOR NEW COVERAGE (or Change in Coverage)

In addition to having a permanent residence in Oklahoma, persons above age 19 applying for coverage, who are not U.S. citizens, must have had a complete physical by a physician in the U.S. within the past two years.

PRIMARY APPLICANT (Must be age 19 or older)

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NO.	SEX M ☐ F ☐	AGE	DATE OF BIRTH (MM / DD / YYYY)	HEIGHT ' "	WEIGHT lbs
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)						
MAILING ADDRESS (STREET, CITY, STATE, ZIP+4) *if different than above*				OCCUPATION / DUTIES (optional)		
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	FAX (if acceptable contact method) ( )	SPOUSE'S PHONE NO.'S (if applying) WORK: ( ) CELL: ( )		
EMAIL (if available and acceptable contact method)			BEST PLACE AND TIME TO CALL (if necessary) ☐ HOME ☐ WORK ☐ MORNING ☐ AFTERNOON ☐ EVENING			

SPOUSE and/or DEPENDENT CHILDREN TO BE COVERED (dependent children must be under age 26)

First Name, Middle Initial, Last Name	Relationship*	Sex	Height	Weight lbs	Date of Birth (MM/DD/YYYY)	Social Security No.
		M ☐ F ☐	' "			
		M ☐ F ☐	' "			
		M ☐ F ☐	' "			
		M ☐ F ☐	' "			
		M ☐ F ☐	' "			

*If a CHILD is to be covered, are ALL children listed above your natural children, stepchildren or adopted children?. . . . . ☐ Yes ☐ No

If "No," 1) Indicate name(s) of applicable child(ren): ____________________

2a) Are you (or your spouse) legally and financially responsible for this/these dependent(s)?. . . . . ☐ Yes ☐ No

2b) If "Yes" in 2a, please submit a copy of the signed court decree.

SECTION B – SELECT COVERAGE SELECT A SIMPLY BLUE OR HEALTH CHECK PLAN, A DEDUCTIBLE AND INDICATE IF DENTAL IS DESIRED.

☐ SIMPLY BLUE Deductible applies to in-network services only. Additional deductibles apply for services received out-of-network.

Choose one deductible:

☐ $1,000 ☐ $2,000 ☐ $3,000 ☐ $5,000 ☐ $7,500 ☐ $10,000

☐ HEALTH CHECK BASIC

Choose one deductible:

☐ $500 ☐ $1,000 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $7,500

☐ HEALTH CHECK SELECT

Choose one deductible:

☐ $200 ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000

☐ HEALTH CHECK HSA FEDERAL LAW SPECIFIES MINIMUM DEDUCTIBLES FOR THIS PRODUCT WHICH ARE SUBJECT TO COST OF LIVING ADJUSTMENTS.

FOR INDIVIDUAL COVERAGE[1]:

	Deductible	Coinsurance[2]	Out–of–Pocket Maximum[3]
☐	$1,500	80%	$3,000
☐	$2,500	80%	$4,000
☐	$2,500	100%	$2,500
☐	$3,500	80%	$5,000
☐	$3,500	100%	$3,500
☐	$5,000	100%	$5,000

FOR FAMILY COVERAGE[1]:

	Deductible	Coinsurance[2]	Out–of–Pocket Maximum[3]
☐	$3,000	80%	$6,000
☐	$5,000	80%	$8,000
☐	$5,000	100%	$5,000
☐	$7,000	80%	$10,000
☐	$7,000	100%	$7,000
☐	$10,000	100%	$10,000

OPTIONAL COVERAGE

☐ BLUECARE DENTAL – I (We) hereby apply for Dental coverage and understand that all Applicants and Dependents approved for health coverage will be covered under the Dental coverage. If any covered health individual is cancelled from the health coverage or if health coverage is cancelled in its entirety, I understand the same action will be applied to Dental coverage. I also understand that if I or any of my dependents are currently Blue Cross and Blue Shield of Oklahoma Voluntary Individual Dental plan members, the VID plan will be cancelled and replaced by this dental addendum without a gap in coverage.

[1] By federal law if you are listed as a dependent on another person's federal income tax return, you are not eligible to participate in the tax–qualified benefits of an HSA plan.
[2] The percentage for coinsurance is based on allowable charges for covered services received from in–network providers.
[3] Out–of–pocket maximum includes deductible.

