



Gregory W. Davies
www.446save.com
PO Box 95210
South Jordan, UT 84095
(801) 446-7283

Thanks for downloading the current Blue Cross Blue Shield of Utah Health Insurance Application. You have made a great choice! Here are a few instructions to make sure the application gets submitted correctly:

- 1) Remember all family members must apply to be considered. The only exceptions would be if a spouse is covered on a Employer plan, or is uninsurable. There is no longer Child only coverage available.
- 2) Fill in Names and address completely. Try not to leave anything blank.
- 3) Choose which plan is best for you from the choices (see following chart)
- 4) Don't use "N/A" or "---" for answers. Fill in all dates of medical treatment and give as much information as possible.
- 5) Submit a VOID Check if you want the premium automatically deducted. If not, then submit a check for the premium + \$5 to get a monthly bill.

Call me with any questions at (801) 446-7283 so I can answer any questions. The deadline is the 20th of the month to be considered for the following 1st. There is a possibility of faxing the application. Call (801) 446-7283 for details.

Mail completed Application and check to:

**IBP of Utah
Attn: Greg Davies
PO Box 95210
South Jordan, UT 84095**

Thanks again!

Gregory W. Davies
(801) 446-7283

BlueAdvantage Copay Plan with Regence ValueCare Network						
Monthly Premium Rates Effective July 1, 2006						
\$20 Office Visits — 80 / 20% Coinsurance						
(Copays before the deductible for office, clinic and urgent care center visits)						
Deductible	\$250		\$500		\$1,000	
	Male	Female	Male	Female	Male	Female
Under 20		\$103.80	\$87.50	\$87.50	\$75.80	\$75.80
20-24	\$122.40	\$130.60	\$103.80	\$110.80	\$90.90	\$96.80
25-29	\$129.40	\$150.40	\$109.60	\$127.10	\$95.60	\$110.80
30-34	\$165.60	\$195.90	\$139.90	\$165.60	\$122.40	\$144.60
35-39	\$181.90	\$211.00	\$153.90	\$178.40	\$134.10	\$156.20
40-44	\$218.00	\$236.70	\$184.20	\$200.60	\$160.90	\$174.90
45-49	\$246.00	\$257.70	\$207.50	\$218.00	\$180.70	\$190.10
50-54	\$292.70	\$300.80	\$247.20	\$254.20	\$215.70	\$221.50
55-59	\$330.00	\$339.30	\$278.70	\$286.80	\$243.70	\$250.70
60-64	\$390.60	\$390.60	\$330.00	\$330.00	\$288.00	\$288.00
Child *	\$81.60	\$81.60	\$68.80	\$68.80	\$59.50	\$59.50

BlueAdvantage Coinsurance Plan with Regence ValueCare Network						
Monthly Premium Rates Effective July 1, 2006						
80 / 20% Coinsurance After Deductible						
(The deductible is paid first then coinsurance begins — office visit copays not available)						
Deductible	\$2,500		\$5,000		\$7,500	
	Male	Female	Male	Female	Male	Female
Under 20		\$64.10	\$52.50	\$52.50	\$45.50	\$45.50
20-24	\$77.00	\$81.60	\$63.00	\$67.60	\$54.80	\$58.30
25-29	\$81.60	\$94.40	\$66.50	\$77.00	\$57.10	\$66.50
30-34	\$103.80	\$122.40	\$85.10	\$100.30	\$73.50	\$87.50
35-39	\$114.30	\$131.80	\$93.30	\$108.40	\$80.50	\$93.30
40-44	\$136.40	\$148.10	\$111.90	\$121.30	\$96.80	\$104.90
45-49	\$153.90	\$160.90	\$125.90	\$131.80	\$109.60	\$114.30
50-54	\$183.10	\$187.70	\$149.20	\$153.90	\$130.60	\$134.10
55-59	\$206.40	\$212.20	\$169.10	\$173.70	\$146.90	\$150.40
60-64	\$243.70	\$243.70	\$199.40	\$199.40	\$173.70	\$173.70
Child *	\$50.10	\$50.10	\$42.00	\$42.00	\$36.10	\$36.10

