



INDIVIDUAL APPLICATION

Last Revised: 10/00

Thank you for selecting Blue Cross Blue Shield of Arizona. To assist us in the quick processing of this machine readable form, please complete the application by printing your answers in BLACK ink. Fill in ovals completely. Do not print in any shaded areas. Do not use commas, dashes, hyphens or any other punctuation. Use only capital letters, print only one letter or number per square, and leave one blank space between words.

For example:

0	1	2	3	4	5	6	7	8	9		W		H		I		L		L		S		T		A		N		Y		T		O		W		N		A		Z
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NOTICE TO APPLICANTS THAT HAVE LOST GROUP OR COBRA HEALTH COVERAGE: If your group or COBRA health plan (employer provided health coverage) terminated within the past 63 days, you may be eligible for Individual Portability Coverage. This coverage does not require medical underwriting and there is no preexisting condition waiting period. To qualify for this coverage you must meet specific criteria. If you think you may qualify for this coverage, please call us at (602) 864-4899, or toll-free at 1-877-864-4899, and ask for the Individual Portability Coverage brochure and application. NOTE: You will lose your eligibility for Individual Portability Coverage if you become insured under any non-group policy.

IMPORTANT: Any applicant designated on this application must be under age 65 and must be a permanent resident of Arizona. Anyone receiving Medicare disability benefits is NOT ELIGIBLE for coverage. Applications for individual / family coverage must be sent with a \$20 NON-REFUNDABLE fee. (No fee is required for child-only applications.) Do not send the first month's premium.

FOR NEW OR EXISTING CUSTOMER, PLEASE COMPLETE ENTIRE APPLICATION.	APPLICATION FOR:	<input type="radio"/> NEW CUSTOMER	<input type="radio"/> EXISTING CUSTOMER	<input type="radio"/> COVERAGE CHANGE	<input type="radio"/> ADD DEPENDENT	<input type="radio"/> LOWER DEDUCTIBLE
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PLAN FOR WHICH YOU ARE APPLYING (CHOOSE ONLY ONE).						
BlueSelect		BluePreferred			BlueClassic	
<input type="radio"/> Plan 1	<input type="radio"/> Plan 2	<input type="radio"/> \$250	<input type="radio"/> \$500	<input type="radio"/> \$1000	<input type="radio"/> \$2500	<input type="radio"/> \$5000
<input type="radio"/> \$250	<input type="radio"/> \$500	<input type="radio"/> \$750	<input type="radio"/> \$1250	<input type="radio"/> \$2500	<input type="radio"/> \$5000	

TYPE OF COVERAGE:	IF FAMILY OR CHILD-ONLY COVERAGE SELECTED, CHECK ALL THAT APPLY:
<input type="radio"/> INDIVIDUAL <input type="radio"/> FAMILY <input type="radio"/> CHILD-ONLY	<input type="radio"/> SPOUSE <input type="radio"/> ONE CHILD <input type="radio"/> TWO CHILDREN <input type="radio"/> THREE OR MORE CHILDREN

IF MY APPLICATION IS APPROVED, PLEASE BILL ME AS FOLLOWS:		THE EFFECTIVE DATE OF YOUR COVERAGE WILL DETERMINE THE DAY OF THE MONTH THAT YOUR PREMIUM WILL BE DUE.	
<input type="radio"/> MONTHLY SURE PAY – ELECTRONIC BANK DRAFT (PLEASE COMPLETE THE SURE PAY APPLICATION)	<input type="radio"/> MONTHLY PAPER BILL	<input type="radio"/> QUARTERLY PAPER BILL (BILLED JAN. / APRIL / JULY / OCT.)	I PREFER MY COVERAGE TO BE EFFECTIVE:
			<input type="radio"/> ON THE FIRST OF THE MONTH <input type="radio"/> ON THE FIFTEENTH OF THE MONTH <input type="radio"/> EARLIEST DATE AVAILABLE (FIRST OR FIFTEENTH)

APPLICANT TO BE NAMED AS CONTRACT HOLDER -OR- IF APPLYING FOR CHILD-ONLY COVERAGE, NAME OF PARENT OR LEGAL GUARDIAN LIVING IN ARIZONA:

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	OFFICE USE ONLY

THIS LINE NOT APPLICABLE IF APPLYING FOR CHILD-ONLY COVERAGE.	DATE OF BIRTH (MM/DD/YYYY)	MALE	FEMALE	MARRIED	SINGLE	HEIGHT	WEIGHT	IF BlueSelect	PERSONAL PHYSICIAN I.D. N.O.	CURRENT PATIENT
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				A Z	<input type="radio"/> YES <input type="radio"/> NO

MAILING ADDRESS (NUMBER & STREET)	APT./UNIT NO.	WORK TELEPHONE (AREA CODE & NO.)	EXTENSION

CITY	STATE	ZIP + FOUR	COUNTY OF RESIDENCE	HOME TELEPHONE (AREA CODE & NO.)