Applicant Name ______________________

SECTION C – HEALTH HISTORY / MEDICAL QUESTIONS

All health history/medical questions must be completed for all individuals (including adults and children) applying for coverage.

If "Yes" to ANY questions in Section C – Health History / Medical Questions, please give complete details in Section D – Details of Health History. Please note the timeframe reference for each question.

1. Within the last 10 years has any person applying for coverage been advised, counseled, tested, diagnosed, treated, prescribed medication, hospitalized or recommended for treatment for the following (please mark "Yes" or "No):
If any boxes are marked "Yes" (☒ Yes), also circle the condition, e.g. (migraines) and give complete details in Section D – Details of Health History.

A. Migraines; headaches; epilepsy or seizure disorder; head injury or concussion; any neurological disorder; neuropathy; paralysis; multiple sclerosis; or any other central or peripheral nervous system disorder? . . . . ☐ Yes ☐ No

B. Attention deficit disorder; anxiety; depression or chemical imbalance; insomnia; bipolar disorder; mental retardation; any behavioral, emotional or mental disorder; eating disorder; pervasive development disorder or autism spectrum disorder; marital or any form of counseling or therapy? . . . . ☐ Yes ☐ No

C. Chest pain; palpitations; heart murmur; mitral valve prolapse; arrhythmia or irregular heartbeat; heart attack; stroke or TIA; or any other heart or circulatory disorder or condition, or hypertension / high blood pressure (HBP)? . . . . ☐ Yes ☐ No

If "Yes" to HBP, provide 3 readings and their dates within the last year:

_______________ and _______________ and _______________

D. Elevated cholesterol, triglycerides or other lipids (including if controlled by diet or exercise)? . . . . ☐ Yes ☐ No
If "Yes", provide the date and results of most recent testing:

Date:________ Total Chol.: ________ HDL: ________ Triglycerides: ________

E. Varicose veins; spider veins; varicosities; blood clot; anemia; or any other blood disorder? . . . . ☐ Yes ☐ No

F. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; breathing difficulty; or any other lung or respiratory disease, disorder or condition? ☐ Yes ☐ No

G. Acid reflux; gastroesophageal reflux (GERD); Barrett's or any other disorder of the esophagus; irritable bowel syndrome (IBS); colitis; diverticular disease; chronic diarrhea or intestinal problem; ulcer; hernia; hemorrhoids or rectal disorder; or any other digestive disorder or condition? . . . . ☐ Yes ☐ No

If "Yes" to hernia, indicate type: ______________________________

H. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; or hepatitis? ☐ Yes ☐ No

If "Yes" to hepatitis, indicate type: ______________________________

I. Cancer; tumor; growth; cyst; polyp; enlarged lymph node(s); or leukemia? . . . . ☐ Yes ☐ No

If "Yes", indicate diagnosis and location: ______________________________

J. Acne; keratosis; psoriasis; basal cell carcinoma; malignant melanoma; lesions of the skin or mouth; hemangiomas; or any other skin disorder? . . . . ☐ Yes ☐ No

Questions continue at right

K. Kidney stones; urinary reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? . . . . ☐ Yes ☐ No

L. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? . . . . ☐ Yes ☐ No

M. Back or spinal disorder; herniated, bulged, protruded, ruptured or slipped disc; degenerative disc disorder; or any other injury to, disease or disorder of the back or spine? ☐ Yes ☐ No

N. Arthritis (e.g. osteoarthritis, rheumatoid, psoriatic, etc.); gout; bursitis; carpal tunnel syndrome; pinched nerve; bunion; temporomandibular joint syndrome (TMJ); or any injury to, disease or disorder of the knees, shoulders, jaw, bones, muscles or joints; joint replacement; or received chiropractic adjustments or manipulation therapy? . . . ☐ Yes ☐ No

O. Hypothyroidism; hyperthyroidism; Graves' disease; goiter; nodule or any other thyroid disorder; diabetes; elevated blood sugar; glucose intolerance; insulin resistance or any other metabolic, endocrine, pituitary or adrenal disorder; lupus; chronic fatigue syndrome; connective tissue or autoimmune disorder? ☐ Yes ☐ No

P. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any other eye, ear, nose, speech or throat disorder? . . . . . ☐ Yes ☐ No