BlueAdvantage Copay Plan with Traditional Network						
Monthly Premium Rates Effective July 1, 2006						
\$20 Office Visits — 80 / 20% Coinsurance						
(Copays before the deductible for office, clinic and urgent care center visits)						
Deductible	\$250		\$500		\$1,000	
	Male	Female	Male	Female	Male	Female
Under 20		\$109.60	\$93.30	\$93.30	\$80.50	\$80.50
20-24	\$129.40	\$138.80	\$109.60	\$117.80	\$96.80	\$102.60
25-29	\$137.60	\$159.70	\$116.60	\$135.30	\$101.40	\$117.80
30-34	\$176.10	\$207.50	\$148.10	\$176.10	\$129.40	\$152.70
35-39	\$192.40	\$223.90	\$163.20	\$188.90	\$142.30	\$165.60
40-44	\$230.90	\$250.70	\$194.70	\$212.20	\$170.20	\$185.40
45-49	\$261.20	\$272.80	\$220.40	\$230.90	\$191.20	\$201.70
50-54	\$310.20	\$318.30	\$262.40	\$269.30	\$228.50	\$234.40
55-59	\$349.80	\$359.10	\$295.00	\$304.30	\$258.90	\$265.80
60-64	\$413.90	\$413.90	\$349.80	\$349.80	\$305.50	\$305.50
Child *	\$86.30	\$86.30	\$73.50	\$73.50	\$63.00	\$63.00

BlueAdvantage Coinsurance Plan with Traditional Network						
Monthly Premium Rates Effective July 1, 2006						
80 / 20% Coinsurance After Deductible						
(The deductible is paid first then coinsurance begins — office visit copays not available)						
Deductible	\$2,500		\$5,000		\$7,500	
	Male	Female	Male	Female	Male	Female
Under 20		\$67.60	\$56.00	\$56.00	\$47.80	\$47.80
20-24	\$81.60	\$86.30	\$66.50	\$71.10	\$58.30	\$61.80
25-29	\$86.30	\$100.30	\$70.00	\$81.60	\$60.60	\$70.00
30-34	\$109.60	\$129.40	\$89.80	\$106.10	\$78.10	\$93.30
35-39	\$121.30	\$139.90	\$99.10	\$115.40	\$85.10	\$99.10
40-44	\$144.60	\$157.40	\$118.90	\$128.30	\$102.60	\$110.80
45-49	\$163.20	\$170.20	\$132.90	\$139.90	\$116.60	\$121.30
50-54	\$193.60	\$199.40	\$158.60	\$163.20	\$138.80	\$142.30
55-59	\$219.20	\$225.00	\$179.60	\$184.20	\$156.20	\$159.70
60-64	\$258.90	\$258.90	\$211.00	\$211.00	\$184.20	\$184.20
Child *	\$53.60	\$53.60	\$44.30	\$44.30	\$38.50	\$38.50

BlueBasic Copay Plan with ValueCare Network						
Monthly Premium Rates Effective July 1, 2006						
\$30 Office Visits — 70 / 30% Coinsurance						
(Copays before the deductible for office, clinic and urgent care center visits)						
Deductible	\$250		\$500		\$1,000	
	Male	Female	Male	Female	Male	Female
Under 20		\$95.30	\$80.50	\$80.50	\$70.60	\$70.60
20-24	\$113.70	\$120.60	\$95.60	\$101.40	\$85.00	\$89.80
25-29	\$119.50	\$139.00	\$100.30	\$116.60	\$88.50	\$102.90
30-34	\$152.80	\$182.60	\$128.30	\$152.70	\$113.70	\$135.20
35-39	\$167.60	\$196.40	\$141.10	\$164.40	\$124.50	\$144.80
40-44	\$201.00	\$219.40	\$169.10	\$184.20	\$149.60	\$162.70
45-49	\$227.40	\$238.90	\$191.20	\$200.60	\$168.70	\$177.10
50-54	\$271.10	\$278.00	\$227.40	\$233.20	\$201.00	\$205.80
55-59	\$305.50	\$313.50	\$256.50	\$263.50	\$226.10	\$232.10
60-64	\$361.80	\$361.80	\$303.20	\$303.20	\$268.00	\$268.00
Child *	\$75.80	\$75.80	\$64.10	\$64.10	\$56.20	\$56.20

BlueBasic Coinsurance Plan with ValueCare Network						
Monthly Premium Rates Effective July 1, 2006						
70 / 30% Coinsurance After Deductible						
(The deductible is paid first then coinsurance begins - office visit copays not available)						
Deductible	\$2,500		\$5,000		\$7,500	
	Male	Female	Male	Female	Male	Female
Under 20		\$57.10	\$47.80	\$47.80	\$42.00	\$42.00
20-24	\$67.60	\$72.30	\$56.00	\$59.50	\$50.10	\$52.50
25-29	\$71.10	\$82.80	\$59.50	\$68.80	\$52.50	\$60.60
30-34	\$90.90	\$108.40	\$75.80	\$89.80	\$66.50	\$79.30
35-39	\$100.30	\$116.60	\$82.80	\$96.80	\$73.50	\$85.10
40-44	\$120.10	\$130.60	\$100.30	\$108.40	\$87.50	\$95.60
45-49	\$135.30	\$142.30	\$113.10	\$117.80	\$99.10	\$103.80
50-54	\$160.90	\$165.60	\$134.10	\$137.60	\$117.80	\$121.30
55-59	\$181.90	\$186.60	\$151.60	\$155.10	\$132.90	\$137.60
60-64	\$215.70	\$215.70	\$178.40	\$178.40	\$157.40	\$157.40
Child *	\$45.50	\$45.50	\$37.30	\$37.30	\$32.60	\$32.60

BlueBasic Copay Plan with Traditional Network						
Monthly Premium Rates Effective July 1, 2006						
\$30 Office Visits — 70 / 30% Coinsurance						
(Copays before the deductible for office, clinic and urgent care center visits)						
Deductible	\$250		\$500		\$1,000	
	Male	Female	Male	Female	Male	Female
Under 20		\$101.10	\$85.10	\$85.10	\$75.40	\$75.40
20-24	\$120.60	\$127.50	\$101.40	\$107.30	\$89.80	\$95.70
25-29	\$126.40	\$147.00	\$106.10	\$123.60	\$93.30	\$108.90
30-34	\$161.90	\$194.10	\$136.40	\$162.10	\$120.90	\$143.50
35-39	\$178.00	\$207.80	\$149.20	\$173.70	\$131.60	\$153.10
40-44	\$213.60	\$232.00	\$179.60	\$194.70	\$159.10	\$172.30
45-49	\$241.20	\$252.70	\$202.90	\$212.20	\$178.20	\$187.90
50-54	\$287.10	\$295.20	\$241.40	\$247.20	\$212.90	\$217.70
55-59	\$323.90	\$331.90	\$271.70	\$279.80	\$239.30	\$246.40
60-64	\$383.60	\$383.60	\$321.80	\$321.80	\$283.50	\$283.50
Child *	\$80.40	\$80.40	\$67.60	\$67.60	\$59.80	\$59.80

BlueBasic Coinsurance Plan with Traditional Network						
Monthly Premium Rates Effective July 1, 2006						
70 / 30% Coinsurance After Deductible						
(The deductible is paid first then coinsurance begins - office visit copays not available)						
Deductible	\$2,500		\$5,000		\$7,500	
	Male	Female	Male	Female	Male	Female
Under 20		\$60.60	\$50.10	\$50.10	\$44.30	\$44.30
20-24	\$71.10	\$77.00	\$59.50	\$63.00	\$53.60	\$56.00
25-29	\$75.80	\$87.50	\$63.00	\$73.50	\$56.00	\$64.10
30-34	\$96.80	\$115.40	\$80.50	\$95.60	\$70.00	\$84.00
35-39	\$106.10	\$123.60	\$87.50	\$102.60	\$78.10	\$89.80
40-44	\$127.10	\$138.80	\$106.10	\$115.40	\$93.30	\$101.40
45-49	\$143.40	\$150.40	\$120.10	\$124.80	\$104.90	\$109.60
50-54	\$170.20	\$176.10	\$142.30	\$145.80	\$124.80	\$128.30
55-59	\$192.40	\$198.20	\$160.90	\$164.40	\$141.10	\$145.80
60-64	\$228.50	\$228.50	\$188.90	\$188.90	\$166.70	\$166.70
Child *	\$47.80	\$47.80	\$39.60	\$39.60	\$35.00	\$35.00

HDHP - HSA Plan with Traditional Network						
Monthly Premium Rates Effective July 1, 2006						
80/20 Plan						
Deductible	\$3,500 / \$7,000		\$2,500 / \$5,000		\$1,500 / \$3,000	
	Male	Female	Male	Female	Male	Female
Under 20		\$46.00	\$50.30	\$50.30	\$57.10	\$57.10
20-24	\$53.90	\$57.40	\$60.20	\$63.80	\$67.90	\$73.30
25-29	\$56.50	\$66.30	\$62.90	\$73.70	\$72.40	\$84.20
30-34	\$73.30	\$87.40	\$80.80	\$96.20	\$92.40	\$110.50
35-39	\$81.20	\$94.60	\$89.00	\$103.40	\$101.40	\$118.60
40-44	\$97.20	\$105.20	\$106.90	\$115.90	\$121.30	\$132.20
45-49	\$109.60	\$114.90	\$120.40	\$126.70	\$137.60	\$143.90
50-54	\$129.90	\$133.40	\$142.80	\$146.40	\$163.00	\$167.50
55-59	\$146.60	\$150.20	\$161.80	\$166.20	\$183.80	\$189.20
60-64	\$173.20	\$173.20	\$190.50	\$190.50	\$218.30	\$218.30
Child *	\$36.30	\$36.30	\$39.60	\$39.60	\$45.30	\$45.30

Please follow instructions carefully. Inaccurate, incomplete, or illegible applications will be returned.

1. **MUST BE COMPLETED EXCLUSIVELY BY THE APPLICANT AND SIGNED AND DATED** on pg. 6.
2. Complete ALL items. Print in **BLACK** or **BLUE** ink.

I. APPLICANT INFORMATION

Last Name _____ First Name _____ Initial _____
 Spouse Last Name _____ First Name _____ Initial _____
 Marital Status Single Married Divorced Widowed Utah Bar or UMA # (if applicable) _____
 Mailing Address _____ City _____ State _____ Zip Code _____
 Home Phone _____ Daytime Phone _____ E-Mail Address _____
 Applicant's Employer _____ Spouse's Employer _____
 Employer's Group Health Insurance (if none, write none) Employer's Group Health Insurance (if none, write none)

II. COVERAGE OPTIONS (Choose BlueChoices OR HSA Plan)

BLUECHOICES HEALTH PLANS AND DEDUCTIBLES Choose one (BlueAdvantage or BlueBasic)				REGENCE HEALTH SAVINGS ACCOUNT (HSA QUALIFIED PLANS)	
BlueAdvantage (80% / 20%)		BlueBasic (70% / 30%)		Single	Family
\$20 Copay Plans	20% Coinsurance Plans	\$30 Copay Plans	30% Coinsurance Plans	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$3,000
<input type="checkbox"/> \$250	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$250	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000
<input type="checkbox"/> \$500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$7,000
<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$7,500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$7,500	HSA plans use the Regence BlueCross BlueShield of Utah "Traditional" Network	
OR					
PROVIDER NETWORKS (Choose One)					
<input type="checkbox"/> Regence BlueCross BlueShield of Utah "Traditional"				<input type="checkbox"/> Regence ValueCare	

III. MEMBERS TO BE ENROLLED (List the Following Information for All Family Members Applying for Coverage)

Family Members	Sex	Relationship To Applicant*	Birthdate Mo/Day/Yr	Height Ft - In	Weight Lbs.	Social Security Number	Name of Current Physician	P E C
Applicant	<input type="checkbox"/> M <input type="checkbox"/> F	Applicant	/ /	-		- -		
Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	Spouse	/ /	-		- -		
Unmarried children (under 26 – eldest first)	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		
	<input type="checkbox"/> M <input type="checkbox"/> F		/ /	-		- -		

* e.g., child, stepchild, adopted child, child under legal guardianship, etc.

Attach additional page if necessary

IV. AGENT/AGENCY AGREEMENT (This section to be completed by Insurance Agent when applicable)

Agent/Agency Name (Please print) _____ Utah License No. _____
 Business Address _____ City, State, ZIP _____
 Business Phone (_____) _____ Regence BCBSU Appt. No. _____ FBL Agent No. (if applicable) _____
 Signature of Agent Gregory W. Slavin _____ Date of Signature _____

I understand and agree that in acting as Agent for this Applicant:

- a. Application must be completed by the Applicant.
- b. I am in possession of a valid license issued by the State of Utah authorizing me to sell and service life insurance and health care service contracts.

- c. I have no authority to: (1) make, alter, interpret, or discharge a contract in the name of **Regence BlueCross BlueShield of Utah** or (2) waive any of the terms or conditions of the contract.
- d. I have no authority to assign effective dates or to effect membership changes.
- e. Cancellation of this Health Care Agreement by either the subscriber or Regence BlueCross BlueShield of Utah will terminate this Agency Agreement.

THIS SECTION TO BE COMPLETED BY REGENCE BLUECROSS BLUESHIELD OF UTAH

Subscriber Name _____ Contract No. _____ Group No. _____
 Effective Date _____ Agent No. _____ PAYMENT PLAN SurePay Monthly Quarterly Condition Specific Rider

V. HEALTH STATEMENT – (EACH CONDITION MUST BE CHECKED “YES” OR “NO”)

If complete health information is not received, this application will be returned. Inaccurate health information may result in your policy being cancelled retroactively. It is your responsibility to notify us of any health status changes prior to approval of this application.

Have you or any listed Family Members EVER experienced problems with, been diagnosed with, or been treated for any of the following:	Within the LAST FIVE YEARS (continued)		Yes	No	Complete the following questions for all immediate family members proposed for insurance.	Yes	No
Yes No	32. Asthma						
1. AIDS/HIV positive	33. Bladder/Urinary Disorder				71. Do you or does any listed Family Member have any serious medical problems, or deformities not listed here?		
2. Amputation	34. Bone/Joint				72. In the past 5 years have you or has any listed Family Member experienced any condition for which future consultation, treatment or surgery is contemplated or advised?		
3. Arteries/Veins	35. Back, neck, or spinal problems, that required medical attention and/or interfered with normal daily activities?				73. Do you smoke now or have you smoked in the past? Does any listed Family Member smoke now or has smoked in the past? If “Yes,” please specify who smoked, for how long, and when the individual quit smoking (if applicable).		
4. Arthritis or Rheumatism	36. Breast Disorder				74. Have you or has any listed Family Member received any treatments or tests within the last 12 months?		
5. Autism	37. Jaw Problems				75. Have you or has any listed Family Member received any medications, drugs or injections within the last 12 months?		
6. Back/Neck Surgery	38. Depression/Chemical Imbalance				76. Have you or has any listed Family Member consulted a physician in the last 12 months? Give date(s) and reason(s).		
7. Birth Defects	39. Digestive System				Complete the following questions for all immediate family members whether or not proposed for insurance.	Yes	No
8. Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis	40. Drug Abuse/Addiction				77. Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period?		
9. Blood Disease or Problems	41. Eyes, Ears, Nose, Throat				78. Are you, your spouse or any eligible child (whether or not proposed for insurance) currently pregnant?		
10. Bowel Disorder/Colitis	42. Female or Menstrual Problems				79. Is anyone currently pregnant with your child, or your spouse’s child?		
11. Cancer	43. Foot Problems				80. Are you or your spouse financially responsible for an unborn child, anticipating adoption, applying for/or have applied for adoption?		
12. Congenital Disorders/Defects	44. Fracture or Dislocation						
13. Diabetes	45. Gall Bladder/Gall Stones						
14. Endometriosis	46. Glandular/Hormone System						
15. Epilepsy, Seizure, or Convulsions	47. Gout						
16. Heart Disease or Problems	48. Hemorrhoids/Rectal Problems/ Polyps						
17. Liver Disorder/Cirrhosis	49. Hernia						
18. Lung Disease/Tuberculosis	50. High Blood Pressure						
19. Lupus	51. Infertility						
20. Mental Retardation	52. Irritable Bowel Syndrome						
21. Neurological Disease	53. Kidney Disorder/Nephritis						
22. Paralysis	54. Kidney Stones						
23. Polio (late effect)	55. Knee Problems						
24. Suicide (attempted)	56. Migraines/Headaches or Dizziness						
25. Stroke/Brain	57. Mental Illness						
26. Tumor or Growth (include location)	58. Muscular/Nervous System						
27. Abnormal Pap Test	59. Pain (intractable or uncontrollable)						
Within the LAST FIVE YEARS have you or any listed Family Members experienced problems with, been diagnosed with, or been treated for any of the following:	60. Pregnancy (complications of)						
Yes No	61. Premature Birth(s) (include gestational age & birth weight)						
28. Abnormal PSA (Prostate Specific Antigen)	62. Prostate Disorder/Male Organs/Impotence						
29. Accidental Injuries	63. Sexually Transmitted Disease						
30. Alcoholism	64. Sinus Disorder						
31. Allergies/Hay Fever	65. Skin Disorder						
	66. Stomach/Intestine Disorder						
	67. Surgical Operation(s)						
	68. Thyroid Disorder or Goiter						
	69. Ulcers						
	70. Varicose Veins						

IF ANY OF THE ABOVE CONDITIONS OR QUESTIONS ARE CHECKED “YES,” PLEASE EXPLAIN IN THE SPACES PROVIDED ON THE FOLLOWING PAGE.
(Attach additional pages if necessary)

V. HEALTH STATEMENT (continued)

IF YOU ANSWERED 'YES' TO ANY OF THE QUESTIONS OR CONDITIONS LISTED UNDER THE HEALTH STATEMENT SECTION OF THE PREVIOUS PAGE, PLEASE EXPLAIN OR PROVIDE THE REQUESTED INFORMATION IN THE SPACES PROVIDED BELOW. ATTACH ADDITIONAL PAGES IF NECESSARY.

Question or Condition Number	Name of Family Member	Describe in detail each of the following that applies: (1) Name and nature of condition, (2) symptoms, (3) type of surgery, test, treatments, consultations, or medications (including dosages) received or contemplated, and (4) degree of recovery.	Was patient hospitalized	Name and Address of Attending Physician	Dates of Care Mo/Yr
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From _____ To _____
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From _____ To _____
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From _____ To _____
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From _____ To _____
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From _____ To _____
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From _____ To _____
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From _____ To _____
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From _____ To _____
			<input type="checkbox"/> YES <input type="checkbox"/> NO		From _____ To _____

VI. REQUIRED AND IMPORTANT INFORMATION. PLEASE ANSWER ALL QUESTIONS

IF AN ANSWER REQUIRES EXPLANATION OR ADDITIONAL INFORMATION, PLEASE PROVIDE INFORMATION, COMMENTS AND EXPLANATIONS BELOW.

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Are you, your spouse, and all eligible children applying for coverage? If no, please explain _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you or any listed Family Member live, work, or attend school outside Utah? _____
If yes, please explain, including percent of time spent outside Utah _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you or any listed Family Member covered or eligible for coverage under any of the following:
(a) public health insurance including, but not limited to, Medicare, Medicaid or the Utah Comprehensive Health Insurance Pool (HIP);
(b) private health insurance including, but not limited to, (i) Medicare Supplement, (ii) conversion coverage, (iii) continuation or extension under COBRA, or (iv) Mini COBRA;
(c) an association;
(d) individual/group health plan coverage?
If yes, please include name of health carrier and policy number _____
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or any listed Family Member transferring coverage from another BlueCross or BlueShield plan?
If yes, please list insurance carrier and dates of coverage _____

_____ | <input type="checkbox"/> | <input type="checkbox"/> |

VI. REQUIRED AND IMPORTANT INFORMATION. (continued)

5. Within the past 93 days, have you or any listed Family Member been covered under any health or medical insurance plan or arrangement? If yes, please explain. _____ Yes No
-
6. Does your employer or any employer of a listed Family Member offer Regence BlueCross BlueShield of Utah or Regence ValueCare group health insurance coverage? If yes, please explain why you are not enrolling the Family Members in that coverage. _____
-
7. To the best of your knowledge has any insurance company (including Regence BlueCross BlueShield of Utah) refused, up-rated or restricted any health coverage on you or any of the listed Family Members? If yes, please explain. Include insurance company's name, reason, and date. _____
-
8. Within the past 93 days, have you or any listed Family Member been declined to be covered under any health or medical insurance plan or arrangement? If yes, please explain. _____
-
9. Have you or any listed Family Member been covered by any health insurance program within the past 63 days from the date of this application? If yes, please attach a "Certification of Coverage" form provided by your prior employer or insurer and complete "Crediting Prior Coverage Information" below.

CREDITING PRIOR COVERAGE INFORMATION

The coverage you are applying for imposes a pre-existing condition exclusion. If you have a condition that existed before enrolling, you might have to wait a certain period of time before having benefits for treatment of that condition. However, you can reduce this waiting period by the number days of certain prior "creditable coverage."

Please complete the following information about any health insurance coverage you and/or your dependents have had at any time during at least the past 24 months. Write "None" if there has been no coverage. Obtaining credit for previous coverage is subject to your eligibility under Public Law 104-191 Section 101 and, therefore, is not guaranteed by the completion of this application. Failure to complete all information and submit a timely "Certificate of Coverage" form or this form with the initial application For Membership, may jeopardize or delay your ability to obtain credit for prior coverage for which you and/or your dependents otherwise would have been eligible. Complete this section even if you and/or your dependents have had no prior coverage.

Prospective enrollees applying for prior coverage credit.

(List below all enrollees to be considered for prior coverage credit and all corresponding insurance policies.)

Name (First, Last)	Birth Date	Prior Insurer Name	Prior Insurer Policy #	Prior Health Coverage From - Thru Mo/Day/Yr - Mo/Day/Yr	Was this proposed enrollee covered under this policy?	
					Yes	No
1.	/ /			/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
2.	/ /			/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
3.	/ /			/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
4.	/ /			/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
5.	/ /			/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
6.	/ /			/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
7.	/ /			/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>
8.	/ /			/ / - / /	<input type="checkbox"/>	<input type="checkbox"/>

VII. CERTIFICATION, AUTHORIZATION and SIGNATURE

TO BE DISCLOSED TO REGENCE BLUE CROSS BLUE SHIELD OF UTAH (REGENCE BCBSU).
PLEASE COMPLETE AND RETURN THIS FORM WITH EACH APPLICATION.

CERTIFICATION OF COMPLETION AND CORRECTNESS

I, the undersigned, hereby make application for membership in Regence BCBSU, as specified above, hereinafter referred to as "the Plan." I understand that the services and benefits set forth in my contract with the Plan will be available only on or after the effective dates of said contract, as shall be determined by the enrollment regulations of the Plan.

I understand and agree that receipt of this application and/or my initial premium by an agent, employee or representative of Regence BCBSU in no way binds Regence BCBSU to cover any Family Members until and unless I receive written notice assigning the date coverage will start.

I understand and agree that if I am accepted for coverage, I will receive a Health Care Agreement which I will have ten days to review before acceptance. If the Health Care Agreement is not acceptable to me for any reason, I may return it to Regence BCBSU within the ten-day period and will receive a full refund of premiums paid.

Any matter in dispute between you and the Plan may be subject to arbitration as an alternative court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographers, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueCross BlueShield of Utah. Incentives may be based on any of several factors, including the size of group business, the products you buy, your broker or agent's volume of business with Regence and the other services your agent or broker provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your broker or agent.

I further certify that all information completed on this form is true, correct and complete and acknowledge my coverage is subject to cancellation if any completed information is found to be false or incorrect.

INDIVIDUAL AUTHORIZATION FOR PROTECTED HEALTH INFORMATION

On behalf of ourselves and the family member(s) listed on the application, we authorize any physician, health-care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Regence BCBSU or its representatives our health information (excluding health information relating to alcohol or chemical dependency, mental treatment, genetic testing, HIV treatment, or sexually transmitted diseases). We acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan or eligibility for benefits. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records or hospital records (including nursing records and progress notes).

We understand that we are not legally obligated to sign this authorization. However, if Regence BCBSU is unable to obtain information necessary to process our application for coverage no further action will be taken with this application. Once this information is received, Regence BCBSU will continue to process this application.

We understand that we may cancel this authorization at any time by sending a written request to Regence BCBSU. Our cancellation of this authorization will not affect any action Regence BCBSU took before it received our request. If we do not revoke this authorization, it will automatically expire upon termination of our coverage with Regence BCBSU or 24 months from the date below, whichever comes first.

VII. CERTIFICATION, AUTHORIZATION and SIGNATURE (continued)

NAME OF APPLICANT (Please Print): _____

SIGNATURE: _____ **DATE:** _____

* If signed by a Personal Representative of the applicant, please complete the following:

✓ Personal Representative's Name: _____

✓ Relationship to Applicant: Parent Legal Guardian** Holder of Power of Attorney**

** Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

SPOUSE'S NAME (Please Print): _____

SPOUSE'S SIGNATURE: _____ **DATE:** _____

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(PSYCHOTHERAPY NOTES are notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

VIII. PAYING YOUR PREMIUMS

Regence BlueCross BlueShield of Utah offers you 3 payment options:

- Monthly billing:** You will receive a monthly bill. Note: An additional \$5 per month will be charged for this option.
- Quarterly billing:** You will receive a bill every 3 months.
- SUREPAY:** Electronic payment from either your checking or savings account.

SUREPAY is a simple and convenient way to keep your health coverage in force. If you select the SUREPAY option of paying for your Regence BlueCross BlueShield of Utah insurance, the premiums will be deducted automatically from your checking or savings account on or about the 1st or the 16th day of the month depending on your policy's effective date.

This will provide several advantages to you:

- You will have no premium statements to keep up with and return.
- Your premiums will always be paid on time (if funds are available in your account).
- Postage expenses will be eliminated.
- You won't have to worry about your policy accidentally lapsing due to forgotten payments.
- Your monthly bank statement will show a withdrawal notation, which is your receipt of payment.

GETTING STARTED is as easy as 1-2-3

1. Choose your method of payment (see next page).
If you choose one of the billing options, you will be billed.
If you choose the **SUREPAY** option, be sure to complete, date and sign the SUREPAY Authorization form and attach your "voided" check/deposit slip.
2. **FOR CHECKING ACCOUNT:** Attach a voided check (**not a deposit slip**) if funds are to be drawn monthly from your **checking** account. (Note: a **checking** account deposit slip does not contain the necessary routing numbers.)
FOR SAVINGS ACCOUNT: Attach a voided savings deposit slip if funds are to be drawn monthly from your **savings** account. Please verify with your financial institution that your name, account and routing numbers are **accurate** and included on the deposit slip.
3. **RETURN** this completed application and SUREPAY Authorization Form with your "voided" check or savings deposit slip in the envelope provided by Regence BlueCross BlueShield of Utah (or self-addressed envelope to SUREPAY Dept. #2, P.O. Box 30270, Salt Lake City, Utah 84130-0270).

SOME SUGGESTIONS

- **CHECKBOOK REMINDERS** — Since you will not be receiving a monthly premium notice, you should put a notation or some other reminder in your checkbook to remind you to deduct the premiums from your account balance each month. This will help you keep your account in balance and avoid overdraft problems.
- **IF YOU CHANGE YOUR BANK OR WISH TO CANCEL YOUR AUTOMATIC DEDUCTION**
 1. Do this at least 15 days before your next premium is due. We suggest you leave enough money in your old bank account to cover your premiums in case there is a delay in processing the change.
 2. Just send us a copy of your new "voided" check and a note explaining that you have changed banks.
- **ADDRESS CHANGES** — Please be sure to let us know when you change your address. We need your current address to notify you of rate, policy or procedure changes, and claims information.

VIII. PAYING YOUR PREMIUMS (continued)
CHOOSE ONE OF THE FOLLOWING THREE OPTIONS
 (Check appropriate box):

SUREPAY		MONTHLY BILL	QUARTERLY BILL
Complete SurePay Authorization below <input type="checkbox"/> Monthly Checking Account Deduction		<input type="checkbox"/> Every Month — Additional \$5 per month will be charged.	<input type="checkbox"/> Every 3 Months
	<input type="checkbox"/> Monthly Savings Account Deduction — Please see “ Special Note ” below		

IMPORTANT: Is any employer reimbursing or paying for any portion of this premium? YES NO

SPECIAL NOTE — SAVINGS ACCOUNT DEDUCTIONS:

Banks do not allow manual drafts on savings accounts. If you are authorizing withdrawals from your savings account, you will be billed until such time that scheduled deductions can start.

SUREPAY Authorization Form

- Checking Account**
- Savings Account**

As a convenience to me, I hereby request and authorize you to pay and charge to my account, checks or electronic debits drawn on my account by and payable to the order of Regence BlueCross BlueShield of Utah, Salt Lake City, Utah. I agree that your rights to each such check or electronic debit shall be the same as if it were a check drawn on you and signed by me. 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 any such check. I further agree that if any checks or electronic debits 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. A photocopy of this executed authorization shall be as valid as the original.

Name of Applicant _____ SSN# _____ - _____ - _____
 (please print)

Signature _____ Date _____
 (as it appears on bank records)

Attach your “voided” check or savings account deposit slip here.
(Please do not attach a savings deposit slip for a checking account.)

Name O. Person 24-242 813
 12345 Street 2424
 City, State 88888 Date _____

Pay to the Order of _____ \$ Dollars

First Bank of Cash
 2222 Commerce
 City, State 88888

Memo _____

|: 123123123 |: 12 31231 2 ||