E-MAIL ADDRESS	FAX (AREA CODE & NO.)

IF YOU WANT YOUR BILL MAILED TO A DIFFERENT ADDRESS, COMPLETE THIS SECTION.

CARE OF (IF APPLICABLE)	ADDRESS (NUMBER & STREET)		
APT./UNIT NO.	CITY	STATE	ZIP + FOUR

IF YOU ARE APPLYING FOR CHILD-ONLY COVERAGE: PROVIDE INFORMATION ON CO-CUSTODIAL PARENT OR LEGAL GUARDIAN, IF APPLICABLE.		
LAST NAME	FIRST NAME	HOME TELEPHONE (AREA CODE & NO.)

DO NOT WRITE IN SHADED SPACE BELOW. FOR OFFICE USE ONLY			
SPOUSE	1	2	3
COMBINED BILL NAME / #	L.I.D. #	BROKER NAME, MAILING ADDRESS, PHONE	BROKER # 04053
ASSOCIATION NAME	ASSN #		

APPLICATION FEE RECEIVED	<input type="radio"/>
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APPLICANT'S SSN _____

APPLICANT'S NAME _____

(For child-only applications, enter the parent or legal guardian's name.)

SPOUSE AND/OR CHILDREN TO BE CONSIDERED FOR COVERAGE. IF YOU HAVE MORE THAN 3 CHILDREN, COMPLETE A SEPARATE SHEET. WHEN ADDING A DEPENDENT TO EXISTING COVERAGE, LIST ONLY THOSE DEPENDENTS YOU ARE ADDING.

SPOUSE	SPOUSE'S LAST NAME										FIRST NAME										M.I.	SOCIAL SECURITY NO.									
	DATE OF BIRTH (MM/DD/YYYY)				MALE	FEMALE	HEIGHT		WEIGHT		DATE OF MARRIAGE (MM/DD/YY)				IF BlueSelect	PERSONAL PHYSICIAN I.D. N.O.				CURRENT PATIENT											
CHILD 1	CHILD'S LAST NAME										FIRST NAME										M.I.	SOCIAL SECURITY NO.									
	DATE OF BIRTH (MM/DD/YYYY)				MALE	FEMALE	HEIGHT		WEIGHT		RELATIONSHIP				IF BlueSelect	PERSONAL PHYSICIAN I.D. N.O.				CURRENT PATIENT											
CHILD 2	CHILD'S LAST NAME										FIRST NAME										M.I.	SOCIAL SECURITY NO.									
	DATE OF BIRTH (MM/DD/YYYY)				MALE	FEMALE	HEIGHT		WEIGHT		RELATIONSHIP				IF BlueSelect	PERSONAL PHYSICIAN I.D. N.O.				CURRENT PATIENT											
CHILD 3	CHILD'S LAST NAME										FIRST NAME										M.I.	SOCIAL SECURITY NO.									
	DATE OF BIRTH (MM/DD/YYYY)				MALE	FEMALE	HEIGHT		WEIGHT		RELATIONSHIP				IF BlueSelect	PERSONAL PHYSICIAN I.D. N.O.				CURRENT PATIENT											

OPTIONAL: INDICATE TERM LIFE INSURANCE FOR WHICH YOU ARE APPLYING.

IF INDIVIDUAL / FAMILY COVERAGE:
 \$20,000 \$30,000 \$50,000 THIS AMOUNT IS AVAILABLE ONLY IF APPLICANT IS 19 YEARS OR OLDER DO NOT WISH TO APPLY **DEPENDENT LIFE:** YES NO AVAILABLE ONLY IF CONTRACT-HOLDER HAS LIFE COVERAGE

IF CHILD-ONLY COVERAGE:
 \$10,000 \$20,000 \$30,000 DO NOT WISH TO APPLY ALL CHILDREN LISTED ON THIS APPLICATION WILL RECEIVE COVERAGE IF APPROVED, WITH PREMIUMS CALCULATED ON A PER CHILD BASIS. NOT AVAILABLE TO CHILDREN UNDER 1 YEAR OF AGE.