Q. Acquired Immune Deficiency Syndrome (AIDS); AIDS–Related Complex (ARC); HIV positive or other immune disorder? . . . . . . ☐ Yes ☐ No

R. <u>For all Male persons applying (adults and children)</u>
Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; erectile dysfunction; or any other disease or disorder of the genital or reproductive system?. . . . . ☐ Yes ☐ No

S. <u>For all Female persons applying (adults and children)</u>
a) Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele; rectocele; sexually transmitted disease; genital warts; herpes; HPV; or any other disease or disorder of the genital or reproductive system? . . . . ☐ Yes ☐ No
b) Has any female person had a C–section? . . . . ☐ Yes ☐ No
c) Has any female person had a Pap smear?. . . . . ☐ Yes ☐ No
If "Yes" for Pap, provide date and results of each person's last 2 Paps:

Name ____________________ Date ________ ☐ Normal ☐ Abnormal

Name ____________________ Date ________ ☐ Normal ☐ Abnormal

Name ____________________ Date ________ ☐ Normal ☐ Abnormal

Name ____________________ Date ________ ☐ Normal ☐ Abnormal

Applicant Name ________________________________

SECTION C – HEALTH HISTORY / MEDICAL QUESTIONS *continued*

All health history/medical questions must be completed for all individuals (including adults and children) applying for coverage.

2. **For EACH person applying for coverage (adults and children),** complete the following information regarding their last physical exam, including checkup:

   Person's Name: ______________________ Exam Date (Month / Year): _______ / _______ Exam Results: ☐ Normal ☐ Abnormal*

   Person's Name: ______________________ Exam Date (Month / Year): _______ / _______ Exam Results: ☐ Normal ☐ Abnormal*

   Person's Name: ______________________ Exam Date (Month / Year): _______ / _______ Exam Results: ☐ Normal ☐ Abnormal*

   Person's Name: ______________________ Exam Date (Month / Year): _______ / _______ Exam Results: ☐ Normal ☐ Abnormal*

   *Abnormal exam results include any recommendation for additional testing, medication or follow up visit(s).

3. **During the last 5 years,** has any person applying for coverage had an **abnormal** result from a physical exam, blood test, urinalysis, lab or diagnostic test? . . . . ☐ Yes ☐ No

4. **During the last 12 months,** has any person applying for coverage been prescribed or advised to take medication (other than for the common cold or flu) that is not indicated elsewhere on this application? *If unsure of the reason for any ongoing medication use, please verify with your physician.* . . . . ☐ Yes ☐ No

5. **During the last 12 months,** have you or your spouse (if to be insured) smoked or used any tobacco product – such as cigarettes, pipes, cigars, snuff, chewing tobacco or used any smoking cessation aid or nicotine substitution product?

   APPLICANT . . . . ☐ Yes ☐ No

   SPOUSE. . . . . ☐ Yes ☐ No

6. A. **Question for all FEMALE persons applying (including dependents):**
   Is any female applying for coverage currently pregnant or now an expectant parent? . . . . ☐ Yes ☐ No

   B. **Question for all MALE persons applying (including dependents):**
   Is any male applying for coverage now an expectant parent?. . . . . ☐ Yes ☐ No

Note for 6A and 6B: *For Simply Blue policies, if "Yes" and the applicant is age 19 or above, coverage cannot be offered.For Health Check policies with an initial effective date prior to Mar. 23, 2010, if you answered "Yes", coverage cannot be offered. For Health Check policies with an initial effective date on or after Mar. 23, 2010, if you answered "Yes" and the applicant is age 19 and over, coverage cannot be offered.*

7. Has any person applying for coverage ever been seen, tested, prescribed or taken medication, or been treated for infertility or to assist in becoming pregnant? . . . . ☐ Yes ☐ No

8. A. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin, or penile implant, etc.), internal fixation (e.g. pins, plates, rods, screws or spinal cage), prosthesis, pacemaker, heart valve replacement, shunt or monitoring device other than indicated elsewhere on this application? . . . . ☐ Yes ☐ No

   If "Yes" to breast implants, please complete the following:

