BasicBlue

An affordable plan offering solid protection against major health care expenses

BlueCross BlueShield of Illinois

BasicBlue

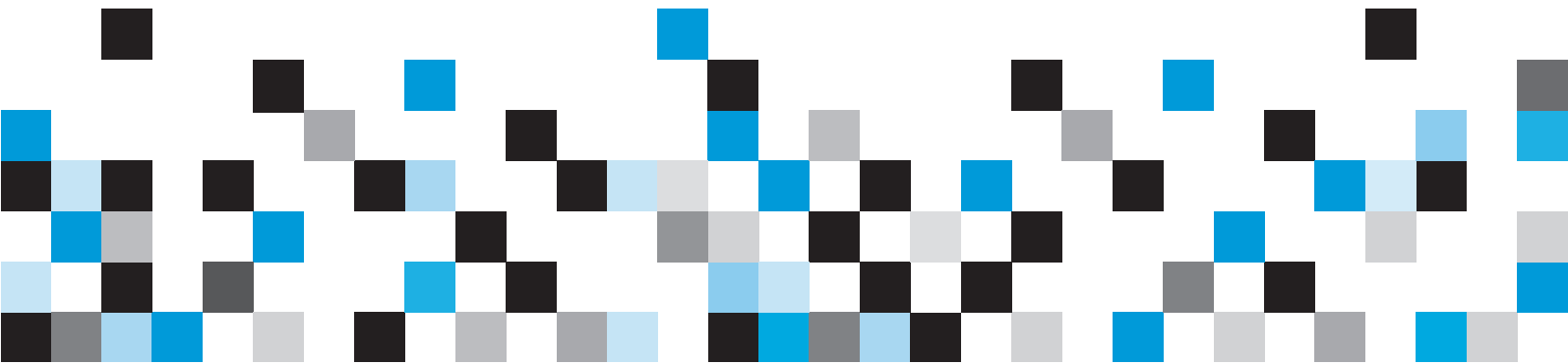
Individual and Family Coverage from Blue Cross and Blue Shield of Illinois

- **Substantial benefits for hospital and medical/surgical expenses**
- **Lower premiums than our traditional major medical plans — save up to 40% or more!**
- **Freedom to choose hospitals from one of the largest networks in Illinois**
- **Up to $5,000,000 in lifetime coverage**

A Lower-Cost Option Covering Major Health Care Expenses at Savings of up to 40% or More!

If you're looking for affordable protection to cover catastrophic hospital and medical/surgical expenses, here's the plan for you. It's called BasicBlue from Blue Cross and Blue Shield of Illinois. And, for individuals and families, it's a plan that spells "peace of mind."

By leaving out benefits for routine and outpatient services such as doctor office visits, outpatient prescription drugs, and most outpatient diagnostic testing, BasicBlue lets you enjoy significantly lower premiums than our major medical plans. In fact, with BasicBlue, **you save up to 40% or more over the cost of our major medical plans!** And by protecting you against the expenses associated with hospitalization, surgery, medical emergencies, and other major health care services, BasicBlue gives you the coverage you need most. Solid protection with premiums you can afford — that's BasicBlue!



BasicBlue

Affordable Coverage for Many of the Most Costly Health Care Services

Strong Benefits for Hospitalization, Surgery, and More

BasicBlue provides the hospital and medical/surgical services you need to help protect your financial security. What does that mean for you? It means you and your family are protected against the high costs of many health care services from hospitalization — including room and board, intensive care, inpatient prescription drugs, and more — to inpatient diagnostic services like X-rays, lab tests, and EKGs. If you're looking for solid protection from potentially catastrophic medical bills, BasicBlue is the plan for you.

A Choice of Deductibles to Fit Your Budget

A deductible is the amount for which you are responsible before the plan begins to pay benefits for covered services. BasicBlue gives you the flexibility of choosing a $500, $1,000, or $2,500 deductible. Given this range of choice, you are certain to find an option that fits your budget.

