MEDICALLY UNDERWRITTEN APPLICATION AND HEALTH QUESTIONNAIRE

HOW TO COMPLETE THIS APPLICATION

To avoid processing delays, take your time to carefully and accurately complete all of the applicable sections.

The underwriting process can take several weeks. Therefore, you may want to continue your existing health care coverage while waiting for the response to this application.

1. Read all materials enclosed with this application, including the Outline of Coverage, so that you understand the cost sharing obligations of the coverage you have selected and to ensure that you have selected the health care coverage that is right for you.
2. Tear off this front page along the perforation. **Keep this page for your records.** You may want to refer to it if you have a question about your application or the appeals process.
3. On page 1, provide all "General Information" and all "Enrollment Information" requested. Provide information about your spouse and dependents only if they are also applying for coverage.
4. On page 2, check the box and deductible for the product for which you are applying.
5. On pages 3 through 6, provide all "Medical Information" requested. Provide information about yourself and each dependent who is also applying.
6. Read and sign pages 7 and 8, if applicable.
7. Read the "Conditions of Enrollment" on page 9. Be sure to sign and date where indicated on page 10. If both you and your spouse are applying for coverage, both of you must sign and date this application.
8. On page 10, all applicants/dependents age 18 and older must sign the application. Highmark will not process your application without these signatures.
9. The "Producer's Certificate" on page 11 should be completed only by a licensed insurance producer acting on your behalf. Do not complete if you are applying on your own.
10. Return your completed application with a check or money order for your initial premium made payable to: "Highmark Blue Cross Blue Shield."

    Mail to:
    Highmark Blue Cross Blue Shield
    P.O. Box 382555
    Pittsburgh, PA 15250-8555

Receipt of your initial payment does not constitute enrollment under this program. Your coverage will not begin until this application has been accepted by Highmark Blue Cross Blue Shield and you have been notified that an effective date of coverage has been assigned. If your application is approved by the medical underwriting department on or before the last day of the month, your coverage will become effective on the first day of the following month. Failure to provide all the information requested may result in a delay in the processing of your application.

Keep this page for your records.

Date: ____________________ Check Number: ________________

Amount Paid: ____________________________________

Deductible Amount Applied For: ___________________________

UNDERWRITING YOUR APPLICATION

The basic source of information we use to determine your eligibility for this insurance policy is your application. Experienced underwriters will carefully and promptly review the information you have provided. In addition, we may also obtain information from other sources, including physicians and hospitals, as authorized by you when you complete your application. **Any physician charges or other fees incurred during the process of completing this application are the responsibility of the applicant.**

A high percentage of our applicants are in good health and meet our underwriting standards. As a result, these applications are quickly approved and insurance policies are issued. Some applicants, however, present a greater insurance risk, usually due to an abnormal physical condition or history of medical problems. By underwriting policies in this way, we try to keep the cost of health care coverage affordable for as many people as possible.

If, due to your medical history, you do not qualify for coverage at the rate for which you apply, you may be eligible for coverage at one of Highmark's higher tiered rates, as determined in accordance with our medical criteria ("underwriting guidelines"*). Each application will be reviewed individually, and you will be notified if you are eligible for coverage and at which rate. You will also be notified if your application is denied.

Underwriting guidelines are based on nationally recognized actuarial and clinical criteria.

If you, your spouse or any dependent applying for coverage receives medical advice or treatment from a physician or other professional provider for a condition which is incurred *after* this application is signed but ***prior*** to the effective date of coverage, you must notify the Highmark Blue Cross Blue Shield Underwriting Department immediately at 120 Fifth Avenue, Suite 1224, Pittsburgh, PA 15222-3099. For individuals age 19 or older, a change in a medical condition that occurs ***prior*** to the effective date could result in a denial of coverage if an application has not yet been approved or cancellation of coverage if an application has been approved but coverage is not yet effective. For individuals under age 19, a change in a medical condition that occurs ***prior*** to the effective date could result in movement to one of Highmark's higher tiered rates.