   B. Indicate reason(s) for breast implants: ☐ Cosmetic reasons ☐ Disease / Illness / Injury / Congenital Anomaly

   C. Have there been any complications or have the breast implants been replaced? . . . . ☐ Yes ☐ No

9. A. Does any person applying for coverage drink beer or alcohol? . . . . ☐ Yes ☐ No

   If "Yes", please complete the following:

   Person's Name: ______________________ Average Number of Drinks Per Week: ______________

   Person's Name: ______________________ Average Number of Drinks Per Week: ______________

   Person's Name: ______________________ Average Number of Drinks Per Week: ______________

   Note: 1 drink is equivalent to one 12 oz. beer, or one 5 oz. glass of wine, or 1.5 oz. of hard liquor

   B. Has any person applying for coverage **ever** been advised to seek treatment for alcohol use or been advised to reduce alcohol intake or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism? . . . . ☐ Yes ☐ No

10. Has any person applying for coverage **ever** used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use (prescription, non–prescription, or illegal), or dependency? . . . . ☐ Yes ☐ No

11. Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery **which has not yet been performed?** . . . . ☐ Yes ☐ No

12. Has any person applying for coverage **ever** been seen, treated, hospitalized, or had surgery for a bypass, angioplasty, stent, aneurysm, valve replacement, cancer, stroke, gastric or weight loss surgery, congenital abnormality, or organ transplant **other** than indicated elsewhere on this application? . . . . ☐ Yes ☐ No

If "Yes" to ANY questions in Section C – Health History / Medical Questions, please give complete details in Section D – Details of Health History.

Applicant Name ______________________

SECTION D – DETAILS OF HEALTH HISTORY

If you answered "Yes" to ANY question in Section C – Health History / Medical Questions section OR have had an abnormal exam or test, please provide further information in the spaces below. Be sure to use the "correct" example as your guide.
(If more space is needed, attach a separate page which must be signed and dated.)

	QUESTION NUMBER	PERSON AFFECTED	CONDITION, INJURY, SYMPTOM, OR DIAGNOSIS			WAS RECOVERY COMPLETE?	TYPES OF TREATMENT, ADVICE GIVEN AND MEDICATIONS PRESCRIBED	DATE LAST TREATED (if applicable)	NAME, ADDRESS & PHONE NUMBER OF DOCTORS AND HOSPITALS
			DESCRIPTION (specify left or right, if applicable)	DATE THAT IT STARTED	DATE OF RECOVERY (if applicable)				
CORRECT	1C	JOE SMITH	HIGH BLOOD PRESSURE	6/95	NONE	NO, ONGOING	40 MG ATENOLOL, ONCE DAILY	TODAY, (STILL USING MEDICINE)	DR. JONES ST. MARY'S ANYTOWN, OK (345) 555–1212

SECTION E – OTHER INSURANCE

1. Does any person applying for coverage currently have, or did they previously have within the last 5 years, Blue Cross and Blue Shield of Oklahoma coverage, either as a primary insured, spouse, or as a dependent? . . . . . ☐ Yes ☐ No
   If "Yes", please complete the following:

   Member Name: ______________ Member Number (optional): ______________ Group Number (optional): ______________

   Member Name: ______________ Member Number (optional): ______________ Group Number (optional): ______________

2. Does any person applying for coverage have any health or major medical insurance coverage with any other Insurer, including other Blue Cross and Blue Shield plans? . . . . . ☐ Yes ☐ No
   If "Yes", please complete the following:
   Name(s) of all individuals covered: ______________________________

   Insurer Name(s): ______________________________ Location / State: ______________

   Policy Effective Date: ______________________________ Anticipated Policy Termination Date: ______________

3. Has any person applying for coverage ever been declined, postponed, charged an extra premium for or had a rider applied to life, health, or disability insurance, or had any such insurance rescinded or cancelled? . . . . . ☐ Yes ☐ No

   If "Yes", provide name(s): ______________________________ Explanation: ______________________________

NOTE: DO NOT CANCEL ANY CURRENT COVERAGE YOU MAY HAVE UNTIL YOUR NEW POLICY IS APPROVED AND IN FORCE.

