



FIRST PRIORITY LIFE[®]

Independent Licensee of the Blue Cross and Blue Shield Association

19 North Main Street
Wilkes-Barre, PA 18711

Toll free: 1-888-338-2211

**An Individual Comprehensive Major Medical Preferred Provider Policy
BLUECARE[®] DIRECT SELECT APPLICATION/CHANGE FORM**

Applicant Information

(Please print)

If you have any questions about this coverage or how to fill out this application, please call a customer service representative at 1-888-338-2211 weekdays from 8:00 a.m until 5:00 p.m.

Applicant's name _____
Last First Middle initial

Home address _____

City _____ State _____ ZIP _____ County _____

E-mail address _____

Home phone () _____ Work phone () _____

Social Security Number (required) _____ Birth date: _____

Age _____ Gender _____ Height _____ Weight _____ Disabled Yes No

Current physician _____ Physician's phone _____

1. If this health care coverage is intended to replace any other accident or health insurance you currently have, please provide the insurance company name and applicable group and identification number(s):

Company name: _____

Group # _____ Agreement or policy ID# _____

2. If you have ever applied and been rejected for medical policies and/or life insurance policies, please provide specifics about the condition and the reason for denial:

3. Are you enrolled in Medicare or Medicaid due to age and/or disability? Those enrolled in Medicare or Medicaid are not eligible for this coverage. Yes No

Please select the deductible option you are applying for: <input type="checkbox"/> \$0 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 Please select the coinsurance option you are applying for: <input type="checkbox"/> 10% <input type="checkbox"/> 20%	<input type="checkbox"/> I am applying for new coverage <input type="checkbox"/> I am applying to reinstate my First Priority Life Insurance Company coverage
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The premium, as determined by the corresponding rate sheet, is \$ _____ per month.
If you do not qualify for coverage at the rate for which you apply, you may be eligible for coverage at a higher rate, as determined in accordance with our medical criteria ("underwriting guidelines"). Each application will be reviewed individually, and you will be notified if you are eligible for coverage and at which rate. You will also be notified if your application is denied.

Medical Information

We use your medical history to determine your eligibility for this insurance policy. Experienced underwriters will carefully and promptly review the information you have provided. In addition, we may also ask you to obtain information from other sources, including attending physicians and hospitals, as authorized by you when you complete your application.

Please DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe that you may be at risk.

Please answer each question completely. If you have supplied materially incorrect or misleading information, or if it is proven that you have supplied fraudulent statements or fraudulent omissions, your policy may be voided.

1. If you use any durable medical equipment (DME) such as a walker, wheelchair, cane or hospital bed or are currently receiving home health care, please provide the specifics about the condition:

2. If you have gained or lost more than 20 pounds over the past 3 months, please provide the amount gained or lost:

Please check the appropriate block(s) if you have been treated by, diagnosed by, or received medical advice from a physician or health care provider for any condition, illness, injury or surgery listed WITHIN THE LAST 5 YEARS.

Conditions	Specify (if requested)
<input type="checkbox"/> 3. AIDS or positive test for HIV, HTLV-III/LAV antibodies	
<input type="checkbox"/> 4. Alcoholism	
<input type="checkbox"/> 5. Alzheimer's disease	
<input type="checkbox"/> 6. Arterio-Venous Malformation (AVM)	
<input type="checkbox"/> 7. Arthritis - Rheumatoid or Psoriatic	
<input type="checkbox"/> 8. Asthma/allergies	
<input type="checkbox"/> 9. Brain tumor	
<input type="checkbox"/> 10. Cancer/Leukemia	
<input type="checkbox"/> 11. Chest pain or Angina	
<input type="checkbox"/> 12. Liver disease or Cirrhosis - please specify.	
<input type="checkbox"/> 13. Congenital anomalies and conditions - please specify.	
<input type="checkbox"/> 14. High cholesterol - please list your level if over 200. Specify any medications you may be taking.	
<input type="checkbox"/> 15. Dementia/"senility"	
<input type="checkbox"/> 16. Diabetes controlled with medication or diet - please specify current fasting blood sugar.	
<input type="checkbox"/> 17. Diseases of the esophagus, stomach, or intestine (for example, Crohn's Disease or Ulcerative Colitis) - please specify.	
<input type="checkbox"/> 18. Drug dependency	
<input type="checkbox"/> 19. Ear conditions or hearing loss - please specify.	
<input type="checkbox"/> 20. Lung disease (including Emphysema or "Black Lung") - please specify.	
<input type="checkbox"/> 21. Heart attack or heart disease - please specify.	
<input type="checkbox"/> 22. High blood pressure - list usual blood pressure reading	
<input type="checkbox"/> 23. Kidney/Renal failure or kidney disorder, urological or urinary tract disorder - please specify.	
<input type="checkbox"/> 24. Hematologic (blood) disorder - please specify.	
<input type="checkbox"/> 25. Neurologic deficit or disorder, including head or spinal injury or paralysis - please specify.	
<input type="checkbox"/> 26. Psychiatric disorder/behavioral health, ADD or ADHD	
<input type="checkbox"/> 27. Severe injury or burns - please specify.	
<input type="checkbox"/> 28. Visual impairment or cataracts - please specify.	
<input type="checkbox"/> 29. Blindness - please specify.	
<input type="checkbox"/> 30. Spinal injuries	
<input type="checkbox"/> 31. Stroke	
<input type="checkbox"/> 32. Surgery of any kind (including amputations, burns, etc.) - please specify.	
<input type="checkbox"/> 33. Transient ischemic attacks (TIAs)	
<input type="checkbox"/> 34. Other joint disease - Please list the name(s) of the attending physician, osteopath or chiropractor and date(s) of treatment here or on a separate sheet of paper.	

Your diagnosis and type of treatment/surgery	Hospital treatment?	Attending physician	Dates of illness
	<input type="checkbox"/> Inpatient	Name:	From:
	<input type="checkbox"/> Outpatient	Address:	
	Date:	Phone: ()	To:
		Hospital name:	

Medical Information (Continued)

35. Back disabilities, back pain, chronic or chiropractic care - Please list the name(s) of the attending physician, osteopath or chiropractor, the number of visits per year and date(s) of treatment here or on a separate sheet of paper.

Your diagnosis and type of treatment/surgery	Hospital treatment?	Attending physician	Dates of illness
	<input type="checkbox"/> Inpatient	Name: _____	From: _____
	<input type="checkbox"/> Outpatient	Address: _____	
	Date: _____	Phone: () _____	To: _____
		Hospital name: _____	

36. Any other conditions, injuries or ailments not specifically mentioned above for which you have been treated by, diagnosed by, or received medical advice from a physician or other health care provider within the last year? Please explain:

37. When was the last time you visited a doctor (other than at an emergency room)? Include date of visit, name and address of physician or other provider (gynecologist/obstetrician, osteopath, chiropractor, etc.) and reason for visit. Use additional paper if necessary.

Provider's name: _____ Date of exam: _____

Provider's address: _____

Reason: _____

Provider's name: _____ Date of exam: _____

Provider's address: _____

Reason: _____

38. When was the last time you visited an emergency room at a hospital or other medical facility? Include date of visit, name and address of emergency room, attending physician's name and reason for visit. Use additional paper if necessary.

Hospital name: _____ Date of visit: _____

Hospital address: _____

Physician's name: _____

Reason: _____

39. If you use or have used tobacco, please indicate the length of use: From: _____ To: _____

Indicate the amount of tobacco (cigarettes, cigars, pipe or smokeless tobacco) consumed per day:

40. If you drink alcoholic beverages, please indicate the number of drinks you consume per week: (Serving size per drink equals 1 1/2 oz. liquor, 12 oz. beer, 5 oz. wine.)

41. If you have taken prescribed drugs within the last year, please list drug(s) taken and reason:

Medication/dosage	Dates from and to	Condition/reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Conditions of Application/Authorization

I have read this completed application. I understand that any answer or statement made within this application that is untrue and is material to the risk assumed by First Priority Life Insurance Company® may prevent the recovery of benefits under the policy. Such answer or statement may also result in the termination or voiding of the policy back to its effective date.

I represent to the best of my knowledge and belief that:

1. I have read and have supplied all the requested information on this form with regard to myself. (If not, I have attached a letter which explains why.)
2. No material information has been withheld or omitted about the past or present state of my health.

I understand and agree that:

1. Failure to provide all the information requested may result in a delay in the processing of the application.
2. Any person eligible for Medicare or Medicare disability benefits is not eligible for this coverage.
3. Any person eligible for health insurance through an employer is not eligible for this individual coverage.
4. Payment is due upon notification of acceptance. Payment of premium prior to notification of acceptance does not constitute coverage.
5. This coverage is provided only to residents of the geographical area serviced by First Priority Life Insurance Company. We reserve the right to investigate and confirm your residence from time to time.
6. Any physician charges or other fees incurred during the process of completing this application are the responsibility of the applicant.
7. Premium must be remitted to First Priority Life Insurance Company for the coverage to become effective.
8. If the application is **received by** the 25th of a month, the policy will become effective the 1st of the following month as long as
 - The application is accepted by the 10th of that month and
 - The premium is received.If the application is **received after** the 25th of a month, the policy will become effective the 1st of the next following month as long as
 - The application is accepted by the 10th of that next month and
 - The premium is received.Examples:
 - The application is received on June 24th and accepted on July 3rd. The policy becomes effective July 1st, as long as the premium is received.
 - The application is received on June 24th and accepted on July 11th. The policy becomes effective August 1st, as long as the premium is received.
 - The application is received on June 26th and accepted on July 3rd. The policy becomes effective on August 1st, as long as the premium is received.
9. The rates for this product vary based on the applicant's age, gender, health and the selected deductible and coinsurance options. If you do not qualify for coverage at the rate for which you apply, you may be eligible for coverage at a higher rate, as determined in accordance with our medical criteria ("underwriting guidelines"). Each application will be reviewed individually, and you will be notified if you are eligible for coverage and at which rate. You will also be notified if your application is denied.

I also understand and agree that First Priority Life Insurance Company may:

1. Require me to provide medical history upon request;
2. Deny this application.
3. Void this policy or deny a claim for loss incurred commencing within three (3) years of the effective date of policy if it is found a material misrepresentation was made in the application. If it is determined that the insured performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the policy, the policy will be terminated.

Preexisting Conditions.

This provision does not pertain to newborn children. I understand if I receive medical advice or treatment from a physician or other professional provider for a condition incurred within a five-year period immediately preceding the Effective Date of coverage, I must notify First Priority Life Insurance Company immediately. A change in your medical condition that occurs

prior to your effective date could result in a denial of coverage if your application has not yet been approved.

I also understand and agree that the First Priority Life Insurance Company policy will not provide benefits for me during the twelve-month period following the effective date on which I become covered under the policy for any condition for which medical advice or treatment was recommended by or received from a physician within a five-year period prior to the effective date of the policy.

Authorization

I understand that by applying for this policy and signing below, I, in connection with the administration of, or delivery or receipt of benefits, under the policy, (1) authorize any insurer, organization and health care service provider to release to First Priority Life Insurance Company all personal health information including information relating to past, present and future health care examinations, treatments and diagnoses and (2) authorize First Priority Life Insurance Company to release the personal health information described above, including medical records, claims, benefits and other administrative data to insurers, health care service providers, and outside vendors. The information will only be released in connection with the following purposes: treatment decisions, appeals, complaints and grievances, coordination of care, quality assessment and measurement, quality improvement, disease state management, preventive measures, audits, utilization management, case management, pharmacy management, physician review, research, fraud investigations, reviews by regulatory and accrediting bodies, claims processing, billing and reimbursement.

I am also authorizing the release of application status, payment information, enrollment and membership status, billing and reimbursement information and claims status to any brokers that I am currently working with for the purpose of obtaining insurance coverage.

To the best of my knowledge, the information provided on this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

If you are over age 18, your signature is required. If you are under age 18, signature of a parent or legal guardian is required on this application. (Failure of a parent or legal guardian to sign this application will not operate as a waiver nor indemnify such person from criminal or civil penalties.)

Signature of Applicant (over 18)

Date

Signature of Parent or Legal Guardian of Minor

Date

Please note: To avoid delays in processing your application, this form must be received by First Priority Life Insurance Company within 15 days of the date of your signature.

Once your application is complete, please be sure to sign it and mail it to us at:

First Priority Life Insurance Company
19 North Main Street
Wilkes-Barre, PA 18711-0302

the date shown on the denial letter you receive.

1. Ask the attending physician to write a letter providing additional medical information about the condition(s) for which coverage was denied. Have the doctor include any pertinent clinical information to support your appeal.
2. Send the physician's letter, clinical information and a copy of the denial letter to:

First Priority Life Insurance Company
19 North Main Street
Wilkes-Barre, PA 18711-0302

Your appeal will be reviewed by a physician on our medical review staff, and a final decision will be issued to you in writing within 30 days.

Do Not Write in this Section

Contract #: _____ Group #: _____ Effective Date: _____
BC/CVG: _____ BS/CVG: _____ MM/CVS: _____ BCOE: _____ BSOE: _____ MMOE: _____

A copy of this authorization is available to me or to my authorized representative, upon request and will serve as the original.