80% Coverage Level Helps Control Your Costs

The coverage level (percentage) that BasicBlue pays for covered services after you meet your deductible is called coinsurance. BasicBlue offers 80% coverage after you've met your deductible when you use PPO hospitals. That means you pay 20% of your eligible bills until you've paid $1,000. At that point, BasicBlue goes on to pay 100% of these services for the remainder of the calendar year.

Freedom of Choice

BasicBlue is supported by one of the largest hospital networks in Illinois. In fact, with more than 200 Illinois hospitals included, it's likely that hospitals near you participate.

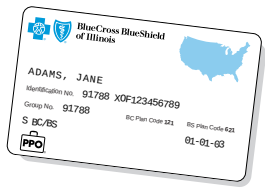
Our Contracts with Providers Help You Save on Out-of-Pocket Costs

Blue Cross and Blue Shield of Illinois has financial arrangements, or contracts, with a large number of hospitals. As an example, when you use one of the network hospitals, your benefit payments are calculated based on a reduced charge, or discounted percentage. Here's how it works:

Example of a $1,000 Hospital Claim — with Deductible Met and an 80% Coverage Level	
Hospital Claim (billed charge for covered services)	$1,000*
Blue Cross and Blue Shield of Illinois Discounted Percentage	-30%*
Reduced Hospital Charges	$700
Amount You Pay	$140 (20% of $700)
Amount You Would Have Paid Without Reduction	$200 (20% of $1,000)
Amount You Save with Blue Cross and Blue Shield of Illinois	***$60*** *($200 - $140)*

**The "billed charge" and "discounted percentage" are for illustrative purposes only. The actual charge and percentages for your claim will vary.*

It's easy to see that by using any of the many contracted network hospitals for your health care services, you can save on out-of-pocket expenses with coverage from Blue Cross and Blue Shield of Illinois. Now that's value!



Carry the Caring Card®

BasicBlue Includes This Unique Combination of Features from Blue Cross and Blue Shield of Illinois

The Security of $5,000,000 in Lifetime Protection

With BasicBlue, you have the option of applying for individual or family coverage to protect yourself, your spouse, and your eligible dependent children under age 19 (age 25 if a single, full-time student). Each person will be eligible for up to $5,000,000 in lifetime benefits. That's substantial protection for today and the years ahead.

Travel with Confidence — You're Covered Away from Home

As a member of Blue Cross and Blue Shield of Illinois, you'll have access to a program called BlueCard PPO. This is a nationwide network of providers that allows you to receive benefits for covered services when you travel. Simply present your Blue Cross and Blue Shield of Illinois ID card to a participating BlueCard PPO provider wherever you are. To find a participating provider while you're away, just call the toll-free number on the back of your card. It's that easy!

Financial Stability You Can Count On

Today 1 American in 4 carries a Blue Cross and Blue Shield membership card. In fact, over 4 million residents across Illinois *Carry the Caring Card®* because they trust Blue Cross and Blue Shield of Illinois to give them more health care value for their premium dollar.

Blue Cross and Blue Shield of Illinois has been serving the health insurance needs of Illinois residents for more than 60 years. We're one of the largest and most financially secure insurance companies in the state. A.M. Best, one of the leading rating agencies of the insurance industry, has awarded us an "A" (Excellent) rating.* We're here to stay!

No Paperwork — Your Claims Are Handled For You

In most cases, all you have to do is show your Blue Cross and Blue Shield ID card at a doctor's office or hospital, and your claim will be filed for you. We want you to concentrate on regaining your health — not worrying about hospital and doctor bills.

Guaranteed Renewability

Your individual or family coverage is guaranteed renewable. This means that as long as your premiums are paid on time, your coverage can be non-renewed only for the following reasons: (1) fraud or an intentional material misrepresentation, or (2) if we cease to offer all plans like yours. In either case, you will be given advance written notice.

