BlueCross BlueShield of Texas

SELECT FAMILY Individual Products Miscellaneous Change Form Non-Underwritten Changes

P.O. Box 3236 Naperville, IL 60566-7236 888-697-0683

Prem: _____ Fee: _____
For Home Office Use

To help us process your application promptly, please remember to:
- Print all answers in black ink. Pencil will not be accepted.
- Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent child(ren) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line. Parent/guardian must sign if primary applicant is a minor.

PART ONE Check one: ☐ Add Dependent ☐ Cancel Coverage ☐ Downgrade (decrease of benefits)

SECTION A — PERSON(S) APPLYING FOR COVERAGE (please print)

In addition to having a permanent residence in Texas, all persons applying for coverage must be a United States citizen, or if not a citizen, must be able to provide medical records from a licensed U. S. Physician, including but not limited to, a health evaluation conducted within the past two years. All others are ineligible for coverage.

Insured Information

First Name, Middle Initial, Last Name		Social Security #	Sex (M/F)	Age	Date of Birth (mo/day/yr)	Height (ft., in.)	Weight (lbs.)
					/ /		
Home Phone # ( )	Business Phone # ( )	Fax # (if available) ( )	Occupation/Duties			Spouse's Business # (if applying)	
Residence Street Address		City/State/ZIP				County	
Email (if available)			Best place and time to call (if necessary) for a phone interview. ☐ Home ☐ Business ☐ Morning ☐ Afternoon				

Cancel Coverage

☐ Health and Dental **(If covered for dental, cancelling health coverage automatically cancels dental coverage)** ☐ Dental Only ☐ All Dependent(s) Coverage ☐ Cancel Spouse

List name of dependent(s) to be cancelled_____

☐ Cancel Insured Only – Continue Dependent(s) – a separate Continuation of Coverage Application Form must be completed.

Reason: ☐ Married ☐ Divorced ☐ Deceased ☐ Other_____

Cancelling all dependents from family coverage will change the deductible to an individual deductible and out-of-pocket maximum.

Add Dependent

Spouse or Dependent Child(ren) you wish to cover (dependents must be under age 26).

Name: First Middle Initial Last	Relation (spouse or child)	Sex	Height (ft., in.)	Current Weight (lbs.)	Date of Birth (mo/day/yr)	Social Security Number	Court Ordered for Dependents
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No
		☐ M ☐ F			/ /		☐ Yes ☐ No

Is any dependent coverage required by court order? ☐ Yes ☐ No If "yes," was it effective within the last 30 days? ☐ Yes ☐ No
If "yes," to apply for court-mandated coverage for dependent children, contact Blue Cross and Blue Shield of Texas for the appropriate form.

Please complete all pages 1-3.

Applicant name: _____ Subscriber no. _____

SECTION B – CHANGE HEALTH COVERAGE (please choose only one plan)

☐ PPO Select® Saver (make selection below)

Options	Health Deductible		Coinsurance Amount		Prescription Drug Plan			
	Network Individual/Family	Out-of-Network Individual/Family	Network	Out-of-Network	Generic	Preferred Brand Name	Non-Preferred Brand Name	Deductible
Plan I ☐	$500/$1,500	$1,000/$3,000	$3,000/$9,000	$5,000/$15,000	$10	$50	$65	$100
Plan II ☐ Plan III ☐	$1,000/$3,000 $1,500/$4,500	$2,000/$6,000 $3,000/$9,000	$3,000/$9,000	$5,000/$15,000	$10	$50	$65	$200
Plan IV ☐ Plan V ☐ Plan VI ☐ Plan VII ☐	$2,500/$7,500 $5,000/$15,000 $8,000/$24,000 $10,000/$30,000	$5,000/$15,000 $10,000/$30,000 $16,000/$48,000 $20,000/$60,000	$3,000/$9,000	$5,000/$15,000	$10	$50	$65	$300

☐ PPO Select® Choice (make selection below)

Options	Health Deductible			Coinsurance Amount		Prescription Drug Plan			
	Network Individual/Family	Out-of-Network Individual/Family	Physician Office Visit Copayment	Network	Out-of-Network	Generic	Preferred Brand Name	Non-Preferred Brand Name	Deductible
Plan I ☐ Plan II ☐	$250/$750 $500/$1,500	$500/$1,500 $1,000/$3,000	$25	$3,000/$6,000	$5,000/$10,000	$15	$25	$40	$100
Plan III ☐ Plan IV ☐	$1,000/$3,000 $1,500/$4,500	$2,000/$6,000 $3,000/$9,000	$25	$3,000/$6,000	$5,000/$10,000	$15	$25	$40	$200
Plan V ☐ Plan VI ☐ Plan VII ☐ Plan VIII ☐	$2,500/$7,500 $5,000/$15,000 $8,000/$24,000 $10,000/$30,000	$5,000/$15,000 $10,000/$30,000 $16,000/$48,000 $20,000/$60,000	$25	$3,000/$6,000	$5,000/$10,000	$15	$25	$40	$300

☐ PPO Select® Blue Advantage (make selection below)

Options	Deductibles		Copayment Amounts		Coinsurance Amount		Prescription Drug Plan Copayment Amounts		
	Network Individual/Family	Out-of-Network Individual/Family	Office Visit	Emergency Room Visit (Facility Only)	Network Individual/Family	Out-of-Network Individual/Family	Generic	Preferred Brand Name	Non-Preferred Brand Name
Plan I ☐ Plan II ☐	$250/$750 $500/$1,500	$500/$1,500 $1,000/$3,000	$30	$75	$2,000/$4,000	$3,000/$6,000	$12	$25	$40
Plan III ☐ Plan IV ☐	$1,000/$3,000 $1,500/$4,500	$2,000/$6,000 $3,000/$9,000	$35	$75	$3,000/$6,000	$5,000/$10,000	$15	$30	$45
Plan V ☐ Plan VI ☐ Plan VII ☐ Plan VIII ☐	$2,500/$7,500 $5,000/$15,000 $8,000/$24,000 $10,000/$30,000	$5,000/$15,000 $10,000/$30,000 $16,000/$48,000 $20,000/$60,000	$45	$75	$5,000/$10,000	$8,000/$16,000	$20	$35	$50

Applicant name: _____ Subscriber no. _____

Change Name/Address

New Name_____ Reason for Change ☐ Married ☐ Divorced

New Address_____ City_____ State_____ZIP_____

Home Phone # ( ) _____ Effective Date of Change_____

As a Supplement to my previous application, I request the change(s) in coverage as indicated on page 1. I understand that an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days' advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage.

Medical Authorization: I authorize any hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Important: Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant's Signature: _____ Date Signed: _____

Spouse's Signature (ONLY if to be insured): _____ Date Signed: _____

Parent/Guardian Signature (if Primary Applicant is a Minor): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

Dependent's Signature (ONLY if 18 or over and only to be insured): _____ Date Signed: _____

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

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association