



Experience. Wellness. Everywhere.SM

HealthCheck

BASIC · SELECT · HSA

Application for Health Coverage or Change in Membership

PLEASE READ THE INSTRUCTIONS ON THE INSIDE THOROUGHLY BEFORE COMPLETING THIS
ENROLLMENT APPLICATION/CHANGE FORM.



**BlueCross BlueShield
of Oklahoma**

HEALTH CHECK APPLICATION OR CHANGE IN COVERAGE

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

- Print all answers in **blue or black ink**. Pencil will not be accepted.
- 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.
- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. 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 include a voided check.

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

APPLY ONLINE (via Internet):
www.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.

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, all persons 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

FIRST NAME, MIDDLE INITIAL, LAST NAME			SOCIAL SECURITY NO.	SEX M <input type="checkbox"/> F <input type="checkbox"/>	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) <i>if different than above</i>						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) <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> MORNING <input type="checkbox"/> AFTERNOON <input type="checkbox"/> EVENING				

SPOUSE and/or UNMARRIED DEPENDENT CHILDREN TO BE COVERED (dependent children must be under age 25)

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

*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): _____

2) Are you (or your spouse) legally and financially responsible for this/these dependent(s)? . . Yes (submit copy of signed court decree) No

SECTION B – COVERAGE APPLIED FOR CHOOSE ONE PLAN AND ONE DEDUCTIBLE

HEALTH CHECK BASIC OR HEALTH CHECK BASIC FOR CHILDREN CHOOSE ONE DEDUCTIBLE:

\$500 \$1,000 \$2,500 \$5,000

HEALTH CHECK SELECT OR HEALTH CHECK SELECT FOR CHILDREN 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 COVERAGE¹:

	Deductible	Coinsurance ²	Out-of-Pocket Maximum ³
<input type="checkbox"/> OPTION 1	\$1,500	80%	\$3,000
<input type="checkbox"/> OPTION 2	\$1,500	80%	\$5,000
<input type="checkbox"/> OPTION 3	\$2,000	80%	\$3,000
<input type="checkbox"/> OPTION 4	\$2,500	80%	\$3,000
<input type="checkbox"/> OPTION 5	\$3,000	80%	\$5,000
<input type="checkbox"/> OPTION 6	\$5,000	100%	\$5,000

FOR FAMILY COVERAGE¹:

	Deductible	Coinsurance ²	Out-of-Pocket Maximum ³
<input type="checkbox"/> OPTION 7	\$3,000	80%	\$6,000
<input type="checkbox"/> OPTION 8	\$3,000	80%	\$10,000
<input type="checkbox"/> OPTION 9	\$4,000	80%	\$6,000
<input type="checkbox"/> OPTION 10	\$5,000	80%	\$6,000
<input type="checkbox"/> OPTION 11	\$6,000	80%	\$10,000
<input type="checkbox"/> OPTION 12	\$10,000	100%	\$10,000

¹By 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.

²The percentage for coinsurance is based on allowable charges for covered services received from in-network providers. ³Out-of-pocket maximum includes deductible.

SECTION B – continued

DO YOU WANT MATERNITY COVERAGE (FOR FEMALE PRIMARY APPLICANT OR SPOUSE, AGE 19 AND OVER)? YES

REQUESTED EFFECTIVE DATE / MONTHLY WITHDRAWAL DATE (NOTE: DAY CANNOT BE ON THE 29TH, 30TH OR 31ST. MONTHLY WITHDRAWAL DATE WILL BE THE SAME AS THE EFFECTIVE DATE) _____

(MM / DD / YYYY)

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
- 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. **For all Male persons applying (adults and children)**
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
Name _____ Date _____ Normal Abnormal
- S. **For all Female persons applying (adults and children)**
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

Questions continue at right

Questions continue on next page

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
If "Yes," coverage cannot be offered.
- B. Question for all MALE persons applying (including dependents):
Is any male applying for coverage now an expectant parent? Yes No
If "Yes," coverage cannot be offered.
7. Has any person applying for coverage ever been seen, tested, prescribed or taken medication, or 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 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.
- 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.
- 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.
- If my application is accepted, 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.
- 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 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 BCBSOK that any medical condition(s) or other information required to be reported was not correctly represented.
- **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 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 BCBSOK 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, 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 below. (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.

PRIMARY APPLICANT'S SIGNATURE (AGE 15 AND OVER) X _____ DATE SIGNED: _____

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

PARENT OR LEGAL GUARDIAN (IF PRIMARY APPLICANT IS UNDER AGE 18) 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, complete the following:

PERSONAL REPRESENTATIVE'S NAME X _____ RELATIONSHIP: _____

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

Applicant Name _____

SECTION F – continued

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 _____

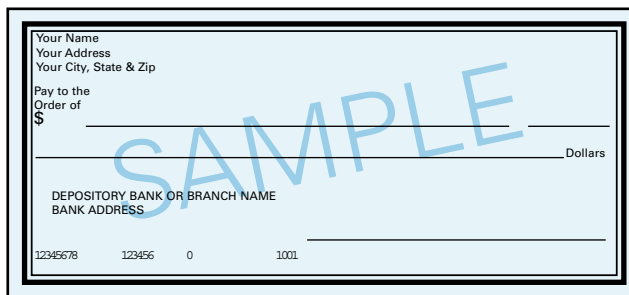
Print Your Name as You Signed It: _____ Date Signed _____ / _____ / _____
Month Day Year

SECTION G – FINANCIAL INSTITUTION DEBIT AUTHORIZATION

Monthly premiums are deducted automatically from participating Oklahoma banks, credit unions or savings and loans.

REMINDER

Please attach your VOIDED CHECK (personal checking) or savings deposit slip from a participating Oklahoma financial institution



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.

AUTHORIZATION AGREEMENT

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

Upon policy activation, I authorize BCBSOK to deduct the initial and ongoing monthly premium payments from my checking or savings account on the monthly premium due date. 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 CHECK ONE: Checking Account Savings Account

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

NAME 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: _____

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

SECTION H – AGENT INFORMATION (if applicable)

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



**BlueCross BlueShield
of Oklahoma**