



Apply Now

- When completing the health history application, try to answer all medical questions with as much detail as possible. Don't worry about leaving anything blank – we will review your application upon receipt and let you know if you missed anything.
- Keep in mind the underwriting process can take up to six weeks. If the underwriter requests medical records, the decision could take longer (up to 60 days). If you need coverage right away, call us or visit our website to sign up for short-term medical insurance (coverage can start as early as midnight tonight).
- Please review the following chart for payment details:

	MEDICA	MCHA	BLUE CROSS	HEALTH PARTNERS
1 st Month's Premium required with application	✓	✓	✓	
Automatic withdrawal required for monthly payment	✓	✓	✓	✓

**Checks must be written from a personal account; however, there are exceptions to this rule. Please contact an InsuranceSmart representative for details. All checks are payable to the insurance carrier NOT InsuranceSmart.*

- Sign and date application. Applications must be received by the home office of the insurance company within 15 days of the signature date.
- Return the application to:

InsuranceSmart

9220 Bass Lake Rd, Suite 300

New Hope, MN 55428

Fax 763-577-0358 (HealthPartners applications may be received via fax)

We will send a confirmation notice upon receipt of your application. Do not cancel your existing medical policy until you have verification that your new policy has been approved. Should you be declined coverage, you may qualify for the Minnesota Comprehensive Health Association (MCHA) Plan. Please contact an InsuranceSmart representative for more details.

We look forward to servicing your insurance needs. Please don't hesitate to contact us at 763-550-0638 or 800-645-6920 with any questions or concerns you may have.



9220 Bass Lake Road, Ste 300 – New Hope, MN 55428

763-550-0638 or 800-645-6920 Fax 763-577-0358

www.InsuranceSmartOnline.com ■ MN Lic #IA-20018362

Application for an Individual Aware Care or Options Blue Health Contract



BlueCross BlueShield of Minnesota
 An Independent Licensee of the Blue Cross and Blue Shield Association
 P.O. Box 64024, St. Paul, MN 55164

FOR AGENT USE ONLY (Please print legibly)					
Agency Code	<input type="checkbox"/>	<input checked="" type="checkbox"/> H	<input checked="" type="checkbox"/> M	<input checked="" type="checkbox"/> M	Agent Name Ron Grams Jr.
Agent's Number	<input type="checkbox"/> 1	<input type="checkbox"/> 1	<input type="checkbox"/> 3	<input type="checkbox"/> 3	
Farm Bureau Employee Number	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1. Reason for Application:

New applicant not covered with BCBSM
 Current BCBSM coverage: ID Number Adding dependent(s) Plan change

2. Applicant's or Contractholder's name

LAST
FIRST
MIDDLE

3. Applicant's or Contractholder's Social Security Number Spouse's Social Security Number

4. Marital Status Single Married If married, Date of Marriage: mo. day yr County and State of Marriage:

5. Applicant's address:

STREET
APT#

CITY
STATE
ZIP

6. Home phone # Applicant's work phone # Spouse's work phone #

7. Payment mode (check one): Annual (12 months) Semiannual (6 months) Quarterly (3 months) Pay-O-Matic (1 month)

Payment must accompany application. Amount paid with this application \$ If paying by check, please make your check payable to Blue Cross and Blue Shield of Minnesota (BCBSM). **We do not accept business checks or any other form of payment from a business for payment of coverage (See exception on page 6).**

8. Applicant's occupation Spouse's occupation

9. Starting with Applicant's name, list each family member applying for coverage:

Full Name and Social Security #	Relationship to Applicant	Birth Date mo/day/yr	Sex	Height	Present Weight	Weight one year ago
Name	Applicant			ft. in.	lbs.	lbs.
Name Social Security #				ft. in.	lbs.	lbs.
Name Social Security #				ft. in.	lbs.	lbs.
Name Social Security #				ft. in.	lbs.	lbs.
Name Social Security #				ft. in.	lbs.	lbs.

Additional dependents on attached page

10. **BEHAVIORAL HEALTH SUBSTANCE ABUSE COVERAGE:**

Coverage for substance abuse is included in the contract. You may choose to delete substance abuse coverage. Your premium will be slightly reduced if you delete substance abuse coverage. Your decision to retain or delete substance abuse coverage applies to all individuals applying for coverage under this contract.
 Check this box if you want to **EXCLUDE** substance abuse coverage

11. **TOBACCO USE DESIGNATION AND DECLARATION:**

Yes No

- A. I (applicant/contractholder) have used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application.
- B. My spouse (if included or being added on this application) has used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application.

NOTE: Tobacco-free rates are available only to persons who have not used tobacco and/or smokeless tobacco in the preceding 24 months.

12. **YOU MUST APPLY FOR THE AWARE CARE OR OPTIONS BLUE HEALTH PLAN:**

AWARE CARE - you must select one (1) deductible option.