** As of June 2003*

BasicBlue

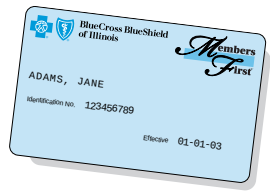
Offers Catastrophic Protection — and Helps You Control Your Costs

Here is a list of benefits included with BasicBlue regardless of the deductible selected. You get maximum benefits at more than 200 participating hospitals.

For additional benefit details, consult the enclosed Outline of Coverage.

Inpatient Hospital Services Includes semi-private room and board; pre-admission testing; prescription drugs; services of a registered physical, occupational, or speech therapist and more.	**Covered**
Inpatient Diagnostic Services Includes X-rays, lab tests, EKGs, ECGs, pathology services, and more.	**Covered**
Inpatient Physician Charges Includes treatment for accident or illness while an inpatient in a hospital, skilled nursing facility, or coordinated home care program; and surgeon, assistant surgeon, and anesthetist fees.	**Covered**
Emergency Care Includes covered services received in a hospital emergency room or a physician's office.	**Covered**
Outpatient Surgery	**Covered**
Other Outpatient Services Includes radiation therapy, chemotherapy, renal dialysis treatments, and mammograms.	**Covered**

Some limitations apply. See the enclosed outline of coverage for details.



Members First®´ — Substantial Savings on Dental, Vision, and Hearing Care Products and Services…

Exclusively from Blue Cross and Blue Shield of Illinois

Members First®´ is a money-saving discount program that automatically comes with BasicBlue. You and your covered family members will receive Members First identification cards for on-the-spot savings on prescription drugs, as well as on dental, vision and hearing care products and services, and chiropractic care. You can even save on vitamins and nutritional supplements. Members First is not insurance and adds nothing to the cost of your coverage. You're free to use the Members First discounts as often as you wish.

With the cooperation of thousands of licensed professionals and providers all across the country, we have been able to secure lower prices for Blue Cross and Blue Shield members on a wide range of health care items and services. To receive Members First discounts, you need only present your Members First ID card to a participating provider, and then pay the provider directly for the item purchased or services rendered.

Save Up to 30% on Prescription Drugs —

Save on generic and brand-name prescription drugs at pharmacies across Illinois and the United States, including Osco Drug, Dominick's, Kmart, Target, and more. Enjoy the same savings on virtually all prescription drugs through a convenient mail-order program as well.

Save Up to 50% on Vision Care —

Save on eyeglasses and contact lenses at more than 9,000 participating locations nationwide, including LensCrafters, Sears, JCPenney, and Pearle Vision. You'll also be entitled to discounts on eye examinations and surgical procedures, including Lasik surgery where available.

Save Up to 40% on Dental Care —

Save on routine and extensive dental care treatments (such as root canals, crowns, and dentures) at more than 16,000 participating providers located all across the country.

Save Up to 20% on Hearing Care Services —

Save up to 20% on hearing aids, and get discounts on consultations and hearing aid evaluations from the largest network of audiologists in the U.S.

Save Up to 40% on Chiropractic Care —

Save at nearly 300 participating chiropractors across Illinois — with unlimited visits for care.

Save on Vitamins and Nutritional Supplements Through Mail Order —

Choose from a variety of vitamins and nutritional supplements and save 30%-50% on already-low mail-order catalog prices.

The Members First Discount Program is our way of saying "Thank You" for being a Blue Cross and Blue Shield of Illinois member.

BlueCross BlueShield of Illinois

BasicBlue

With your choice of deductibles.