Applicant Name ____________________

SECTION F – REPRESENTATIONS, ACKNOWLEDGEMENTS AND AUTHORIZATIONS

I and any persons whose names appear on this application hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma (BCBSOK) as indicated in this application. I understand, certify and agree to the items listed below:

- This is an application only, and I should not cancel any existing coverage unless I am notified in writing by Blue Cross and Blue Shield of Oklahoma of acceptance.
- Any insurance agent, examining physician, or other person who knowingly and willfully makes a false or fraudulent statement or representation in or relative to any application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.
- If someone, other than myself, has completed any portion of this application on my behalf, I have reviewed the information and agree it is accurately reflected.
- The primary applicant is a resident of, and has principal residence located within, the State of Oklahoma and understands that proof of residency may be required at any time.
- Maternity benefits for normal pregnancy are not available.
- If my application is being handled through an independent insurance agent, I understand that the insurance agent is my agent for this application process.
- If my application is accepted and I am age 19 or older, no benefits will be provided for any preexisting condition or complication of a preexisting condition for a period of 12 months after my coverage becomes effective. A condition or complication thereof is considered "preexisting" if any of the following events occurred within 12 months before the Subscriber's Effective Date: medical expenses were incurred; medical advice or diagnosis was given; medication was taken or prescribed; treatment was recommended by or received from a Physician or other Provider; or the Subscriber had an awareness of symptoms.
- This coverage is not an employer–group health plan and is not intended in any way to be an employer sponsored health insurance plan. Further, I certify that my employer will not contribute any part of the premium, nor will I be reimbursed for any part of the premium by my employer now, or in the future.
- If I am age 19 or above, this application when processed may result in acceptance, denial, exclusion, or limitation of coverage.
- This is an age–rated plan. Rates are subject to change based upon age and other factors.
- I understand that an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact, with the intent to deceive the Plan, on this application may result in rescission of coverage. Rescission means the cancellation or discontinuance of coverage retroactive to the effective date. Rescission does not include the cancellation or discontinuance of coverage attributable to a failure to timely pay required premiums or contributions toward the cost of coverage, a voluntary termination by a covered person, or cancellation due to a covered person becoming ineligible for coverage. I will be provided with at least 30 days advance written notice before my or my dependent's coverage may be rescinded.
- **Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.**
- **WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

MEDICAL AUTHORIZATION: I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, or other medical or medically related facility, governmental agency or other person or firm, to disclose to BCBSOK or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize BCBSOK to review and research its own records for information.

The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.

I understand my authorization is voluntary and that such information will be used by BCBSOK for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for BCBSOK to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re–disclosed by BCBSOK as permitted or required by law and may no longer be protected by federal privacy laws. I understand that I or any authorized representative will be sent a copy of this authorization upon written request. This authorization is valid from the date signed and shall remain valid for 24 months, unless revoked by me in writing, which I may do at any time by sending a written request to Blue Cross and Blue Shield of Oklahoma, Privacy Department, P.O. Box 3283, Tulsa, Oklahoma 74102–3283. Any revocation will not affect the activities of BCBSOK prior to receipt of the revocation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

INDIVIDUAL(S) AUTHORIZING USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION: I have had a full opportunity to read and consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

IMPORTANT: Your application must be signed and dated by all persons applying for coverage, as indicated on the next page. (This includes your spouse and all dependents age 18 or over if they are applying for coverage). Missing signatures or dates will cause a delay in processing. We must also receive your application within 30 days of the earliest date signed, so please return it promptly. Applications received after 30 days will require a new application.

Applicant Name ______________________________

SECTION F – REQUIRED SIGNATURES

PRIMARY APPLICANT'S SIGNATURE (AGE 19 AND OVER) X __________________________ DATE SIGNED: __________

SPOUSE'S SIGNATURE (IF APPLYING) X __________________________ DATE SIGNED __________

DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED) X __________________________ DATE SIGNED: __________

DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED) X __________________________ DATE SIGNED: __________

DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED) X __________________________ DATE SIGNED: __________

If this authorization is signed by a personal representative, on behalf of an individual (other than a parent for a minor child), complete the following:

PERSONAL REPRESENTATIVE'S NAME (PLEASE PRINT) __________________________ RELATIONSHIP: __________

PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. YOU ARE ENTITLED TO A COPY OF THIS SIGNED AUTHORIZATION.

SECTION G – PROXY STATEMENT

PROXY STATEMENT: The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Primary Applicant's Signature *(Optional)* *YOU MUST ALSO SIGN IN SECTION F ABOVE.*

X __________________________

Print Your Name as You Signed It: __________________________ Date Signed ______ / ______ / ______
Month Day Year

SECTION H – BILLING INFORMATION

NOTE: Do not cancel any current coverage you may have until your new policy is approved and in force.

REQUESTED EFFECTIVE DATE **(Mo./Day/Yr.)** ____ / ____ / ____ **(Note: Day cannot be 29th, 30th or 31st)** **or** ☐ **1st or** ☐ **15th of (Mo./Yr.)** ____ / ____

PREMIUM MODE:

Health Check

☐ Monthly Bank Draft includes initial and ongoing payments. Monthly premiums are deducted automatically from participating Oklahoma banks, credit unions or savings and loans upon approval of your application.

(Must complete Authorization Agreement on next page.)

Simply Blue

(Make check payable to Blue Cross and Blue Shield of Oklahoma. Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.)

MONTHLY BANK DRAFT:

☐ Monthly Bank Draft (Payment will be drafted upon receipt of this application. You must complete the Authorization Agreement below.)

- ☐ Deduct initial premium payment only
- ☐ Deduct ongoing monthly premium payments only **(First month premium amount of $________enclosed)**
- ☐ Deduct both the initial premium payment and ongoing monthly payments

☐ **SEND ME A PAPER BILL: (First month premium amount of $________enclosed)**

- ☐ One-Month Direct Bill ☐ Two-Month Direct Bill

NOTE: CASHING OF THE PREMIUM DEPOSIT DOES NOT CONSTITUTE APPROVAL OF THIS APPLICATION. IF THIS APPLICATION IS NOT APPROVED, THE PREMIUM DEPOSIT WILL BE RETURNED TO THE PRIMARY APPLICANT AND NEITHER THE PRIMARY APPLICANT NOR ANY OTHER PERSON APPLYING FOR COVERAGE UNDER THIS APPLICATION SHALL BE ENTITLED TO BENEFITS OR COVERAGE.

☐ **EMPLOYER BILL:** List Bill (Indicate Name of Employer below.)

Complete for Simply Blue ONLY

Billing Name and Address (If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless requested otherwise.)

FIRST NAME, MIDDLE INITIAL, LAST NAME
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)
NAME OF EMPLOYER (if requesting List Bill only)

Applicant Name ______________________

SECTION H – *continued*

AUTHORIZATION AGREEMENT – Required for Bank Draft Payments Only

I request and authorize Blue Cross and Blue Shield of Oklahoma (BCBSOK) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer–sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future. I also understand that both the financial institution and BCBSOK reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advance notice to Blue Cross and Blue Shield of Oklahoma by telephone prior to a scheduled withdrawal date.

PLEASE COMPLETE THE FOLLOWING – PRINT OR TYPE INFORMATION

I authorize BCBSOK to deduct the premium payments from my checking or savings account. If the draft date falls on a non–business day or a holiday, the premium payment will be deducted from my account on the next business day.

PLEASE ENSURE ADEQUATE FUNDS ARE AVAILABLE AT THE TIME OF APPLICATION. BLUE CROSS AND BLUE SHIELD OF OKLAHOMA IS NOT RESPONSIBLE FOR FEES INCURRED DUE TO INSUFFICIENT FUNDS.

PLEASE CHECK ONE: ☐ Checking Account ☐ Savings Account

NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT: ______________________

NAME AND LOCATION OF BANK WHERE ACCOUNT IS AUTHORIZED: ______________________

BANK TRANSIT NUMBER: ______________________ DEPOSITOR'S ACCOUNT NUMBER: ______________________

I HAVE READ AND ACCEPT THE ABOVE AGREEMENT.

DEPOSITOR'S SIGNATURE: X ______________________ DATE: ______________

RELATIONSHIP TO APPLICANT: ______________________

SECTION I – AGENT INFORMATION

If customer applied for Simply Blue, I have provided the customer with a copy of the Outline of Coverage.

AGENT'S SIGNATURE	DATE	AGENT'S CODE
PRINT AGENT'S NAME	AGENT'S PHONE	AGENT'S FAX

THANK YOU FOR APPLYING. PLEASE INCLUDE ALL NECESSARY MATERIALS WHEN SUBMITTING THIS APPLICATION. IF LEGAL GUARDIAN, PLEASE ENCLOSE SIGNED COURT DECREE.