HOW TO APPEAL A DENIAL FOR INSURANCE COVERAGE

You have the right to appeal a denial for medical insurance. To do so, complete the following steps within 180 days from your receipt of the denial letter:

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

   Highmark Blue Cross Blue Shield Appeal
   120 Fifth Avenue, Suite 1720
   Pittsburgh, PA 15222-3099

   or fax them to 412-544-4009 (for appeals only)

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

FOR MORE INFORMATION OR HELP CONCERNING THIS APPLICATION...

If you have questions about this coverage or how to complete this application, please call a Customer Service Representative Monday through Friday between 9:00 a.m. and 9:00 p.m. at 1-800-847-2004.

MEDICALLY UNDERWRITTEN APPLICATION AND HEALTH QUESTIONNAIRE

For husband/wife or family coverage, applicant must be the older spouse.

GENERAL INFORMATION

(PRINT CLEARLY) Applicant's Last Name	First Name	Middle Initial	County

Address	City	State	Zip Code

Preferred Phone Number ( )	❑ Home ❑ Work ❑ Other	Alternate Phone Number ( )	❑ Home ❑ Work ❑ Other	E-mail

When possible, I prefer to be contacted via: ❑ Mail ❑ Phone ❑ E-mail

❑ I am adding dependent(s) to my existing coverage. Refer to the Change Form for additional instructions on which portions of the application you should complete.

ENROLLMENT INFORMATION

Complete the information requested about yourself and any other family members you are enrolling. List spouse and/or eligible dependent child(ren) (up to age 26) who are applying for coverage.

	Applicant	Spouse	Dependent	Dependent	Dependent
Name					
Have you smoked or used any form of tobacco within the last year?	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
Social Security Number (If no SSN, write N/A)					
Birth Date (MM/DD/YY)	/ /	/ /	/ /	/ /	/ /
Gender	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Height/Weight	/	/	/	/	/
Current Physician					
Physician's Phone Number	( )	( )	( )	( )	( )

1. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have in force? This includes any current Highmark Blue Cross Blue Shield policy.

   ❑ No – If "no," proceed to question 2. ❑ Yes – If "yes," proceed to 1 (a) and (b).

   1 (a). If you answered "yes" to question 1, provide the insurance company name and applicable group and identification number(s):

   Company Name: ______________________

   Group No: ______________________ Agreement or I.D. No.: ______________________

   1 (b). If you answered "yes" to question 1, complete the Notice to Applicant Regarding Replacement of Accident and Sickness Coverage form on page 7 and mail it with your application.

2. Has any person applying ever been turned down for any health reasons for:

   Name of Person(s) Turned Down and Reason

   Medical policies ❑ No ❑ Yes ______________________

   Life Insurance policies ❑ No ❑ Yes ______________________

3. Is any person applying for this coverage enrolled in or eligible for Medicare due to age and/or disability? Except for dependent children under the age of 26, any person eligible for Medicare or Medicare Disability Benefits is not eligible for this coverage. ❑ No ❑ Yes

Payment Enclosed	Group Number	Applicant's Social Security Number
$	039000-00	

Mail to Highmark Blue Cross Blue Shield, P.O. Box 382555, Pittsburgh, PA 15250-8555

PRODUCT AND DEDUCTIBLE SELECTION (check one)

Refer to Conditions of Enrollment (starting on page 9) for explanation of how the Family Deductible works, changing your deductible, and paying your premium.

I am applying for new coverage under:

❑ **DirectBlue®** Comprehensive Major Medical Preferred-Provider Subscription Agreement for Individual Members, Utilizing the Keystone Health Plan West Network of Providers, Without a Gatekeeper ("Agreement").

DirectBlue Annual Deductible You Prefer:

❑ $250 Individual/$750 Family

❑ $500 Individual/$1,500 Family

❑ **Advance Blue℠** Individual Comprehensive Major Medical Non-Gatekeeper Preferred-Provider Agreement identified as Advance Blue ("Agreement").

