



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 Health Contract for Simply Blue



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"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Agent's Number	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Agent Name Ron Grams Jr.
Farm Bureau Employee Number	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Applicant must be 90 days or older to apply.

1. Reason for Application:

New applicant not covered with BCBSM
 Current BCBSM coverage: ID Number Plan change

2. Applicant's name

LAST
FIRST
MIDDLE

3. Applicant's Social Security #

- -

4. Occupation

5. Date of Birth

- -
Month Day Year

6. Sex

Male Female

7. Marital Status

Single Married

8. Applicant's address

STREET
APT#

CITY
STATE
ZIP

9. Home phone #

Work phone #

10. SELECT YOUR CHOICE OF CALENDAR YEAR DEDUCTIBLE:

\$5,000 \$7,500 \$10,000

NOTE: Simply Blue provides benefits for prenatal care only and does not cover maternity-related services. Newborns or newly born children under 90 days old are not covered under the Individual Simply Blue contract. This is single coverage only, no dependents can be added to the contract.

11. 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 4).**

12. 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.

Check this box if you want to **EXCLUDE** substance abuse coverage

13. TOBACCO USE DESIGNATION AND DECLARATION:

I have used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application **Yes** **No**

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

14. EFFECTIVE DATE:

Have you completed an application for an Insta-Care contract to precede this coverage? **Yes** **No**

If **Yes**, please leave the requested effective date blank. We cannot process this application if the termination date of the Insta-Care contract 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 - - . (This date cannot be more than 60 days beyond the signature date.)
Month Day Year

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

15. **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.

Do you currently have any health insurance or have you had any health insurance within the past 63 days? Yes No

If YES, you must fully complete the following section by providing all health insurance information for the past 12 months for yourself. Make sure to include information for other Blue Cross and Blue Shield of Minnesota coverages.

Insurance Company Name and Policy Number	Date Coverage Started month/day/year	Date Coverage Ended (If active, state active) month/day/year	Was the previous coverage individual or group coverage?
	/ /	/ /	
	/ /	/ /	

16. **COORDINATION OF BENEFITS** - If the response is Yes, you may be contacted for more information. Will you have other health or medical coverage, including Medicare, once this policy is in force? Yes No

17. **Your Height:** _____ ft. _____ in. **Current Weight:** _____ lbs. **Weight One (1) Year Ago** _____ lbs.

18. **HEALTH HISTORY (Complete information is required)**
In the past five (5) years, have you 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 serve 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"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| D. BREAST DISORDERS—Disorders of the male or female breast, including complications from breast implants..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| E. RESPIRATORY DISORDERS—Asthma, emphysema, bronchitis, allergy or allergic reaction, lung, breathing disorder, or sleep apnea | <input type="checkbox"/> | <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"/> | <input type="checkbox"/> |
| G. ENDOCRINE OR GLANDULAR DISORDERS—Diabetes, thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement | <input type="checkbox"/> | <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"/> | <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"/> | <input type="checkbox"/> |
| J. TUMOR, CYST, OR POLYP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| K. SKIN DISORDERS—Acne, rash, warts, or growth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| L. COLLAGEN DISEASE—Lupus, scleroderma, or rheumatoid arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| M. GENERAL FATIGUE OR MALAISE, MONONUCLEOSIS, OR EPSTEIN-BARR SYNDROME | <input type="checkbox"/> | <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"/> | <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"/> | <input type="checkbox"/> |

19. Have you ever had, been treated for or diagnosed as having cancer? Yes No

- Yes No
20. Female applicant: Are you pregnant?
21. Have you:
- A. Had a medical operation within the last five (5) years?
- B. Been hospitalized within the last 10 years?
- C. Seen a doctor, chiropractor, psychologist, therapist, or any other health care professional within the past five (5) years?
- D. Received speech, physical, behavioral, or occupational therapy within the past five (5) years?
- E. Ever had any positive test for or any disease or disorder of the immune system?
- F. Had a health-related screening or diagnostic test such as a blood test, mammogram, x-ray, CT or MRI scan during the last five (5) years?
- G. Ever been treated for or currently have a congenital abnormality?
22. Have you:
- A. In the past five (5) years, used drugs on a regular basis, other than drugs prescribed by a physician, or been treated for the abuse of any drugs or alcohol?
- B. In the past five (5) years, have you been convicted of DWI or DUI or have you had your driver's license suspended or revoked for driving while under the influence of alcohol or a controlled substance? If **Yes**, give details, including names, dates, and driver's license numbers in number 26.
- C. In the past five (5) years, have you been medically advised by a health care professional to quit or reduce use of alcohol or drugs? If **Yes**, please provide details including individuals involved, dates, and driver's license number in number 26.
- D. Do you drink alcohol? If **Yes**, please explain in number 26 the average amount used weekly.
23. Have you 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?
24. Have you ever been declined coverage, charged an increased rate, or had benefits excluded for health coverage?
25. Do you plan to travel in a foreign country in the next year?

If **Yes**,

Date of Departure	Destination	Date of Return

26. **IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS (18-24), PLEASE COMPLETE THIS SECTION. GIVE COMPLETE DETAILS. ADD AN ADDITIONAL PAGE IF YOU NEED MORE SPACE.**

Ques. no. & letter	Date of onset	Diagnosis, treatment, or reason for physical check-up including all results of physical examinations and diagnostic tests	Days in hospital	Date of complete recovery (If ongoing, state ongoing)	Doctor, Clinic or Hospital Name

- Yes No
27. Have you taken any prescription medication within the past 24 months?
- If **Yes**:

Drug Name and Dosage	Diagnosis	Dates Used	Doctor's Name

28. **PROVIDE NAMES OF THE PHYSICIANS/HEALTH CARE PROFESSIONALS WITH THE MOST COMPLETE KNOWLEDGE OF YOUR MEDICAL HISTORY:**

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.

Attach a void check here with tape

DO NOT STAPLE

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.

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