\$300 \$500 \$750 \$1,000 \$1,500 \$2,000 \$3,000 \$10,000

\$5,000 – 80% Coinsurance \$5,000 – 100% Coinsurance

OR _____

OPTIONS BLUE - you must select one (1) Plan, Deductible, and Preventive Care option.

Plan: Options Blue 100 Options Blue 80

Deductible: Low Middle High

Preventive Care: 100% to a \$300 maximum, then Deductible/Coinsurance Subject to Deductible/Coinsurance

The Options Blue deductible and out-of-pocket maximum benefits are subject to annual adjustments on the annual renewal date. These adjustments are based on the Consumer Price Index (CPI) published by the Federal Department of Labor.

13. **PREVIOUS HEALTH INSURANCE INFORMATION** - If you are approved for coverage, **your contract will not cover preexisting conditions for the first 12 months.** You will not be subject to this exclusion to the extent you have already fully satisfied this type of requirement under prior continuous coverage. Please provide details of other coverages below.

Yes No

Do you or any family member on this application currently have or had any health insurance within the past 63 days?

If YES, you must complete the following section. Provide health insurance information for the past 12 months for you and any family member included on this application. Make sure to include information for other Blue Cross Blue Shield of Minnesota coverages.

Person Covered	Insurance Company Name and Policy Number	Date Coverage Started mo/day/yr	Date Coverage Ended (if active, state active) mo/day/yr	Was the previous coverage individual or group coverage?

14. **COORDINATION OF BENEFITS** - If the response is **Yes**, you may be contacted for more information.

Yes No

Will you or any family member on this application have other health or medical coverage, including Medicare, once this policy is in force?

15. **EFFECTIVE DATE:**

Yes No

Have you completed an application for an Insta-Care contract to precede this coverage?

If **Yes**, please leave the requested effective date blank. We cannot process this application if the termination date of the Insta-Care contact is greater than 60 days beyond your signature date on this application.

If approved, coverage will be effective as of:

- the date that coincides with the termination date of the Insta-Care contract if you have applied for Insta-Care and we have received this completed application by that date; or
- the day the completed application is received by mail in the home office of BCBSM; or
- the day after the completed application is received in the home office of BCBSM if delivered to the lobby or submitted electronically; or
- a later effective date as requested here month – day – year. (This date cannot be more than 60 days beyond the signature date.)

If this application is not approved, no coverage will be effective.

16. HEALTH HISTORY (Complete information is required for all family members who are applying for coverage.)

In the past five (5) years, have you or any other family member listed in this application had, been treated for or diagnosed as having diseases or disorders related to the following conditions? (Check each item either "Yes" or "No" and circle conditions.)

You do not have to disclose tests to detect the presence of human immune deficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), or other bloodborne pathogens which were administered to you at the time you were: (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) an emergency medical personnel who was tested as a result of performing emergency medical services while employed; (3) corrections employees or inmates; or (4) patients or employees of a secured facility. The term emergency medical personnel includes individuals employed to provide out of hospital medical emergency services, licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who service as employees or volunteers of an ambulance service who provide emergency medical services; a member of an organized first responder squad that is formally recognized by a political subdivision in Minnesota; crime lab personnel; other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law; and any individual who, in the process of executing a citizen's arrest, may have experienced a significant exposure.

