



Tonik Individual Enrollment Application

The Tonik plan is offered by BC Life & Health Insurance Company (BCL&H): Blue Cross of California and BCL&H are Independent licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.

Applicant's Social Security or ID No.

ALL INFORMATION YOU PROVIDE MUST BE ACCURATE.

1. Applicant Information (Please print)

Applicant's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

Reason for Application (Check one)

New enrollment(s) Change of Coverage

To change existing Blue Cross plan, please enter ID No:

Applicant's Social Security or ID No.	Home Phone No.	Daytime Phone No.	FAX No.
Billing Address (If different than above) or P.O. Box Personal Mail Box (PMB) No.			
City	State	ZIP Code	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
E-mail Address		Spouse's Social Security or ID No.	
If possible, do you want e-mail notification?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Choice (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese			

<input type="checkbox"/> Male	Birthdate	Age	Height	Weight
<input type="checkbox"/> Female				

2. Plan Selection

<input type="checkbox"/> 1500 (T773)	<input type="checkbox"/> 3000 (T774)	<input type="checkbox"/> 5000 (T775)
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3. Prior Insurance History and HIPAA Eligibility – Please answer ALL of the following questions.

Blue Cross credits prior coverage toward the preexisting period for those applicants who apply and are accepted for coverage and request an effective date within 63 days after termination of qualifying prior coverage as required by law. To obtain credit toward the preexisting period, please complete the following.

A. Do you currently have health care coverage? Yes No

B. Have you had coverage in the last 63 days? Yes No

If you answered "Yes" to A or B above, please provide the following information:

Certificate/Policyholder No.	Plan Name	State	Most recent coverage start date
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If No, please explain:

You must discontinue your current coverage if this application is accepted.

C. HIPAA Coverage – If I do not qualify for this plan, I would like to be considered for coverage under HIPAA. HIPAA does require eligibility. I understand that no underwriting is required and rates may be higher than for the Individual Plans. If I qualify, please offer the HIPAA coverage and send complete details regarding my options and rates. Yes No



4. Health History

4A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.
Give COMPLETE details of any "Yes" answers in Section 3B on the following page.

<p>1. Have you had a physical exam, any diagnostic test or screening test such as blood tests, x-rays, CAT scan, MRI, mammogram etc within the past 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you discussed or been advised to have testing, treatment, therapy or surgery that has not yet been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 day) antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. For Females over age 16: • Date of your last menstrual period: Month___/Day___/Year___ • Was it more than 40 days ago? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you been diagnosed, treated, evaluated for or experienced any female reproductive organ problems within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you an expectant parent (spouse or significant other currently pregnant)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you had or been treated for any Sexually Transmitted Disease (STD) within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you been treated for any mental, emotional or behavioral disorder within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you been treated, diagnosed, or evaluated for symptoms related to alcoholism, use or abuse of alcohol within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you been advised to decrease alcohol consumption, been cited for driving under the influence, or been aware of any symptoms related to alcoholism such as blackouts, DT's, abnormal liver function test in the past two years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. In the last 5 years, have you taken illegal drugs or been treated for drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you ever used IV Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Have you been diagnosed, treated, evaluated for or experienced any of the following within the last six months?</p> <p>A. Receive allergy injections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Increased heart rate <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Irregular heart beat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. Heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>F. High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>G. Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>H. Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I. Recurrent diarrhea and/or excessive vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>J. Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>K. Loss of consciousness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>L. Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>M. Persistent and/or intense pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>N. Unexplained rash and/or skin lesions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Do you have any implants or prosthesis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you sustained any sports injuries within the last six (6) months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Have you ever been diagnosed, treated or received treatment for any of the following?</p> <p>A. AIDS/ARC; Evaluated for or recommended Antiviral treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Heart/Circulatory/Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Endocrine/Metabolic/Immunity Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. Kidney/Liver/Digestive Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Musculoskeletal Injuries <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>F. Brain/Nervous Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>G. Birth Defects/Congenital Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>H. Respiratory Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever had or been treated for cancer or a malignant tumor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Have you been diagnosed, had symptoms or received treatment for any condition(s) not listed elsewhere on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Have you been hospitalized or treated in the emergency room within the last 12 months except for pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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I HAVE PERSONALLY REVIEWED AND ANSWERED ALL HEALTH QUESTIONS CORRECTLY

Applicant's Signature _____ Date _____



4B. Professional Services

Give COMPLETE details in all sections below of any "Yes" answers to the questions in Section 4A.