Outline of Coverage

1. READ YOUR POLICY CAREFULLY—This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. BasicBlue Coverage — BasicBlue coverage is designed to provide you with economic incentives for using designated hospitals. It provides, to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services, and Out-of-Hospital care, subject to any Deductibles, Copayment provisions, or other limitations which may be set forth in the Policy. **Although you can go to the Hospitals of your choice, your benefits under the BasicBlue plan will be greater when you use the services of participating Hospitals.**

BASIC PROVISIONS	BASICBLUE Participating Provider Option (PPO) Coverage
Lifetime Benefit	$5,000,000
Deductible Per individual, per calendar year. (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.) *Carryover Deductible* If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as credit toward the Deductible for the following calendar year.	$500* $1,000* $2,500*
Family Aggregate Deductible Per family, per calendar year.	Equal to three times the individual Deductible
Hospital Admission Deductible Per admission, per individual.	$0
Coinsurance The level of coverage provided by the plan after the calendar year Deductible has been satisfied.	80%
Out-of-Pocket Expense Limit The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Deductibles, reduction in benefits applicable to the Medical Services Advisory, emergency care copayment, charges that exceed the Usual and Customary Fee or the Eligible Charges, and items asterisked (*) do not apply to the out-of-pocket expense limit.	$1,000
Family Aggregate Out-of-Pocket Expense Limit Equal to three times the individual out-of-pocket limit, per family, per calendar year.	$3,000
Inpatient Hospital Services Includes semi-private room and board; intensive care and related miscellaneous expenses for services and supplies including pre-admission testing; prescription drugs; services of a registered physical, occupational, or speech therapist; initial expense for artificial limbs; prosthetic devices; oxygen and its administration; blood and blood plasma.	80%

BASIC PROVISIONS	BASICBLUE Participating Provider Option (PPO) Coverage
Inpatient Diagnostic Services Includes but not limited to X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.	80%
Outpatient Diagnostic Services Includes but is not limited to X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms **ONLY** (1) when rendered on the same day as and in connection with Surgery, or (2) as part of covered emergency care.	80%
Inpatient Physician Charges (Medical/Surgical Services) For treatment due to accident or illness while an inpatient in a Hospital, Skilled Nursing Facility, or Coordinated Home Care Program; surgeon, assistant surgeon, and anesthetist fees. *Mental illness and substance abuse charges are NOT covered. Outpatient physician medical services are covered ONLY when related to (1) emergency care, and (2) postmastectomy care within 48 hours after discharge from the hospital.*	80%
Emergency Care (Hospital and Physician) Copayment applies to Covered Services received in a Hospital emergency room or a Physician's office. Copayment does not apply to Covered Services provided for the treatment of criminal sexual assault or abuse.	80% after you pay $125 copayment,*†
Outpatient Surgery Includes surgeon, assistant surgeon, and anesthetist fees; also includes surgical and anesthetic services and supplies; pre-operative tests related to the surgery.	80%
Other Outpatient Services Includes radiation therapy, chemotherapy, and renal dialysis treatments; and mammograms; and local ambulance service when related to covered Hospital admission or covered emergency care.	80%
Human Organ Tissue Transplant Includes expenses for cornea, kidney, bone marrow, heart valve, muscular/skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas, pancreas/kidney, and inpatient and outpatient immunosuppressive drugs related to transplant.	80%

**Medical Services Advisory (MSA®) ** The MSA helps you maximize your benefits. The Participating Provider is responsible for notifying MSA when services are rendered at a Participating Hospital. The Policyholder is responsible for notifying MSA for Hospital admissions at Non-PPO and Non-Plan Hospitals. MSA notification is required within three business days for non-emergencies and within one business day for emergencies and maternity admissions. If Policyholder does not notify MSA, Hospital benefits are reduced by $1,000.*

Benefits for covered services are provided at either the Eligible Charge or the Usual and Customary Fee.

** Does not apply to out-of-pocket expense limit.*
† Deductible does not apply.

IF USING A NON-PPO HOSPITAL OR NON-PLAN HOSPITAL...
A $300 per admission Deductible will apply in addition to the individual or family Deductible.* Hospital benefits shown above, which are paid at 80% at Participating Hospitals, are paid at 60% at Non-PPO Hospitals and 50% at Non-Plan Hospitals, except for Outpatient Hospital emergency care which is paid at 80% (after the copayment), regardless of the Hospital selected. The out-of-pocket expense limit for Non-PPO Hospitals is $5,000 for individual coverage and $15,000 for family coverage.

PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-45 HCSC policies. Premiums can be changed based on age, sex, and rating area.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for non-payment of premium. Blue Cross and Blue Shield can refuse to renew this Policy only for the following reasons:

A. If all Policies bearing form number DB-45 HCSC are not renewed, written notice will be provided at least 90 days before coverage is discontinued. Furthermore, you may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

B. In the event of fraud or an intentional misrepresentation of material fact under the terms of the coverage, written notice will be given at least 30 days before coverage is discontinued.

Exclusions and Limitations:

Hospitalization, services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits; Services or supplies that are furnished to you by the local, state, or federal government; Services or supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; Services or supplies that do not meet accepted standards of medical and/or dental practice; Investigational Services and Supplies and all related services and supplies; Custodial Care Service; Outpatient Medical Care including, but not limited to, routine physical examinations; Immunizations; Outpatient Diagnostic Service except when rendered on the same day as and in connection with Surgery, as part of covered Emergency Accident Care or Emergency Medical Care, or when rendered in connection with Chemotherapy or radiation therapy treatment; Outpatient drugs or medicines except for immunosuppressive drugs prescribed in connection with a human organ transplant; Services or supplies rendered for Substance Abuse Rehabilitation Treatment or for the treatment of Mental Illness; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Medical equipment or special braces, splints, specialized equipment, appliances, ambulatory apparatus, or battery controlled implants, except as specifically mentioned in this Policy; Procurement or use of prosthetic devices, special appliances, or surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Replacement or repair of or adjustments to prosthetic devices, special appliances, or surgical implants; Private Duty Nursing Service; Eyeglasses, contact lenses, or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye; Hearing aids or examinations for the prescription or fitting of hearing aids; Services and supplies rendered in connection with Temporomandibular Joint Dysfunction and Related Disorders, except as otherwise specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions, treatment of subluxations of the foot, routine foot care, or corrective shoes; Outpatient Occupational, Physical, or Speech Therapy; Maternity Service, including related services and supplies; Services and supplies rendered or provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in-vitro fertilization; Elective sterilization.

APPLICATION FOR INDIVIDUAL COVERAGE

BlueCross BlueShield of Illinois

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(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.
- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid.

HOME OFFICE USE ONLY

CWA:

PART ONE

Check one: ☐ New Policy ☐ Add Dependent ☐ Upgrade (increase of benefits)

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

In addition to having a permanent residence in Illinois, all persons applying for coverage who are not U.S. citizens must have resided in the U.S. for at least six months AND have had a complete physical by a physician in the U.S. within the past two years.

PRIMARY APPLICANT

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 Phone # (*if applying*)
( )	( )	( )		( )

Residence Street Address	City / State / ZIP	County

Email (*if available*)	Best place and time to call (*if necessary*)
	❑ Home ❑ Business ❑ Morning ❑ Afternoon

SPOUSE and DEPENDENT CHILDREN YOU WISH TO COVER (dependent children must be under age 19, or under age 25 if unmarried, full-time student)

NAME: First M.I. Last	RELATION (spouse or child)	SEX	HEIGHT (ft., in.)	WEIGHT (lbs.)	DATE OF BIRTH (mo/day/yr)	SOCIAL SECURITY NUMBER	FULL-TIME STUDENT
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No
		❑ M ❑ F			/ /	– –	❑ Yes ❑ No

SECTION B — COVERAGE APPLIED FOR (please choose only one plan)

☐ **SelectBlue®**
Deductible: ☐ $0 ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **SelectBlue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **BlueChoice℠ Select**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **Traditional Blue℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **BlueValue℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **BlueValue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **BlueChoice℠ Value**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%
Do You Want Maternity Coverage? ☐ Yes

☐ **BasicBlue®**
Deductible: ☐ $500 ☐ $1,000 ☐ $2,500
Level of Coverage: 80%
Maternity Option Not Available

SECTION C — BILLING INFORMATION

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

REQUESTED EFFECTIVE DATE (mo./day/yr.) _____ **PREMIUM AMOUNT ENCLOSED $** _____

PREMIUM MODE: ☐ Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
☐ Two-Month Direct Bill

Billing Name and Address (if different than name and residence address given above)

PART TWO — EVIDENCE OF INSURABILITY

All health history/medical questions must be completed for all individuals (including dependents) applying for coverage.