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. HEART OR CIRCULATORY DISORDERS—Chest pain, rheumatic fever, heart murmur, stroke, high blood pressure, anemia, bleeding disorders, varicose veins, myocardial infarction or heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| B. GASTROINTESTINAL DISORDERS—Stomach, gallbladder, liver, intestinal bleeding or disorders, ulcers, hernia, hemorrhoids, chronic diarrhea, rectal disorders, or any treatment for obesity | <input type="checkbox"/> | <input type="checkbox"/> |
| C. GENITOURINARY DISORDERS—Kidney, urinary tract disorders, sexually transmitted diseases, infertility, disorders of the male reproductive system including prostate gland, disorders of the female reproductive system including menstrual disorders and abnormal pap smears | <input type="checkbox"/> | <input type="checkbox"/> |
| D. BREAST DISORDERS—Disorders of the male or female breast, including complications from breast implants. | <input type="checkbox"/> | <input type="checkbox"/> |
| E. RESPIRATORY DISORDERS—Asthma, emphysema, bronchitis, allergy/allergic reaction, lung, breathing disorder, or sleep apnea. | <input type="checkbox"/> | <input type="checkbox"/> |
| F. NERVOUS, EMOTIONAL, MENTAL, OR PERSONALITY DISORDERS—Depression, anxiety, adjustment disorders, autism, eating disorders, attention deficit disorders, hyperactivity, behavioral, or psychotic disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| G. ENDOCRINE OR GLANDULAR DISORDERS—Diabetes, thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement | <input type="checkbox"/> | <input type="checkbox"/> |
| H. NEUROLOGICAL OR NEUROMUSCULAR DISORDERS—Headache or migraine, head injury, seizure disorder, multiple sclerosis, cerebral palsy, paralysis, or chronic fatigue syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| I. MUSCULOSKELETAL DISORDERS—Back disorders, scoliosis, temporomandibular joint disorder (TMJ), fibrositis, osteoporosis, fibromyalgia, carpal tunnel syndrome, gout, arthritis, joint disorders, or amputation | <input type="checkbox"/> | <input type="checkbox"/> |
| J. TUMOR, CYST, OR POLYP | <input type="checkbox"/> | <input type="checkbox"/> |
| K. SKIN DISORDERS—Acne, rash, warts, or growth | <input type="checkbox"/> | <input type="checkbox"/> |
| L. COLLAGEN DISEASE—Lupus, scleroderma, or rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| M. GENERAL FATIGUE OR MALAISE, MONONUCLEOSIS, OR EPSTEIN-BARR SYNDROME | <input type="checkbox"/> | <input type="checkbox"/> |
| N. EYES, EARS, NOSE, THROAT DISORDERS—Impairment of sight, cataracts, eye muscle, otitis media, earache, hearing impairment, nasal or sinus disorders, tonsillitis, or adenoiditis | <input type="checkbox"/> | <input type="checkbox"/> |
| O. IMMUNE DISORDERS—Congenital or acquired disease or disorder of the immune system, including AIDS or an ARC (AIDS Related Complex) | <input type="checkbox"/> | <input type="checkbox"/> |

17. Have you or any other family member listed in this application ever had, been treated for or diagnosed as having cancer? **Yes No**

18. Do you or any family member, including persons not applying for coverage, expect to add dependents to your coverage through birth or adoption within the next 12 months? **Yes No**

If **Yes**, expected date of birth or placement:

mo.	day	yr
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19. Is any family member now pregnant or expecting a child through adoption, even if they are not applying on this application? **Yes No**

If **Yes**, expected date of birth or placement:

mo.	day	yr
-----	-----	----

24. Do you or any other family member listed in this application drink alcohol? **Yes** **No**
 If **Yes**:

Person's Name	Average amount of alcohol used weekly

25. Have you or any other family member listed in this application been advised by a health care professional to have evaluation, testing, or treatment for a medical, dental, or mental health condition that has not yet been performed? **Yes** **No**
 If **Yes**:

Person's Name	Dates and Details

26. Have you or any family members listed in this application ever been declined coverage, charged an increased rate, or had benefits excluded from coverage for any health coverage? **Yes** **No**
 If **Yes**:

Person's Name	Dates and Details

27. Do you or any family member listed in this application plan to travel in a foreign country in the next year? **Yes** **No**
 If **Yes**:

Person's Name	Date of Departure	Destination	Date of Return

28. **PLEASE LIST THE NAMES AND ADDRESSES OF THE PHYSICIANS OR HEALTH CARE PROFESSIONALS WITH THE MOST COMPLETE KNOWLEDGE OF THE MEDICAL HISTORY FOR YOU AND ALL FAMILY MEMBERS APPLYING FOR COVERAGE.**

Name of family member	Provider's name	Provider's address

29. **TO BE SIGNED BY APPLICANT (AND SPOUSE IF APPLYING FOR COVERAGE):**

I understand and agree that coverage, if approved, will commence in accordance with question 15. I have included payment with this application. For administrative convenience, BCBSM will deposit in a bank any payment I submit with this application, but such deposit shall not constitute an approval of this application or issuance of coverage. If this application is rejected, any money submitted will be refunded to me. When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment and you will not receive your check back from your financial institution.

29. (Continued):

In order to process your application, we may collect personal information regarding your health history and motor vehicle driving records from persons other than you. The information collected by us or our agents may in certain circumstances be disclosed to third parties without authorization. You have the right to see your personal records that are maintained by us and to correct personal information we have collected about you. Upon your request, we will furnish a more detailed notice of our information practices. The sole purpose for collecting this information is to underwrite your application for coverage.

I hereby authorize and request any hospital, clinic, institution, physician, pharmacy and pharmacy related service organizations or other person to furnish Blue Cross and Blue Shield of Minnesota full details of diagnosis, treatment, medical history, pharmaceutical records and any other information and conclusions about me and any member of my family, and to accept as valid a photocopy of this authorization and my signature. We need this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. We keep this information confidential, but may release it if you authorize release, or if State or Federal law permits or requires release without authorization. For claims purposes, this release is valid while you are enrolled in this health plan and until all claims are adjudicated following your termination of coverage. For purposes of obtaining information in connection with this application, reinstatement, or change in policy benefits, this release is valid up to 26 months from the date you sign this application. You are entitled to receive a copy of this release. This authorization excludes the release of information about bloodborne pathogen tests that were administered to individuals described on page 3 of the application.