Question #	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ()
Date of Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment
Name of Condition/Illness		Address Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / Results		City / State / ZIP Code FAX No. (Optional) ()

Question #	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ()
Date of Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment
Name of Condition/Illness		Address Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / Results		City / State / ZIP Code FAX No. (Optional) ()

Question #	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ()
Date of Treatment (Month/Year)	Date Ended	<input type="checkbox"/> Still under treatment
Name of Condition/Illness		Address Suite No.
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / Results		City / State / ZIP Code FAX No. (Optional) ()

4C. Prescription Medications – List all medications taken within the last 12 months

Medication/Dosage/Frequency (i.e., Ritalin/10mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. of Physician or Hospital
				Name: _____ Phone: _____
				Name: _____ Phone: _____
				Name: _____ Phone: _____
				Name: _____ Phone: _____

5. Application Understandings, Conditions and Agreement

IMPORTANT: It is important that you carefully read and fully understand the following. All Applicants age 18 and over must personally read, agree to and sign the following.



5. Application Understandings, Conditions and Agreement (Continued)

I, the undersigned, understand that under the Blue Cross plan in which I am enrolling, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use a network hospital or physician.

Effective Date**REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED.**

- If Blue Cross approves my application, please assign an effective date of _____.
- The effective date must be after the signature date but not greater than 75 days from the signature date on this application.
- If Blue Cross approves my application, please assign an effective date of the first day after Blue Cross approval.
- Please note:** If you are changing coverage, your effective date will always be the first of the **month following approval**.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

CURRENT HEALTH COVERAGE: If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 60 to 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.

Agreement

By applying for coverage, I, the undersigned, agree to the following:

- Blue Cross may decline my application. No coverage comes into effect until Blue Cross approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Blue Cross at its discretion (except for HIPAA).
- Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Blue Cross nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, I will not be entitled to benefits or coverage from Blue Cross.
- The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or the terms of any Blue Cross coverage.
- If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
- In no event shall Blue Cross or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the money submitted with this application if this application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Blue Cross.

- I understand Blue Cross may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if I intentionally provided incomplete or false material information Blue Cross may revoke my coverage. This means Blue Cross will cancel membership as if it never existed. Also, after approval for membership, if material information is discovered by Blue Cross that was not provided to the Plan prior to the effective date of the policy, Blue Cross may deny coverage.

I understand that if my coverage is revoked I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I will be required to pay for any services that were covered while a member and that Blue Cross will refund all amounts paid by me except amounts owed to Blue Cross.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Blue Cross and me. I agree to abide by the terms of that contract.

Requirement for Binding Arbitration

ARBITRATION AGREEMENT: I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF AND BC LIFE & HEALTH INSURANCE COMPANY MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND BC LIFE & HEALTH INSURANCE COMPANY ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. BC LIFE & HEALTH INSURANCE COMPANY AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR POLICY.

I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF AND BLUE CROSS OF CALIFORNIA OR ITS AFFILIATE, INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND BLUE CROSS OF CALIFORNIA OR ITS AFFILIATES ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. BLUE CROSS OF CALIFORNIA OR ITS AFFILIATES AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR POLICY.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

Signature (Required) – IMPORTANT: All applicants over age 18 must sign and date.

Applicant/Parent or Legal Guardian	Today's Date



6. Payment Method Premium payment required. First payment will be credited to approved applicants only. By sending your check to us, you authorize BC Life & Health Insurance Company to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

6A. Checking Account Automatic Premium Payment

Monthly checking account deduction premium payments

Name of Bank or Financial Institution: _____

Account No.: _____ Bank Routing No.: _____

If your application is approved, the premium will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment Authorization – As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BC Life & Health Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize BC Life & Health Insurance Company to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my BC Life & Health Insurance Company premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. **You will incur a \$25 service charge for any withdrawal not honored.**

Authorized Signature <i>(As it appears in the financial institution's records)</i>	Date
X	

6B. Credit Card

Initial premium **Monthly premiums**

Monthly Credit Card Authorization - As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. Credit Card: VISA MasterCard Discover

Card No.: _____ Exp.: _____ Cardholder's Zip Code _____

Cardholder's Name <i>(As it appears on the credit card)</i> PRINT	Authorized Signature <i>(As it appears on the credit card)</i>	Date
X	X	

6C. Billing (To be used if an automatic payment option is NOT selected from 6A or 6B above.)

Bi-monthly (Submit 2 months premium) **Quarterly** (Submit 3 months premium)

TO BE COMPLETED BY YOUR BLUE CROSS-APPOINTED AGENT

1. Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk? Yes No
If yes, please attach explanation.
2. Did you see the proposed subscriber at the time this application was executed? Yes No
If no, please explain: _____
3. I verify that this application was completed by the applicant unless the Statement of Accountability was completed.

