Individual Change of Coverage Application – *For existing enrollments only.*

The following plans are offered by Blue Cross of California: PPO Share 2500/1500/1000/500, Select HMO, HMO Saver, Individual HMO, EPO and DentalSelect HMO plans. The following plans are offered by BC Life & Health Insurance Company (BCL&H): Basic PPO 1000/2500, PPO Saver, PPO Share 5000/1000/500, RightPlan PPO 40 plans, PPO 3500 (HSA-Compatible), 3500 Deductible PPO, Dental PPO and Term Life products. Blue Cross of California and BCL&H are Independent licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.

IMPORTANT: If you are applying for a change of coverage from any HMO or Basic Plan, you must complete the Individual Enrollment Application (IU2138).

1. Subscriber Information

Current subscriber must complete this section.

Last Name	First Name	M.I.
Street Address *(Must be complete: P.O. Box not acceptable)*		
City	State	ZIP Code

Social Security or ID No.	Marital Status ☐ Married ☐ Single
Mailing Address *(If different than above or P.O. Box)*	
City / State / ZIP Code	
Home Phone No. ( )	Business Phone No. ( )
Applicant/Spouse Maiden Name	Spouse Social Security or ID No.
Mail Service Agreement to: ☐ Primary Subscriber ☐ Your BCC agent	

2. Choice of Blue Cross Individual Coverage

MEDICAL COVERAGE:

PPO Coverage:

- ☐ BC Life Basic PPO 1000 (7900)
- ☐ BC Life Basic PPO 1000 without Life (PE25)
- ☐ BC Life Basic PPO 2500 (R418)
- ☐ BC Life Basic PPO 2500 without Life (R419)
- ☐ BC Life Share 5000 (H062)
- ☐ BC Life PPO Saver (NM31)
- ☐ BC Life PPO Saver without Life (PE27)
- ☐ BC Life 3500 Deductible PPO (R420)
- ☐ BC Life RightPlan PPO 40-No Rx (P958)
- ☐ BC Life RightPlan PPO 40-Generic Rx (PE48)
- ☐ BC Life RightPlan PPO 40-Comprehensive Rx (PE49)
- ☐ BC Life Share 1000 (1930)
- ☐ BC Life Share 500 (1929)
- ☐ PPO Share 2500 (7891)
- ☐ PPO Share 1500 (7889)
- ☐ PPO Share 1000 (1393)
- ☐ PPO Share 500 (7895)
- ☐ EPO (HSA Compatible) (7892)
- ☐ BC Life PPO 3500 (HSA-Compatible) (T160)
- ☐ _____

HMO Alternative Coverage*

- ☐ Select HMO* (PE43)
- ☐ HMO Saver* (7896)
- ☐ Individual HMO* (7898)

DENTAL COVERAGE:

- ☐ BC Life Dental PPO (7874)
- ☐ Dental Saver SelectHMO (ZE6N)
- ☐ Dental SelectHMO (ZE7N)
- ☐ Dental Premier SelectHMO (ZE8N)

List dental applicants below. If you are only adding dental coverage, do not complete Section 4, "Health History." You must complete all other sections.

BLUE CROSS DENTAL PROVIDER NO: ☐☐☐☐☐☐
(Required for any Dental SelectHMO)

3. Subscriber Family Information

List yourself and all enrolled family members requesting a change in coverage.

If spouse's last name is different from yours, please explain: _____

***3A. Select an IPA or PMG for yourself and each family member.**
If an IPA is selected, also provide the Primary Care Physician (PCP) number.
Please list your selections below.

	Last Name	First Name	M.I.	Height	Weight	Birthdate	Age	Social Security or ID Number	PMG/IPA	Primary Care Physician (PCP)
10 ☐ Male 20 ☐ Female	Subscriber									
30 ☐ Male 40 ☐ Female	Spouse									
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										

4. *Health History of Members Listed on this Application*

Your claims history with Blue Cross will also be used in addition to the history listed on this application.

Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months? ..... ☐ Yes ☐ No

If Yes, please provide the required medical information below.

Member Name	Hospital / Provider Name and Address	Medication Prescribed	Condition / Illness Treated

Has any enrolled family member used any tobacco products within the last 24 months? ..... ☐ Yes ☐ No

Is either the applicant or spouse, whether or not listed on application, currently pregnant? ..... ☐ Yes ☐ No

If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application? ..... ☐ Yes ☐ No

FEMALES ONLY – Please provide the following information. (Applicable to ALL females listed on this application.)

Do you menstruate?..... ☐ Yes ☐ No Has it been more than 40 days since her/their last menstrual period?..... ☐ Yes ☐ No

Are you currently pregnant?..... ☐ Yes ☐ No

5. *Conditions of Application* It is important that you carefully read and understand the following.

ELIGIBLE/INELIGIBLE APPLICANTS

All Applicants age 18 and over must personally read, agree to, and sign the following:

☐ Applicant does read and write English. If an Applicant does not read English, the translator must sign and submit a Statement of Accountability (see Page 3).

Blue Cross will enroll all eligible family members unless otherwise instructed.

☐ I, the Applicant, request that Blue Cross not enroll eligible applicants unless all family members qualify.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

I, the undersigned, understand that:

1. If my application for Blue Cross coverage is accepted as applied for, Blue Cross will assign the effective date, but I agree that I have no coverage under this application **until notified in writing** by Blue Cross that I am accepted.
2. I understand that Blue Cross has the right to deny my application and if so, I will be notified in writing.
3. **MINOR CHILDREN:** I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. **If the responsible adult is not the natural parent, please submit court papers authorizing guardianship.**

   PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing this plan, the custodial parent or guardian must complete the Health History Section and sign the Conditions of Application accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse.
4. **DEPENDENTS AGE 18 AND OVER:** To the best of my knowledge and belief, I represent that (1) my dependents age 18 and over have read this application and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application with my dependents age 18 and over, and (3) all information contained in this application regarding dependents age 18 and over is complete and accurate.

   I understand and agree that if Blue Cross denies my application, under no circumstances will any benefits be payable for any person listed on this application.
5. If I am accepted, this application will become part of the agreement between Blue Cross and myself. Enrolled family members and I agree to be bound by the arbitration clause in the Blue Cross contract instead of trial by court or jury.
6. Blue Cross may request additional information and this may delay processing of this application. If the health care provider bills for these services, Blue Cross will determine payment and I will be responsible for any difference.
7. The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or terms of any Blue Cross coverage.

5. *Conditions of Application (Continued)* It is important that you carefully read and understand the following.

8. **I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if I intentionally provided incomplete or false material information Blue Cross may revoke my coverage. This means Blue Cross will cancel membership as if it never existed. Also, after approval for membership, if material information is discovered by Blue Cross that was not provided to the Plan prior to the effective date of the policy, Blue Cross may deny coverage.**

I have personally read and completed this application. I understand and agree to all the Conditions of Application. I understand that coverage will come into effect only if this application is approved by Blue Cross of California. I, the Applicant, acknowledge that I have read and understand this application in its entirety.

REQUIREMENT FOR BINDING ARBITRATION: If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes against Blue Cross, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: **"It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."** Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

X		X	
Signature of Applicant/Parent or Legal Guardian	Today's Date *(Required)*	Signature of Applicant's Spouse	Today's Date *(Required)*
X		X	
Signature of Applicant's Dependent Age 18 or over	Today's Date *(Required)*	Signature of Applicant's Dependent Age 18 or over	Today's Date *(Required)*

Statement of Accountability – To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Individual Change of Coverage Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Conditions of Application."

Signature of Translator *(Required)*	Today's Date *(Required)*

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