I have read the preceding statements and answers and declare them to be true and complete to the best of my knowledge and belief. I understand and agree BCBSM will act in reliance upon the information I have provided in this application and that any false information, omissions or misstatements in this application which materially affect either the acceptance of risk or hazard assumed by BCBSM may result in the denial of a claim(s), rescission of the contract or the issuance of a contract amendment. I also understand and agree that payment of a claim does not preclude the right of the company to deny future claims or take any action it determines appropriate.

I agree to notify BCBSM immediately of any change in my (or my spouse's or children's) health condition between the date of this application and the effective date of coverage. Failure to notify BCBSM of any change in my (or spouse's or children's) health condition may result in the denial of a claim(s), rescission of the contract or the issuance of a contract amendment.

Upon request, I agree to furnish additional information needed concerning eligibility of any dependents.

_____ _____ _____ _____
 Date Applicant's Signature Date Spouse's Signature (if applying for coverage)

_____ _____
 Date Parent or Guarantor's Signature (if applicant is a minor)

As Parent or Guarantor, I understand that: (1) The applicant is the contractholder; (2) I guarantee payment to Blue Cross and Blue Shield of Minnesota; and (3) Any Blue Cross and Blue Shield of Minnesota issued payments will be made to the applicant or contractholder and not to me.

PLEASE ANSWER ALL QUESTIONS, OTHERWISE YOUR APPLICATION OR EFFECTIVE DATE MAY BE DELAYED. YOUR PAYMENT MUST ACCOMPANY THIS APPLICATION.

EXCEPTION FOR BUSINESS CHECKS OR OTHER FORMS OF PAYMENT FROM A BUSINESS

We do not accept business checks, Pay-O-Matic electronic payments, or any other form of payment from employers with two (2) or more individuals working 20 hours or more per week.

The only exception is if the business does not have two (2) or more individuals working 20 hours or more per week. If this exception applies to your application, you must sign and date the following statement:

I am paying for this coverage with a business check, Pay-O-Matic electronic payment, or any other form of payment from a business. I confirm this business does not have two (2) or more individuals working 20 hours or more per week.

_____ _____
 Date Applicant's Signature

IF APPLICATION COMPLETED BY AGENT, COMPLETE AND SIGN BELOW

If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, and the answers recorded in this application are complete and accurate as provided by the applicant.

_____ () _____
 Agent's Signature Agent's Phone Number Date

Pay-O-Matic is convenient!

You won't need to write a single check or buy a stamp. And there's no extra cost to you! Once a month, on your billing date, we'll deduct your payment directly from your bank or credit union account.

Getting started

- 1** Complete the Pay-O-Matic authorization form.
- 2** Attach a void check if using a checking account.
Attach a savings deposit slip if using a savings account.
- 3** Mail this form with your void check attached to the address shown.

Attach a void check here with tape

DO NOT STAPLE

You can choose to stop Pay-O-Matic withdrawals and switch back to quarterly paper billing any time. Just let us know in writing **at least 15 days before your next withdrawal date** to allow for timely deactivation.

Pay-O-Matic

AUTHORIZATION FORM

I request and authorize Blue Cross and Blue Shield of Minnesota and Blue Plus to deduct my payment from my checking or savings account shown below.

Name on bank account _____

Bank name _____

Bank account number (attach a void check above) _____

Branch office address _____

City _____ State _____ Zip _____

FOR NEW CUSTOMERS: If you are sending this authorization along with an application for coverage, please enclose a check for one month's payment. If you are already a customer, do not send money.

Blue Cross or Blue Plus has the right to end this authorization by sending written notice to my current address as shown in Blue Cross or Blue Plus records.

I understand that this authorization may be stopped by notifying Blue Cross or Blue Plus **at least 15 days before my account is to be charged for the next payment**. I also understand that only the amount of the payment deducted by Blue Cross or Blue Plus will be repaid to me by check after notification in accordance with these instructions.

Name of applicant/member (please print) _____

Applicant/member's social security number or Blue Cross id#: _____

X _____ Date _____
Signature of account holder

X _____ Date _____
Signature of account holder (if joint account)

Important information if using a business account ...

We do not accept Pay-O-Matic electronic payments from employers with two (2) or more individuals working 20 hours or more per week. If your electronic payment will come from a business account, you must sign the following statement:

I am paying for this coverage with a Pay-O-Matic electronic payment from a business account. I confirm this business does not have two (2) or more individuals working 20 hours or more per week.

Signature _____ Date _____

MAIL TO: Blue Cross and Blue Shield of Minnesota, P.O. Box 64560, St. Paul, MN 55164-0560