Signature of Agent <i>(Required)</i>	Date <i>(Required)</i>
X	

4. **Total funds collected:** \$ _____

Name of Agent (Print Name)	Agent's Street Address Suite No./Personal Mail Box (PMB) No.
Agent ID No.	Sub-Agent ID No.
City/State/ZIP Code	Phone No. FAX No.
()	()



4B. Professional Services Addendum

Give COMPLETE details in all sections below of any 'Yes' answers to the questions in Section 4B.

Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.
Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.
Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.
Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
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Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.
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Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
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Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.

4B. Professional Services Addendum, cont.

Give COMPLETE details in all sections below of any 'Yes' answers to the questions in Section 4B.

Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.
Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.
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Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
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Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.
Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.
Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.
Ques #	Name of Hospital, Clinic and/or Person Providing Care		Phone No.
Date of Onset/Treatment (Month/Year)		Date Ended <input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness		Address	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.)/Results		City/State/Zip Code	Fax No.

4C. Prescription Medication Addendum

List all medication taken within the last 12 months

Medication/Dosage/Frequency (i.e., Zantac/50mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. & Fax No. of Physician or Hospital Complete Address/ City/ State/ Zip Code
				Name _____ Phone _____ Fax _____ Address _____
				Name _____ Phone _____ Fax _____ Address _____
				Name _____ Phone _____ Fax _____ Address _____
				Name _____ Phone _____ Fax _____ Address _____
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				Name _____ Phone _____ Fax _____ Address _____
				Name _____ Phone _____ Fax _____ Address _____

Electronically Review and Sign Your Application

1. Review the information below and complete the required fields in the Agreement and Signature section below.
2. Click the "I AGREE" button.
3. Once you have successfully submitted your application, a copy will be e-mailed to you as confirmation. Please download and print your completed application from the confirmation e-mail and retain it for your records.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

Agreement (all applicants):

By applying for coverage, I, the undersigned, agree to the following:

1. Blue Cross may decline my application. No coverage comes into effect until Blue Cross approves this Application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Blue Cross at its discretion.
2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Blue Cross nor any affiliated company shall have any liability to me except for the obligation to refund the money submitted with this application. If this application is not accepted, I will not be entitled to benefits or coverage from Blue Cross.
3. The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or the terms of any Blue Cross coverage.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
5. In no event shall Blue Cross or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the money submitted with this application if this application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Blue Cross of California.
6. I understand Blue Cross of California may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Blue Cross and me. I agree to abide by the terms of that contract.

Arbitration: I agree to any dispute between me and Blue Cross of California and/or its affiliates must be resolved by binding arbitration if the amount in dispute exceeds the jurisdictional limits of the Small Claims Court. Any such dispute will be resolved not by lawsuit or resort to court process, except as California law provides for judicial review or arbitration proceedings. Under this coverage, I and Blue Cross of California and its affiliates, are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross and the Member also agree to give up any right to pursue on a class basis any claim or controversy against the other.

Monthly Checking Account Deduction Authorization: As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California dues. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring such debit. I further agree if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed bi-monthly. After 12 months, you may re-apply for the monthly checking account deduction option. You may incur a \$25 service charge for any withdrawal not honored.

Monthly Credit Card Authorization: As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums approximately 10 days prior to each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment to be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

BY CHECKING THE BOXES AND ENTERING MY NAME BELOW I AM INDICATING MY INTENT TO ELECTRONICALLY SIGN THIS APPLICATION AND WARRANT THAT ALL OF THE INFORMATION I HAVE PROVIDED IS TRUE, COMPLETE AND ACCURATE.

Electronic Signature

Acknowledgement

- I agree to provide an original (non-electronic) signature if necessary to authorize the release of medical information should it be required in the future.
- I understand that by applying for coverage I am agreeing to the items under Agreement above.
- I understand I am authorizing Blue Cross of California to debit my credit card for the initial premium
- I understand I am authorizing Blue Cross of California to debit my credit card for ongoing monthly premiums as explained under Monthly Credit Card Authorization above.
- I understand I am authorizing Blue Cross of California to debit my checking account for ongoing monthly premiums as explained under Monthly Checking Account Deduction Authorization above.
- I agree to **binding arbitration** as described above.

Please type your name in the spaces below to electronically sign your application:

FIRST NAME <input type="text"/>	MI <input type="text"/>	LAST NAME <input type="text"/>
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(Parent of Guardian if under 18 years of age)

Please re-type your name in the spaces below to confirm your electronic signature:

FIRST NAME <input type="text"/>	MI <input type="text"/>	LAST NAME <input type="text"/>
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Please type your city and state below:

CITY <input type="text"/>	STATE <input type="text"/>
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ON: