

Application for Membership



# HealthCheck *Select*

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# HealthCheck *Basic*

and Children's Major Medical



**BlueCross BlueShield  
of Oklahoma**

[www.bcbsok.com](http://www.bcbsok.com)



**FORT DEARBORN LIFE**  
*Insurance Company*



# HEALTH CHECK APPLICATION FOR MEMBERSHIP

To help us process your application promptly, please print all answers in blue or black ink and remember to return this signed application with your voided check attached to:

**Blue Cross and Blue Shield of Oklahoma**  
Attn: Health Check Enrollment  
P.O. Box 3283  
Tulsa, OK 74102-3283

## FINANCIAL INSTITUTION DEBIT AUTHORIZATION

Monthly premiums are deducted automatically from participating Oklahoma banks, credit unions or savings and loans. Please provide the following information and your voided personal check.

### REMINDER

Your **VOIDED CHECK (personal checking) or savings deposit slip** from a **participating Oklahoma financial institution** must be attached here.

Please attach check with **TAPE**.  
Do not use glue,  
staples or paper clips.

PLEASE TAPE CHECK HERE

|   |                |         |
|---|----------------|---------|
| Your Name<br>Your Address<br>Your City, State & Zip     |                |         |
| Pay to the<br>Order of                                  | _____ \$ _____ | Dollars |
| DEPOSITORY BANK OR BRANCH NAME<br>BANK ADDRESS<br>_____ |                |         |
| ⑆ 234 56 78   | ⑆ 234 56       | ⑆ 00 ⑆  |

- I hereby request and authorize Blue Cross and Blue Shield of Oklahoma to initiate debit entries to my account on or around the date payment is due.
- 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.
- 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.**

Preference of effective date/monthly withdrawal date:  1st only  15th only  Either  
(Please note that effective date and monthly withdrawal date are the same)

Please indicate type of account from which withdrawal will be made:  Checking  Savings

THIS AUTHORITY IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL BLUE CROSS AND BLUE SHIELD OF OKLAHOMA HAS RECEIVED WRITTEN NOTIFICATION FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD IT A REASONABLE OPPORTUNITY TO ACT.

|                                       |                           |
|---------------------------------------|---------------------------|
| NAME OF ACCOUNT HOLDER (PLEASE PRINT) | TODAY'S DATE              |
| SIGNATURE OF ACCOUNT HOLDER           | RELATIONSHIP TO APPLICANT |

## HOW MAY WE CONTACT YOU?

Additional information may be needed to process your application. Please provide the following information:

APPLICANT NAME: \_\_\_\_\_

PLEASE INDICATE THE PREFERRED TELEPHONE NUMBER(S) FOR US TO CALL:  RESIDENTIAL  BUSINESS  ALTERNATE

WHEN IS THE MOST CONVENIENT TIME FOR US TO REACH YOU? (INDICATE TIME FRAME. EX: 7-9 AM OR 5-8 PM)  AM \_\_\_\_\_  PM \_\_\_\_\_

MAY WE CONTACT YOU BY E-MAIL?  NO  YES, E-MAIL ADDRESS: \_\_\_\_\_

MAY WE SEND YOU A FAX?  NO  YES, FAX NUMBER (INCLUDING AREA CODE): \_\_\_\_\_

PREFERRED LANGUAGE (IF OTHER THAN ENGLISH): \_\_\_\_\_

# WHO DO YOU WANT TO ENROLL? *(check one box below)*

TOTAL NUMBER OF PERSONS APPLYING FOR COVERAGE

- APPLICANT     
  APPLICANT AND SPOUSE     
  APPLICANT AND UNMARRIED CHILDREN     
  APPLICANT, SPOUSE AND UNMARRIED CHILDREN