SECTION A — HEALTH HISTORY / MEDICAL QUESTIONS

If you answer "Yes" to ANY questions on this page, please give complete details on the next page. Please note the timeframe reference for each question.

1. Has any person applying for coverage been advised to seek treatment for alcohol use or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism **within the last 10 years?** ☐ Yes ☐ No

2. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use or dependency **within the last 10 years?** ☐ Yes ☐ No

3. **Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last 10 years for the following: Please check ☑ Yes or ☑ No.** ***If any boxes are checked "Yes" (☑ Yes), also circle the condition, e.g. migraines, and give details on the next page.***

A. Migraines; headaches; carpal tunnel syndrome; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? ☐ Yes ☐ No

B. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? ☐ Yes ☐ No

C. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? ☐ Yes ☐ No
If "Yes" to HBP, provide 3 readings and their dates w/in the last year
_____ *and* _____ *and* _____

D. Varicose veins/spider veins/varicosities; elevated cholesterol or lipids; anemia; blood clot or any other blood disorder? ☐ Yes ☐ No

E. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; or any breathing difficulty, lung or respiratory disease, disorder or condition? ☐ Yes ☐ No

F. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach or duodenum, or any other digestive disorder or condition? ☐ Yes ☐ No

G. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? *(indicate type of hepatitis)* ☐ Yes ☐ No

H. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? *(indicate diagnosis and location)* ☐ Yes ☐ No

I. Acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other skin disorder? ☐ Yes ☐ No

J. Kidney stones; reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? ☐ Yes ☐ No

K. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? ☐ Yes ☐ No

L. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; bunions; joint replacement; or manipulation therapy? ☐ Yes ☐ No

M. Thyroid disorder; goiter; Graves disease; diabetes; lupus; pituitary or adrenal disorder? ☐ Yes ☐ No

N. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? ☐ Yes ☐ No

O. Acquired Immune Deficiency Syndrome (AIDS); AIDS-Related Complex (ARC); HIV positive or other immune disorders? ☐ Yes ☐ No

P. *Question for Male Applicants and Dependents Only*

Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? ☐ Yes ☐ No

Q. *Question for Female Applicants and Dependents Only*

Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? ☐ Yes ☐ No

QUESTION CONTINUES AT RIGHT

4. **During the last 5 years,** has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist? ☐ Yes ☐ No

5. Has any person applying for coverage been prescribed or taken any medication due to any sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss **in the last 12 months?** ☐ Yes ☐ No

6. Have you or your spouse (if to be insured) smoked or used any tobacco products – such as cigarettes, pipes, cigars, snuff or chewing tobacco – **in the last 12 months?**
YOU ☐ Yes ☐ No
YOUR SPOUSE ☐ Yes ☐ No

7. A. *Question for Female Applicants and Dependents Only:* Is any female applying for coverage now pregnant? ☐ Yes ☐ No
B. *Question for Male Applicants and Dependents Only:* Is any male applying for coverage now an expectant parent? ☐ Yes ☐ No
If "Yes" to either question, coverage cannot be offered.

8. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin or penile implant), internal fixation (e.g. pins, plates or screws), prosthesis, pacemaker, valve replacement, shunt or monitoring device? ☐ Yes ☐ No

9. Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery **which has not yet been performed?** ☐ Yes ☐ No

10. Has any person applying for coverage **ever** been hospitalized or been treated in the emergency room or had any physical impairment, deformity, congenital anomaly, sickness, operation, injury or hospitalization **other than** admitted to on this page? ☐ Yes ☐ No

PART TWO – CONTINUED

SECTION B — DETAILS OF HEALTH HISTORY

If you answered "Yes" to ANY questions on the previous page, please provide further information using the chart below. Be sure to use the "correct" example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

	Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment, Advice Given, and Medications Prescribed	Name, Address and Phone Number of Doctors and Hospitals
			What is it?	Date that it Started	Date of Recovery (if applicable)			
Incorrect Example:	~~C~~	~~Mr. Smith~~	~~blood pressure~~	~~1995~~	~~N/A~~	~~N/A~~	~~prescription~~	~~Dr. Jones St. Mary's Hospital~~
Correct Example:	3C	Joe Smith	high blood pressure	6/95	none	no, ongoing	40mg Atenolol once a day 140/80 - 7/8/01 138/78 - 10/12/01 139/77 - 2/9/02	Dr. Jones St. Mary's Peoria, IL (309) 555-1212

If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)?..... ☐ Yes ☐ No

SECTION C — OTHER INSURANCE INFORMATION

1. Does any person applying for coverage currently have, or did they previously have, Blue Cross and Blue Shield of Illinois coverage, either as a primary insured or as a dependent? ☐ **Yes** ☐ **No** *If "Yes", please complete the following:*

   Member Name _____ Member No. _____ Group No. _____

2. Does any person to be covered have any Major Medical, HMO, or PPO Medical Insurance with any other Insurer? ☐ **Yes** ☐ **No**

3. Will the issuance of this coverage cause you to discontinue your existing coverage? ☐ **Yes** ☐ **No**

   If "Yes", when is coverage to be discontinued (mo./day/yr.)? ____/____/____ (Note: A Notice of Replacement Form must also be submitted with your application, even if replacing Blue Cross and Blue Shield of Illinois coverage.)

   If "No", please explain _____

4. Has any person applying for coverage ever been declined, postponed, charged an extra premium for or had a rider applied to life, health, or disability insurance, or had any such insurance rescinded? ☐ **Yes** ☐ **No**

   If "Yes", please explain _____

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

PART THREE

SECTION A — REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I apply for coverage as indicated in PART ONE, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical coverage) which is herein called the Company. **I have read all the statements in PARTS ONE and TWO, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on PARTS ONE and TWO of this application may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of the Company.**

I have read and understand the Outline of Coverage that has been provided to me by my agent who sells Blue Cross and Blue Shield of Illinois insurance plans. My agent has informed me of the provisions of the Blue Cross and Blue Shield of Illinois health plan and the Medical Services Advisory (MSA®) Program (along with the provisions of the Mental Health Unit if applicable).

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.

Medical Authorization: I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, health plan, 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 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: X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Spouse's Signature (ONLY if to be insured): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Parent/Guardian Signature (If Primary Applicant is UNDER the age of 18): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Dependent's Signature (ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Primary Applicant's Signature: X _____

Print Your Name as You Signed It: _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

SECTION B — AGENT STATEMENT

I have personally, completely and accurately reaffirmed the information supplied by the applicant(s).

Agent's Signature: X _____ **Date Signed:** ____/____/____ (mo. / day / yr.)

Print Your Name as You Signed It: _____ **Agent's Phone Number:** _____

Agent's Code: _____

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Health Care Service Corporation. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAD NEVER BEEN IN FORCE. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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NOTE TO PRODUCER: An applicant who is replacing existing health insurance with Blue Cross and Blue Shield coverage must read, sign, and date the grey replacement form at right. You must then submit that replacement form along with the application. This form must remain with the applicant.

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Health Care Service Corporation. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

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The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
Applicant's Signature

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This form must be signed by the applicant and returned with the application.

This form stays with the applicant.

CONDITIONAL RECEIPT FOR

BlueCross BlueShield of Illinois
DIRECT MARKETS

Proposed Insured: _____

Date of Application: _____ Amount Received: _____ Date of Receipt: _____

NO INSURANCE WILL BECOME EFFECTIVE UNLESS EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO PRODUCER IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.

Subject to the limitations shown below, insurance will become effective under the receipt if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Health Care Service Corporation, a Mutual Legal Reserve Company (Blue Cross and Blue Shield of Illinois) hereafter "HCSC," at its Home Office (or the office of the designated administrator).
2. The first full premium, according to the mode of premium payment chosen, has been paid and the check is honored on first presentation for payment.

   "An effective date in compliance with HCSC guidelines" means the later of:
   a. The requested coverage date, if any, shown on the application; or
   b. The date upon which the application is approved by HCSC at its Home Office (or office of the designated administrator).
3. The policy is issued by HCSC exactly as applied for within 60 days from date of application, delivered, and accepted by the proposed insured.

Applicant's Copy (if paying by check or money order)

(over, please)

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____ Check One: ☐ Checking Account ☐ Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

Applicant's Copy (if paying by automatic bank withdrawal)

▲ DETACH HERE ▲

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____ Check One: ☐ Checking Account ☐ Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED		
ADDRESS OF BANK		
CITY	STATE	ZIP
NAME OF INSURED, APPLICANT (PRINT)		
NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED	RELATIONSHIP TO INSURED	
SIGNATURE OF DEPOSITOR	DATE	

For Home Office Use Only:	BANK TRANSIT NUMBER	DEPOSITOR'S ACCOUNT NUMBER

PLEASE ATTACH VOIDED CHECK OR DEPOSIT SLIP

Company's Copy (if applicant is paying by automatic bank withdrawal)

Limitation:

This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided herein. In the event HCSC declines to issue a policy as applied for, the amount received by HCSC will be refunded.

Hugo Tagli Jr.

Signature of Secretary

Signature of Producer

Producer's Code: _____

Blue Cross and Blue Shield of Illinois
Administrator: Hallmark Services Corp.
PO Box 2038
Aurora, Illinois 60507-2038

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF ILLINOIS. DO NOT PAY CASH OR MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

If you do not hear from HCSC regarding the proposed insurance within 30 days, please call 1-800-538-8833.

THIS FORM LIMITS OUR LIABILITY.
BE SURE TO READ AND SIGN THE APPLICATION AND, IF DESIRED, THE AUTOMATIC PAYMENT REQUEST FORM. KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.

Producer's New Business Checklist

Assure quick processing of all applications…

Use this simple checklist before submitting your applications to assure prompt processing.

Have you:

- ❑ Reviewed each application to verify that it is complete and legible?
- ❑ Assured that the necessary signatures are provided?
- ❑ Assured that any changes to an application are initialed by the applicant?
- ❑ Attached detailed descriptions for any health questions which have been answered "YES"?
- ❑ Included your Agent Code and phone number on the application?
- ❑ Completed the "Conditional Receipt" form?
- ❑ Given the applicant a copy of the Outline of Coverage?

IMPORTANT!

Use this checklist to make sure you've completed all needed information.

In addition…

- ❑ There are NO C.O.D.s.
- ❑ The check for the exact amount should be made payable to: Blue Cross and Blue Shield of Illinois.

  If applicant is paying by bank draft authorization, make sure the authorization form is completed, a voided check or deposit slip is attached, and a check for the first month's premium is submitted.

  If applicant is selecting the two-month payment mode, a check for the first two months' premium should be submitted.
- ❑ If applicant is replacing his/her current coverage, make sure a signed replacement form is also attached.

This Sales Kit provides plan highlights only.

When we receive your application, we will evaluate your medical history, and if approved, you will receive your ID card and policy.

Your coverage documents include a full description of benefits, limitations, exclusions, and other features of coverage. You have 30 days to examine your coverage with no risk or obligation. We want you to be 100% satisfied. If you should change your mind about your Blue Cross and Blue Shield policy, even after you've made your first premium payment, simply return your policy and membership card to your insurance representative within 30 days of the activation of the policy. If no claims were filed, you will get a refund of your premium. You'll be under no further obligation.

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

DIRECT MARKETS