Advance Blue Annual Deductible You Prefer:

❑ $1,200 Individual/$2,400 Family

❑ $2,600 Individual/$5,200 Family

❑ $3,500 Individual/$7,000 Family

❑ **PPOBlue℠** Comprehensive Major Medical Preferred-Provider High-Deductible Subscription Agreement for Individual Members, Utilizing the Keystone Health Plan West Network of Providers, Without a Gatekeeper ("Agreement").

PPOBlue Annual Deductible You Prefer:

❑ $1,200 Individual/$2,400 Family

❑ $2,600 Individual/$5,200 Family

❑ $3,500 Individual/$7,000 Family

❑ **Simply Blue℠** Individual Comprehensive Major Medical Non-Gatekeeper Preferred-Provider Subscription Agreement identifed as Simply Blue ("Agreement").

Simply Blue Annual Deductible You Prefer:

❑ $500 Individual/$1,000 Family

❑ $750 Individual/$1,500 Family

Monthly premium for the Product you selected: $ ______________________

MEDICAL INFORMATION

Include information on all conditions for which any applicant has been diagnosed, treated, advised, counseled, tested, hospitalized or recommended treatment by a licensed health care practitioner. **<u>DO NOT INCLUDE</u> any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which any applicant may be at risk.**

1. Has any person applying used any medical equipment (such as a walker, wheelchair, cane, hospital bed, CPAP, BiPAP or oxygen)? Has any person applying ever had an implant (e.g., breast, chin or penile implant), internal fixation (e.g., pins, plates, or screws), prosthesis, pacemaker, defibrillator, valve replacement, shunt or monitoring device (e.g., electrical stimulation device) or any other device? .... ❑ No ❑ Yes

2. Is any person applying currently receiving home health care? .... ❑ No ❑ Yes

3. Has any person applying received occupational, physical, or speech therapy or chiropractic treatments in the past 5 years? ❑ No ❑ Yes

4. Has any person applying been advised by a licensed health care practitioner of any abnormal lab results, X-rays, diagnostic studies, or physical exam results within the last 5 years? .... ❑ No ❑ Yes

5. Has any person applying been advised by a licensed health care practitioner to have treatment, testing, counseling, therapy, or surgery which has not yet been performed? .... ❑ No ❑ Yes

If you have answered "Yes" to any of the above questions (#1 – #5), provide details on the "Details of Health History" chart on page 5.

6. Give date of last menstrual period for each female family member applying.

Name of Person	Date of Last Period	If none or more than a month ago, please explain

7. Has any person applying been recently (i.e., within the past 9 months) medically diagnosed or treated for pregnancy? .... ❑ No ❑ Yes

Name of Pregnant Person	Diagnosis or Treatment	Date (mm/dd/yyyyy)

8. Has any person applying gained or lost more than 20 pounds over the past 6 months? .... ❑ No ❑ Yes

If "Yes," provide person's name, amount gained or lost and reason for gain/loss.

Name of Person	Weight Gained	Weight Lost	Reason

9. Is each person (age 18 and below) applying current on his/her childhood immunizations? If "No," please explain. .... ❑ No ❑ Yes

Name of Person	Reason

MEDICAL INFORMATION (continued)

10. Has any person applying been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment by a licensed health care practitioner for the following? **Conditions listed are examples only. All known health conditions must be disclosed.**

A. Behavioral Health/Psychiatric/Substance Abuse: Current addiction/substance abuse; History of addiction/substance abuse; Psychosis; Eating disorder; Sleep disorders/sleeping medications; Any condition requiring psychiatric/psychological counseling or medications such as: Depression, Manic depression, Bipolar disorder, Anxiety, Panic disorder, Obsessive/Compulsive disorder, and Schizophrenia, Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity disorder (ADHD) ❑ No ❑ Yes

B. Heart/Blood/Circulation: Irregular heart beat; Pacemaker, angina/chest pain;, Congestive heart failure; Abnormality/anemia blood disorders; Heart attack; Problems with veins and arteries/blood clotting disorder/Deep Vein Thrombosis; Hypertension/hypotension; Cholesterol/hyperlipidemia; Stroke/cerebrovascular accident; Cardiomyopathy; Enlarged heart; Heart valve problems or replacement. ❑ No ❑ Yes

C. Eyes/Ears/Nose/Throat: Glaucoma; Macular degeneration; Cataracts; Visual Impairment; Enucleated/removed eye; Iritis; Retinal/corneal problems; Frequent ear infections; Cochlear implants; Deviated septum; Jaw or Temporomandibular Joint problems; Excessive snoring; Frequent throat infections ❑ No ❑ Yes

D. Endocrine/Hormones/Metabolic/Glandular: Adrenal gland problems; Diabetes (insulin or diet controlled); Thyroid (Hypothyroid or Hyperthyroid); Goiter/nodule/other; Pituitary or pineal gland problems; Chronic fatigue ❑ No ❑ Yes

E. GI – Gastrointestinal/stomach/intestines: Abscess/infection; Constipation or diarrhea-frequent; Cirrhosis/liver disease; Ulcerative colitis/ Crohns; Diverticulitis/diverticulosis/frequent abdominal pain; Nutritional disorder; Fistula/fissure; Bariatric surgery; Hemorrhoids; Hernia; Hepatitis; Irritable Bowel Syndrome; Pancreatitis; Cancer; Gastritis/ulcer/esophagitis/Gastroesophageal Reflux Disease; Polyps ❑ No ❑ Yes

F. GU – Urinary/Kidney/Bladder: BPH/enlarged prostate; Incontinence; Kidney cysts; Kidney failure/renal failure/CRF/ESRD; Kidney stones; Pyelonephritis/cystitis/frequent infections; Strictures or narrowing; Cancer ❑ No ❑ Yes

G. Immune System/Infections: AIDS/HIV; Allergies; Current infections; Lupus; Scleroderma; Lyme disease; Viral infections; Chronic Fatigue/ Epstein Barr Virus/Mononucleosis ❑ No ❑ Yes

H. Skin/Nails/Hair/Cosmetic: Cellulitis; Hair loss; Psoriasis; Skin lesions/skin cancer/pre-cancer; Other skin conditions requiring treatment (acne, fungal infections, rosacea, rashes, dermatitis, warts, eczema, keratosis); Cosmetic problems ❑ No ❑ Yes

I. Muscles/Bones: Amputations; Arthritis; Fracture/joint replacements/pins/screws; Bunion/foot conditions/plantar fasciitis; Carpal Tunnel Syndrome; Fibromyalgia; Osteopenia/osteoporosis; Recurrent pain; Physical therapy, Chiropractic; Spine problems/disc problems/ scoliosis/kyphosis; Tendonitis/bursitis/myositis ❑ No ❑ Yes

J. Brain/Spine/Nervous System: Neuro/muscular disorders/Guillain-Barrē/Multiple Sclerosis; Headaches/migraines; Memory loss/ cognitive problems/physical development delays; Narcolepsy; Parkinson's Disease; Pinched nerve/numbness/tingling/paralysis; Seizure disorder; Dizziness/Meniere's Disease/fainting; Head or spinal injury; Tremors; Stroke/Cerebral Vascular Accident; Transient Ischemic Attack ❑ No ❑ Yes

K. Reproductive System – Female: Breast augmentation; Breast problems/fibrocystic breast/mastitis/lumps/lumpectomy/mastectomy; Childbirth; Miscarriage; Infertility; Abnormal PAP test; Infectious disease/Sexually Transmitted Disease/genital warts/chlamydia/HPV/ syphilis/gonorrhea/herpes; Menstrual problems; fibroids/endometriosis; Ovarian cysts; Sexual issues/transgender/dysfunction. ❑ No ❑ Yes

L. Reproductive System – Male: Prostate problems/Benign prostatic hypertrophy; Epididymitis; Erectile dysfunction; Sexual issues/ transgender/ dysfunction; Infectious disease/Sexually Transmitted Disease/genital warts/chlamydia/HPV/syphilis/gonorrhea/herpes ❑ No ❑ Yes

M. Respiratory: Asthma; Bronchitis/pneumonia/upper respiratory infections; Chronic cough; Shortness of breath; Pleurisy/pneumothorax; Pulmonary embolism/blood clots; Tuberculosis, Emphysema/COPD/other lung disease/work-related breathing problems ❑ No ❑ Yes

N. Other Conditions: Accident/injury; Birth conditions/congenital abnormalities; Surgery; Cancer; Leukemia ❑ No ❑ Yes

If you have answered "Yes" to any of the above questions,
provide details on the "Details of Health History" chart on page 5.

MEDICAL INFORMATION (continued)

11. Does any person applying have any other conditions, illnesses or injuries not specifically mentioned on this application for which you or your eligible dependents have been diagnosed, treated or monitored or for which ongoing evaluation, treatment or monitoring has been recommended? If "Yes," specify condition and provide details on the "**Details of Health History"** chart below .... ❑ No ❑ Yes

Details of Health History

Question number	Applicant Name	Condition, Injury, Symptom, Diagnosis or Other			Was person affected released from care?	Required: • Readings, levels, lab results. • Types of treatment/advice given. • Number of visits and date range for therapy and chiropractic	Name, address and phone number of doctors and hospitals
		What condition is it?	Date that it started	Date of recovery (if applicable)			
Incorrect example ~~10~~	~~Mark~~	~~blood pressure~~	~~2008~~	~~N/A~~	~~N/A~~	~~get regular readings~~	~~Dr. Wilson~~ ~~3 Rivers Hospital~~
Correct example 10 B	Mark Jones	high blood pressure or hypertension	6/2008	none	no, ongoing	Blood pressure readings: 140/80 — 7/6/2008 138/77 — 2/2/2009	Dr. Wilson, 3 Rivers Hospital, 127 Main St., Pgh., PA 15222 412-000-0000

MEDICAL INFORMATION (continued)

12. If any person applying has taken prescribed drugs in the past 12 months, list drug(s) taken and reason:

Applicant('s) Name	Medication	Dosage	Frequency	Condition/Reason	Dates of Use (mm/yyyy)
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:

13. Indicate the last physician office or clinical visit for each applicant. If additional space is needed, attach a separate piece of paper.

Applicant Name	Physician Name		Physician Phone Number ( )
Physician Address	City	State	Zip Code
Reason			Date
Applicant Name	Physician Name		Physician Phone Number ( )
Physician Address	City	State	Zip Code
Reason			Date

14. If not provided on previous pages, indicate the last emergency room and/or hospital visit and specific results.

Applicant Name	Reason	Results	Date (mm/dd/yyyy)

15. If any person applying drinks alcoholic beverages, indicate frequency of use. If you do not drink, write "0." If you drink less than one drink per week, indicate "Less than one." (Serving size per drink equals 1 1/2 oz. liquor, 12 oz. beer, 5 oz. wine)

Applicant Name	Number of Drinks per Week	Applicant Name	Number of Drinks per Week

16. If any person applying, within the last year, used tobacco products, indicate amount of cigarettes, cigars, pipes or smokeless tobacco (snuff, chewing tobacco, etc.) used and length of use. If you do not use tobacco products, write "0." If you use tobacco less than once per day, indicate "Less than once."

Applicant Name	Amount per Day	Type	Dates of Use (mm/yyyy)
			From: To:
			From: To:

17. Is there anything else you want to tell us?

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS COVERAGE

If you intend to replace your current health insurance with this Agreement, provide your signature and date below. Otherwise continue to page 9.

According to the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness coverage and replace it with the Agreement to be issued by Highmark Blue Cross Blue Shield. Your new Agreement provides 10 days within which you may decide whether you desire to keep the Agreement. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the coverage available to you under the new Agreement.

1. Health conditions you and/or your dependents age 19 or older may presently have (pre-existing conditions) may not be immediately or fully covered under the new Agreement. This could result in denial or delay of a claim for benefits related to these pre-existing conditions under the new Agreement, whereas a similar claim might have been payable under your present policy.

2. Even though some of your and/or your dependents age 19 or older current health conditions may be covered under the new Agreement, these current health conditions may be subject to certain waiting periods under the new Agreement before coverage is effective for these conditions.

3. 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 is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. 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 enrollment application. Failure to include all required enrollment and all material medical information on an enrollment application, or making intentional misrepresentations of a material fact or fraudulent misstatements, may provide a basis for Highmark to deny any future claims and to refund your premiums as though your Agreement had never been in force. Also, omissions or misstatements on the enrollment form could cause an otherwise valid claim to be denied.

5. The approval process of your Highmark Blue Cross Blue Shield application can take several weeks. You should not terminate your present coverage until Highmark Blue Cross Blue Shield has notified you that your application for enrollment has been accepted and an effective date of coverage for this new Agreement has been assigned.

After the enrollment application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded. Write to Highmark Blue Cross Blue Shield at Fifth Avenue Place, 120 Fifth Avenue, Suite 2318, Pittsburgh, PA 15222-3099, within 10 days if any information is not correct and complete, or if any past history has been omitted.

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

______________________________	______________________________
Applicant's Signature	*Date*

WHITE copy to be signed and returned to Highmark Blue Cross Blue Shield along with application.
Please retain **YELLOW** copy for your records.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS COVERAGE

If you intend to replace your current health insurance with this Agreement, provide your signature and date below. Otherwise continue to page 9.

According to the information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness coverage and replace it with the Agreement to be issued by Highmark Blue Cross Blue Shield. Your new Agreement provides 10 days within which you may decide whether you desire to keep the Agreement. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the coverage available to you under the new Agreement.

1. Health conditions you and/or your dependents age 19 or older may presently have (pre-existing conditions) may not be immediately or fully covered under the new Agreement. This could result in denial or delay of a claim for benefits related to these pre-existing conditions under the new Agreement, whereas a similar claim might have been payable under your present policy.

2. Even though some of your and/or your dependents age 19 or older current health conditions may be covered under the new Agreement, these current health conditions may be subject to certain waiting periods under the new Agreement before coverage is effective for these conditions.

3. 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 is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. 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 enrollment application. Failure to include all required enrollment and all material medical information on an enrollment application, or making intentional misrepresentations of a material fact or fraudulent misstatements, may provide a basis for Highmark to deny any future claims and to refund your premiums as though your Agreement had never been in force. Also, omissions or misstatements on the enrollment form could cause an otherwise valid claim to be denied.

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

______________________________	______________________
Applicant's Signature	*Date*

WHITE copy to be signed and returned to Highmark Blue Cross Blue Shield along with application.
Please retain **YELLOW** copy for your records.

IMPORTANT: READ AND SIGN ON PAGE 10

I, the undersigned, hereby apply for coverage for myself and all my listed eligible dependents.

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

1. I have read and have supplied all the requested information on this form with regard to myself and any family members applying for coverage (If not, I have attached a letter which explains why.);
2. All applicants for this policy are in good health except for those conditions listed in the Medical Information portion of the application; and
3. No material information has been withheld or omitted about the past or present state of my health or any family member(s) applying.

I understand and agree that:

1. Except for dependent children under the age of 26, any person eligible for Medicare or Medicare disability benefits is **not** eligible for this coverage;
2. This coverage does not begin until this application is accepted by Highmark Blue Cross Blue Shield and an Effective Date of coverage is assigned;
3. Initial payment must be submitted with the application;
4. Receipt of my money (check or money order) does not constitute enrollment under any program;
5. Highmark Blue Cross Blue Shield Agreements renew on a month-to-month basis. The premium is payable in advance to Highmark Blue Cross Blue Shield on a monthly basis. Members may, for their convenience, submit amounts in excess of the specific monthly amount. However, such excess amounts will be applied on a monthly basis by Highmark Blue Cross Blue Shield and will be subject to premium increases on the date the increase becomes effective.
6. This coverage is provided only to residents of the geographical area of western Pennsylvania served by Highmark Blue Cross Blue Shield. We reserve the right to investigate and confirm your residence from time to time; and
7. If applicant is under age 18, the signature of a parent or guardian is required on this application.

I also understand and agree that Highmark Blue Cross Blue Shield may:

1. Require me and any family member(s) applying to provide upon request medical history or to have a medical examination, blood test or other applicable medical test prior to acceptance of the application (Highmark Blue Cross Blue Shield may choose to specify the provider);
2. Require me or any family member(s) applying to notify the Highmark Blue Cross Blue Shield Underwriting Department immediately if I, my spouse or any of my dependents applying for coverage receive medical advice or treatment from a physician or other professional provider for a condition which occurs after the application is signed, but prior to the Effective Date of coverage. I understand that, for individuals age 19 or older, change in a medical condition could result in a denial of coverage if my application has not yet been approved or cancellation of coverage if my application has been approved but coverage is not effective; and that, for individuals under age 19, change in a medical condition that occurs prior to the Effective Date could result in movement to one of Highmark's higher tiered rates;
3. Deny this application, in which case any premium submitted will be refunded and accepted by me;
4. Void this Agreement or deny a claim for loss incurred or disability (as defined in the Agreement) if the applicant has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the Agreement.

I also understand and agree that the Agreement will not provide benefits related to a pre-existing condition for any applicant (including dependents) age 19 or older during the 12-month pre-existing condition period following the Effective Date on which I and any dependents become enrolled under the Agreement. A pre-existing condition is any condition, including normal pregnancy, for which medical advice, care, treatment or diagnosis has been recommended by or received from a health care provider within a five-year period prior to the Effective Date of the Agreement.

I understand and agree that the terms and conditions of our coverage will be controlled by the written Agreement with Highmark Blue Cross Blue Shield and that it may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I recognize that our coverage will only apply to admissions that occur and services that are provided on or after the Effective Date of our coverage.

Authorization for Disclosure of Health Information for Coverage Eligibility and Underwriting

I hereby authorize Highmark to request for those who are enrolling for coverage under this application information and/or medical records relating to past, present and future health care examinations, prescription drugs, treatment and diagnosis, including copies of records concerning advice, care or treatment provided to me and/or my dependents, including, without limitation, information involving mental health (excluding psychotherapy notes, unless specifically and separately authorized), substance abuse and HIV/AIDS.

I further authorize any physician, medical practitioner, hospital, medical or medically related facility, insurer, pharmacy benefits manager, or any other health care organization to release the information described above to Highmark and its subsidiaries.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

Highmark • 120 Fifth Ave • JCS 10 • Pittsburgh, PA 15222

I understand that revocation of this authorization will *not* affect any action Highmark or any other person/entity took in reliance on this authorization before it received my written notice of revocation. Unless otherwise revoked, this authorization will expire one (1) year from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization. However, Highmark may condition my enrollment and determine my eligibility or risk rating from information obtained through this signed authorization.

In the event of enrollment, I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose protected health information for payment, treatment and health care operations.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

(continued on next page)

CONDITIONS OF ENROLLMENT (continued)

A copy of Highmark's Notice of Privacy Practices is available on Highmark's website, or from the Highmark Privacy Office.

EXPLANATION OF FAMILY DEDUCTIBLE

Read the explanation of the Family Deductible for the product for which you are applying.

DirectBlue

* Family Deductible: For an Agreement covering more than one (1) family member, each covered individual must meet his/her individual deductible (within a benefit period) before Highmark will pay for covered services for that individual. No individual member may satisfy the entire family deductible.

I understand and accept that, under the terms of the DirectBlue Agreement, only after three (3) individual family members have satisfied their deductibles will the deductibles for all remaining family members also be considered to have been satisfied.

PPOBlue

* Family Deductible: For an Agreement covering more than one (1) family member, the ENTIRE family deductible must be met (within a benefit period) before Highmark will pay for covered services for ANY family member. The family deductible can be satisfied by an individual family member or a combination of one or more family members.

I understand and accept that, under the terms of the PPOBlue Agreement, when more than one (1) family member is covered, one (1) or more family member(s) must satisfy the ENTIRE family deductible (within a benefit period) before Highmark will pay for covered services for ANY family member.

The PPOBlue High Deductible Health Plan is available to individuals who wish to purchase a qualified high deductible health plan for use with a Health Savings Account as defined by the Internal Revenue Service.

Advance Blue and Simply Blue

* Family Deductible: For an Agreement covering more than one (1) family member, the ENTIRE family deductible must be met (within a benefit period) before Highmark will pay for covered services for ANY family member. The family deductible can be satisfied by an individual family member or a combination of one or more family members.

I understand and accept that, under the terms of the Advance Blue Agreement or the Simply Blue Agreement, when more than one (1) family member is covered, one (1) or more family member(s) must satisfy the ENTIRE family deductible (within a benefit period) before Highmark will pay for covered services for ANY family member.

Changing your Deductible

Deductible level can be **increased** only on the contract anniversary date provided that the request is received one month prior to the contract anniversary date. Deductible level can be **decreased** as of the contract anniversary date only after the member holds the contract for two consecutive years and if the request is received at least one month prior to the contract anniversary date.

APPLICANT SIGNATURE(S) - REQUIRED

To the best of my knowledge and belief, the information provided on this application is true and correct.

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

Sign and date where requested below. All applicants and dependents age 18 or older must read and understand this "Conditions of Enrollment" and sign and date where requested below. Your requested Effective Date must be within two (2) months of your date of signature below.

I request this coverage to become effective ____________________.

The Effective Date of coverage is usually the first day of the month following medical underwriting approval. However, we cannot guarantee that your requested Effective Date can be met. The Effective Date is in all cases the date on which your coverage begins following medical underwriting approval and assignment of an Effective Date.

To avoid delays in processing your application, this form must be received by Highmark Blue Cross Blue Shield within fifteen (15) days of the date of your signature.

Applicant's Signature Date

Spouse's Signature Date

Dependent's (age 18 or older) Signature Date

Dependent's (age 18 or older) Signature Date

FOR PRODUCER USE ONLY

PRODUCER'S CERTIFICATE

Attention Producer:

If you have questions concerning the completion of this application, please call the Producer Line at 1-866-602-1248.

If this section is not fully completed, commission will not be paid.

Blue Cross Blue Shield Agency No. ☐☐☐☐☐   Producer No. ☐☐☐☐☐

Agency Name ____________________

Producer's Name ____________________
LAST *FIRST* *MI*

Producer's Signature ____________________

Business Phone (   ) ____________________
Area Code

Completion of this section is required BY A PRODUCER if the producer wishes to act on the applicant's behalf.

1. Except for the information set forth in the Medical Information Section of this application, are you aware, based on the applicant's responses to your inquiries, of any additional factors impacting the insurability and/or eligibility of the applicant and each of his/her dependents applying for this coverage? ❑ No ❑ Yes

____
Producer Signature   Date

____
Agency

2. Have you provided the applicant with all relevant marketing materials, including the Outline of Coverage? ❑ No ❑ Yes

3. Have you advised the applicant of the features of the product that they have selected, including satisfying their deductible(s)? ❑ No ❑ Yes

4. Is this applicant a current customer of Highmark Blue Cross Blue Shield? ❑ No ❑ Yes

5. Have you retained a signed copy of this application for your records? ❑ No ❑ Yes

Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the application or policy; or
3. Waive any of Highmark Blue Cross Blue Shield's rights or requirements.

HIGHMARK®

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Highmark Blue Cross Blue Shield
120 Fifth Avenue
Pittsburgh, PA 15222-3099

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Advance Blue and PPOBlue are service marks of the Blue Cross and Blue Shield Association.