|  |                            |  |   |               |                |  |  |
|--|----------------------------|--|---|---------------|----------------|--|--|
| LAST NAME OF APPLICANT   |                            | FIRST  | MIDDLE  | HEIGHT<br>' " | WEIGHT         | RESIDENCE PHONE  |  |
| MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP+4)   |                            |  |   |               |                | ALTERNATE PHONE  |  |
| RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)  |                            |  | EMPLOYED BY   |               | BUSINESS PHONE |  |  |
| APPLICANT'S SOCIAL SECURITY NUMBER   | DATE OF BIRTH (MM/DD/YYYY) | SEX<br>M <input type="checkbox"/> F <input type="checkbox"/>   | MARITAL STATUS<br><input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE<br><input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED | EMAIL ADDRESS |                | FAX NUMBER   |  |
| LAST NAME OF SPOUSE  |                            | FIRST  | MIDDLE  | HEIGHT<br>' " | WEIGHT         | DATE OF BIRTH (MM/DD/YYYY)                                   | SEX<br>M <input type="checkbox"/> F <input type="checkbox"/> |
| SPOUSE SOCIAL SECURITY NUMBER  |                            | EMPLOYED BY  |   |               | BUSINESS PHONE |  |  |
| UNMARRIED DEPENDENT'S LAST NAME  | FIRST                      | MIDDLE   | DATE OF BIRTH (MM/DD/YYYY)  | HEIGHT<br>' " | WEIGHT         | SEX<br>M <input type="checkbox"/> F <input type="checkbox"/> | SOCIAL SECURITY NUMBER                                       |
| IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE |                            | IF NOT YOUR NATURAL CHILD, STEP-CHILD OR ADOPTED CHILD ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO |   |               |                | RELATIONSHIP TO APPLICANT                                    |  |
| UNMARRIED DEPENDENT'S LAST NAME  | FIRST                      | MIDDLE   | DATE OF BIRTH (MM/DD/YYYY)  | HEIGHT<br>' " | WEIGHT         | SEX<br>M <input type="checkbox"/> F <input type="checkbox"/> | SOCIAL SECURITY NUMBER                                       |
| IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE |                            | IF NOT YOUR NATURAL CHILD, STEP-CHILD OR ADOPTED CHILD ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO |   |               |                | RELATIONSHIP TO APPLICANT                                    |  |
| UNMARRIED DEPENDENT'S LAST NAME  | FIRST                      | MIDDLE   | DATE OF BIRTH (MM/DD/YYYY)  | HEIGHT<br>' " | WEIGHT         | SEX<br>M <input type="checkbox"/> F <input type="checkbox"/> | SOCIAL SECURITY NUMBER                                       |
| IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE |                            | IF NOT YOUR NATURAL CHILD, STEP-CHILD OR ADOPTED CHILD ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO |   |               |                | RELATIONSHIP TO APPLICANT                                    |  |
| UNMARRIED DEPENDENT'S LAST NAME  | FIRST                      | MIDDLE   | DATE OF BIRTH (MM/DD/YYYY)  | HEIGHT<br>' " | WEIGHT         | SEX<br>M <input type="checkbox"/> F <input type="checkbox"/> | SOCIAL SECURITY NUMBER                                       |
| IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD?<br><input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE |                            | IF NOT YOUR NATURAL CHILD, STEP-CHILD OR ADOPTED CHILD ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO |   |               |                | RELATIONSHIP TO APPLICANT                                    |  |

## PLEASE COMPLETE THIS SECTION FOR ALL DEPENDENTS APPLYING FOR COVERAGE THAT ARE OVER AGE 19 AND UNDER AGE 23 AND ARE FULL-TIME STUDENTS AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY

|                       |                |  |  |                  |
|-----------------------|----------------|--|--|------------------|
| FIRST NAME OF STUDENT | NAME OF SCHOOL | CURRENT SEMESTER ENROLLED<br><input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER | <input type="checkbox"/> UNDER GRADUATE<br><input type="checkbox"/> GRADUATE PROGRAM | # HOURS ENROLLED |
| FIRST NAME OF STUDENT | NAME OF SCHOOL | CURRENT SEMESTER ENROLLED<br><input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER | <input type="checkbox"/> UNDER GRADUATE<br><input type="checkbox"/> GRADUATE PROGRAM | # HOURS ENROLLED |
| FIRST NAME OF STUDENT | NAME OF SCHOOL | CURRENT SEMESTER ENROLLED<br><input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER | <input type="checkbox"/> UNDER GRADUATE<br><input type="checkbox"/> GRADUATE PROGRAM | # HOURS ENROLLED |
| FIRST NAME OF STUDENT | NAME OF SCHOOL | CURRENT SEMESTER ENROLLED<br><input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER | <input type="checkbox"/> UNDER GRADUATE<br><input type="checkbox"/> GRADUATE PROGRAM | # HOURS ENROLLED |

## CHOOSE ONE PLAN AND ONE DEDUCTIBLE

- HEALTH CHECK SELECT CARE **OR** CHILDREN'S MAJOR MEDICAL     
 CHOOSE ONE DEDUCTIBLE:  
 \$200     \$500     \$1,000     \$1,500     \$2,500     \$5,000

- HEALTH CHECK BASIC     
 CHOOSE ONE DEDUCTIBLE:  
 \$500     \$1,000     \$2,500     \$5,000

|   |  |   |                     |
|---|--|---|---------------------|
| MATERNITY BENEFITS (FOR FEMALE APPLICANT OR SPOUSE, AGE 19 AND OVER - CHECK ONE)<br><input type="checkbox"/> WITH MATERNITY COVERAGE <input type="checkbox"/> NO MATERNITY COVERAGE |  | APPLICANT: <input type="checkbox"/> I HAVE <input type="checkbox"/> I HAVE NOT      SPOUSE: <input type="checkbox"/> I HAVE <input type="checkbox"/> I HAVE NOT<br>SMOKED OR USED TOBACCO IN THE LAST 12 MONTHS |                     |
| DO YOU NOW HAVE BLUE CROSS AND BLUE SHIELD INSURANCE?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   | IF YES, YOUR CURRENT BLUE CROSS AND BLUE SHIELD SUBSCRIBER NUMBER _____  | CURRENT BLUE CROSS AND BLUE SHIELD GROUP NUMBER _____   |                     |
| IS THIS AN APPLICATION FOR TRANSFER FROM EXISTING BLUE CROSS AND BLUE SHIELD COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO                                     | LOCATION OF CURRENT BLUE CROSS AND BLUE SHIELD PLAN (CITY/STATE) _____   | DOES ANYONE APPLYING FOR THIS COVERAGE HAVE OTHER GROUP HEALTH INSURANCE OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO  |                     |
| IF YES, LIST OTHER GROUP INSURER _____  | WILL COVERAGE BE CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF NO, EXPECTED CANCEL DATE: _____ | NAME OF POLICY HOLDER _____   | POLICY NUMBER _____ |
|   |  | TYPE OF COVERAGE:<br><input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY  |                     |

|                     |                              |                             |           |                |         |
|---------------------|------------------------------|-----------------------------|-----------|----------------|---------|
| VENDOR NO.          | PRINT INSURANCE AGENT'S NAME | INSURANCE AGENT'S SIGNATURE | PHONE NO. | E-MAIL ADDRESS | FAX NO. |
| FOR OFFICE USE ONLY | TM                           | GROUP #                     | LIFE      |                |         |

Continued on next page →

## EVIDENCE OF INSURABILITY

All health history/medical questions must be completed for all individuals (including dependents) applying for coverage. Each person applying for coverage may be accepted, denied, or offered coverage with a limitation of coverage (Exclusion of Coverage Rider). An Exclusion of Coverage Rider does not have an expiration date.

If any health changes occur prior to the effective date (if coverage approved), or while this application is being reviewed, all health changes for each person (self, and/or spouse and/or dependent children), must be reported to Blue Cross and Blue Shield of Oklahoma, Individual Enrollment Department within 5 days of the change in health. Medical conditions that occur after the signature date of this application, and before the effective date of the application (if approved), are considered in the decision to issue coverage.

