BlueCross BlueShield of Texas

PO Box 3238
Naperville, IL 60566-7238

Application for Transfer of Coverage

Please check *only one box* below to tell us why you are requesting a change in coverage.

☐ To become the Primary Policyholder of my health coverage because I am at least age 26.

☐ To become the Primary Policyholder of my health coverage because: (Check One)

- ☐ Divorce (Divorce Decree Required)
- ☐ Death of Primary Insured (Death Certificate Required)
- ☐ Primary Insured is Medicare Eligible
- ☐ Primary Insured is Eligible for Other Coverage
- ☐ Other (Please be specific): _____

PART 1 – NEW POLICY OWNER

Name _____ County _____

Street Address _____ Home Phone (_____) _____

City _____ State _____ ZIP _____ Work Phone (_____) _____

E-mail Address _____ Sex ☐ M ☐ F Birthdate _____/_____/_____

BILLING ADDRESS If the billing address is different from above, please print it here: _____

SMOKING STATUS Have you or your spouse (if insured) smoked cigarettes or used tobacco in any form in the last 12 months?
You ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

PRIMARY POLICYHOLDER OF CURRENT POLICY _____ ***Policy No.:*** _____

SPOUSE AND/OR DEPENDENT CHILD(REN)
Note: You may only change coverage for a spouse and/or dependent child(ren) who are now covered under the current health insurance policy.

If you wish to add additional dependent children, for the correct application please call 1-888-697-0683

Do you wish to change coverage for your spouse and/or dependent child(ren) now insured on the current policy? ☐ Yes ☐ No
If "**Yes**," complete the following: *(for additional space, continue on separate sheet of paper and attach to application)*

Name of Spouse and/or Dependent Child(ren)	*Date of Birth*	*Name of Spouse and/or Dependent Child(ren)*	*Date of Birth*

1. Does any person applying for coverage currently have health or major medical insurance coverage with any other Insurer, including other Blue Cross and Blue Shield plans? ☐ Yes ☐ No If "**Yes**," please complete the following:

   Name(s) of all individuals covered: _____

   Insurer Name(s): _____ Location / State: _____

   Policy Effective Date: _____ Anticipated Policy Termination Date: _____

2. If "Yes" to question 1, is the issuance of this coverage replacing your existing coverage? ☐ Yes ☐ No

   If "**Yes**", when is coverage to be replaced (mo./day/yr.)? _____/_____/_____

   If "**No**", please explain _____

PART 2 – REPRESENTATIONS AND ACKNOWLEDGMENTS

I apply for coverage as indicated for which I am eligible with Blue Cross and Blue Shield of Texas which is herein called the Company.

I understand that the insurance plan applied for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws.

I know that any fraudulent misstatements or omissions, or intentional misrepresentations of a material fact that are made on this application or any act or practice that constitutes fraud, will result in the cancellation of my or my spouse's and/or dependent child(ren)'s coverage retroactive to the effective date of coverage subject to prior notification.

I agree and understand that the terms of this application will remain consistent with the terms of the original Application for Coverage that were previously in place.

X _____ ____/____/____
Primary Applicant's Signature **Date Signed** (Mo./Day/Yr.)

X _____ ____/____/____
Spouse's Signature *(only if spouse is currently covered and wishes to be covered under the new plan)* **Date Signed** (Mo./Day/Yr.)

Dependent(s) Child(ren)'s Signature *(only if dependent child is 18 or over, currently covered, and wishes to be covered under the new plan):*

X _____ ____/____/____
Date Signed (Mo./Day/Yr.)

X _____ ____/____/____
Date Signed (Mo./Day/Yr.)

X _____ ____/____/____
Date Signed (Mo./Day/Yr.)

X _____ ____/____/____
Date Signed (Mo./Day/Yr.)

X _____ ____/____/____
Date Signed (Mo./Day/Yr.)

X _____ ____/____/____
Date Signed (Mo./Day/Yr.)

If the primary insured of the original policy wants to cancel coverage, please sign below.

_____ _____
Primary Signature Date

Questions? Call 1-888-697-0683. We're here to help.

Mail this application to:
P.O. Box 3238
Naperville, IL 60566-7238

Changes in state or federal law, or regulations or interpretations thereof, may change the terms and conditions of coverage.