### HEALTH HISTORY / MEDICAL QUESTIONS

If you answer "Yes" to ANY questions on this page, please give complete details on the next page. Please note the timeframe reference for each question.

1. Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last 10 years for the following:

If any boxes are marked "Yes" (  Yes), also circle the condition – migraines, for example – and give details on the next page

- A. Migraines; headaches; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? .....  Yes  No
- B. Memory Loss, Dementia, Narcolepsy, Alzheimer's Disease. ....  Yes  No
- C. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? .....  Yes  No
- D. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? .....  Yes  No  
If "Yes" to HBP, provide reading by a health care professional within the last 30 days  
BP Reading \_\_\_\_\_ Date \_\_\_\_\_
- E. Varicose veins/spider veins/varicosities; anemia; blood clot or any other blood disorder? .....  Yes  No
- F. Asthma; allergies; sinusitis; bronchitis; pneumonia; RSV; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; or any breathing difficulty, lung or respiratory disease, disorder or condition? ...  Yes  No
- G. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach; diverticular disease or any other digestive disorder or condition? .....  Yes  No
- H. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? .....  Yes  No  
(if yes, indicate type of hepatitis: \_\_\_\_\_)
- I. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? .....  Yes  No  
(if yes, indicate diagnosis and location) \_\_\_\_\_
- J. Acne; keratosis; psoriasis; basal cell carcinoma; skin lesions, eczema or any other skin disorder? .....  Yes  No
- K. Kidney stones; 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. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; TMJ; any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; bunions; carpal tunnel syndrome; joint replacement; manipulation therapy or spinal fusion? .....  Yes  No
- N. Thyroid disorder; goiter; Graves' disease; diabetes; lupus; pituitary or adrenal disorder? .....  Yes  No
- O. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? .....  Yes  No  
How many ear infections in the last 2 years?  
Date of last ear infection \_\_\_\_\_ Tubes? ...  Yes  No  
If yes, date tubes removed \_\_\_\_\_
- P. Acquired Immune Deficiency Syndrome (AIDS); AIDS-Related Complex (ARC); HIV positive or other immune disorders? .....  Yes  No
- Q. Question for MALES applying for coverage  
Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? .....  Yes  No
- R. Question for FEMALES applying for coverage  
Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? .....  Yes  No  
Is any female applying for coverage now pregnant? .....  Yes  No

Questions continue on next page

Questions continue at right



APPLICANT NAME: \_\_\_\_\_

## APPLICATION AGREEMENT AND SIGNATURES *Please read and sign at bottom.*

I and any persons whose names appear on this application hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma and Fort Dearborn Life Insurance Company 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.
- I am a resident of, and have principal residence located within, the State of Oklahoma and understand that proof of residency may be required at any time.
- 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.
- Maternity coverage must be in effect for 365 days prior to delivery before maternity benefits will be 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.
- This application when processed may result in acceptance, denial, exclusion, or limitation of coverage.
- If my application is accepted, no benefits will be provided for any preexisting condition or complication of a preexisting condition for a period of twelve (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.
- I have read all the statements on this application and represent that they are true and complete to the best of my knowledge and belief. I understand that any false or incomplete information can result in retroactive cancellation of membership and coverage for all persons covered under the membership, and I will be obligated to repay promptly any benefit payments to which persons covered under the membership were not entitled. Blue Cross and Blue Shield of Oklahoma may also recoup any monies paid as benefits prior to a determination by the Plan that any medical condition(s) or other information required to be reported was not correctly represented.
- This is an age-rated health plan. Rates are subject to change based upon age and other factors.

**WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, make any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

APPLICANT'S SIGNATURE (IF AGE 15 OR OVER) X \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

SPOUSE'S SIGNATURE (IF APPLYING FOR COVERAGE) X \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

PARENT OR LEGAL GUARDIAN (IF APPLICANT IS UNDER 18) X \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

DEPENDENT'S SIGNATURE (AGE 18 OR OVER, IF APPLYING) X \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

DEPENDENT'S SIGNATURE (AGE 18 OR OVER, IF APPLYING) X \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

**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**

X \_\_\_\_\_

Print Your Name as You Signed It: \_\_\_\_\_ Date Signed \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**THANK YOU FOR APPLYING. PLEASE BE SURE TO COMPLETE THE HIPAA AUTHORIZATIONS ON THE FOLLOWING PAGES. PLEASE INCLUDE ALL NECESSARY MATERIALS BEFORE MAILING. IF LEGAL GUARDIAN, PLEASE ENCLOSE COURT DECREE.**



APPLICANT NAME: \_\_\_\_\_

## FORT DEARBORN LIFE INSURANCE COMPANY *Beneficiary Information*

|   |       |  |                           |
|---|-------|--|---------------------------|
| <b>APPLICANT:</b> I, on behalf of myself only, hereby apply for \$5,000 of guaranteed renewable life insurance and \$5,000 of guaranteed renewable accidental death and dismemberment benefits with Fort Dearborn Life Insurance Company. |       |  |                           |
| BENEFICIARY LAST NAME   | FIRST | MIDDLE                                 | RELATIONSHIP TO APPLICANT |
| IS THIS LIFE INSURANCE TO REPLACE ANY OTHER POLICY? <input type="checkbox"/> YES <input type="checkbox"/> NO  |       | IF YES, COMPANY NAME AND POLICY NUMBER |                           |
| <b>SPOUSE:</b> I, on behalf of myself only, hereby apply for \$5,000 of guaranteed renewable life insurance and \$5,000 of guaranteed renewable accidental death and dismemberment benefits with Fort Dearborn Life Insurance Company.    |       |  |                           |
| BENEFICIARY LAST NAME   | FIRST | MIDDLE                                 | RELATIONSHIP TO APPLICANT |
| IS THIS LIFE INSURANCE TO REPLACE ANY OTHER POLICY? <input type="checkbox"/> YES <input type="checkbox"/> NO  |       | IF YES, COMPANY NAME AND POLICY NUMBER |                           |

## BLUE CROSS AND BLUE SHIELD OF OKLAHOMA AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION. *Please read and sign at bottom.*

### FORT DEARBORN LIFE INSURANCE COMPANY

### HEALTH CHECK SELECT CARE, HEALTH CHECK BASIC, HEALTH CHECK HSA, CHILDREN'S MAJOR MEDICAL AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

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 Blue Cross and Blue Shield of Oklahoma, Fort Dearborn Life Insurance Company (FDL) 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 Blue Cross and Blue Shield of Oklahoma and FDL to review and research its own records for information.

As mandated by state law, it is understood that this release must contain wording to the effect that information authorized for release may include information which may be considered a communicable or venereal disease which may include, but not be limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), or other conditions for which I may have had symptoms or have been treated as a patient.

I understand my authorization is voluntary and that such information will be used by Blue Cross and Blue Shield of Oklahoma and FDL for the purpose of evaluating my application. Further, I understand that my authorization is required for Blue Cross and Blue Shield of Oklahoma and FDL 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 Blue Cross and Blue Shield of Oklahoma and FDL as permitted or required by law and no longer 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, provided Blue Cross and Blue Shield of Oklahoma and FDL approves coverage, until a policy is put in force 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, OK 74102-3283. Any revocation will not affect the activities of Blue Cross and Blue Shield of Oklahoma or FDL 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.

APPLICANT'S SIGNATURE X \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

SPOUSE'S SIGNATURE (IF APPLYING) X \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

PARENT OR LEGAL GUARDIAN (IF APPLICANT IS UNDER 18) X \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

If this authorization is signed by a personal representative, on behalf of an individual, complete the following:

PERSONAL REPRESENTATIVE'S NAME X \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

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