BENEFICIARY - LAST NAME										FIRST NAME										M.I.	RELATIONSHIP									
CONTINGENT BENEFICIARY - LAST NAME										FIRST NAME										M.I.	RELATIONSHIP									

IF APPLYING FOR TERM LIFE INSURANCE, WILL ALL OR PART OF THIS LIFE INSURANCE REPLACE EXISTING LIFE INSURANCE? <input type="radio"/> YES <input type="radio"/> NO	IF YES, PLEASE INDICATE NAME OF PRESENT CARRIER AND EFFECTIVE DATE OF COVERAGE	EFFECTIVE DATE (MM/DD/YYYY)
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BROKER STATEMENT I ACKNOWLEDGE THAT THIS IS IS NOT A REPLACEMENT OF EXISTING LIFE INSURANCE

BROKER SIGNATURE _____



APPLICANT'S SSN _____

APPLICANT'S NAME _____

(For child-only applications, enter the parent or legal guardian's name.)

EVIDENCE OF INSURABILITY

IMPORTANT: BCBSAZ will rely on the information provided to make a determination about coverage for all persons named on the application. If information about any applicant's medical background is misstated or omitted, it could result in limitations on coverage or your contract could be rescinded/cancelled and considered never to have been in effect. In that case, you would become responsible for all incurred medical expenses from the effective date of coverage.

Any change in the health status of any applicant that occurs between the date of this application and the effective date of coverage must be reported to Medical Risk Assessment at (602) 864-4040, or toll-free 1-800-232-2345, ext. 4040.

Table with 10 columns: Item ID, Description, YES, NO, Item ID, Description, YES, NO, Item ID, Description, YES, NO. Rows include categories like Allergies, Back, Birth, Blood, Blood Vessels, Bone, Brain, Breast, Elevated Cholesterol, Convulsions, Developmental, Diabetes, Ear, Nose, Throat, Eating Disorders, Eyes, Female Organs, Fractures, Gallbladder, Headaches, Heart Conditions, Hernia, High Blood Pressure, Hormonal, Illicit Drug Use, Immune System, Kidney, Liver, Lungs, Male Organs, Manic Depressive Disorder, Muscular System, Nervous System, Prosthetic Implants, Psychiatric, Reconstructive Surgery, Sexually Transmitted Diseases, Skin, Steroid Use, Stroke, Benign Tumors, Ulcers, Weight Problems.

IN THE PAST 10 YEARS:

Table with 3 columns: Question #, Question text, YES, NO. Questions 2-6 regarding surgery, alcoholism, and alcohol consumption.

If the answer is "yes" to any item in questions 1-6, indicate the question # or letter and provide full details below, including the onset and ending dates of injury/illness/symptoms and treatment. Providing full details may reduce the need for medical records and should include specifics concerning the type of disorder; conditions or symptoms; body location; tests or treatment advised, ordered or received; names and addresses of health care providers. Use extra paper if needed. THE COST OF OBTAINING MEDICAL RECORDS IS THE RESPONSIBILITY OF THE APPLICANT.



APPLICANT'S SSN _____

APPLICANT'S NAME _____

(For child-only applications, enter the parent or legal guardian's name.)

NAME OF PERSON		# OR LTR	DESCRIPTION, i.e. SYMPTOMS DIAGNOSIS, CONDITION, ILLNESS	TYPES OF TREATMENT, TESTING, MONITORING, SURGERY, OR MEDICATION	NAME AND ADDRESS OF PAST & PRESENT PHYSICIANS, HOSPITALS, ETC.
NAME					
ONSET DATE (MM/YY) /	END DATE (MM/YY) /				
NAME					
ONSET DATE (MM/YY) /	END DATE (MM/YY) /				
NAME					
ONSET DATE (MM/YY) /	END DATE (MM/YY) /				
NAME					
ONSET DATE (MM/YY) /	END DATE (MM/YY) /				

7 IN THE PAST TEN (10) YEARS HAS ANY APPLICANT BEEN ARRESTED OR CONVICTED FOR DUI / DWI? YES NO {IF "YES," PLEASE PROVIDE DETAILS BELOW}

NAME	HOW MANY TIMES	WHAT STATES	DATES

8 Has any applicant **EVER** been aware of, evaluated, advised, tested (other than routine screenings), diagnosed or treated for cancer or malignant neoplasms (e.g. tumors, leukemia, Hodgkin's or melanoma)? YES NO

9 Has any applicant **EVER** been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions or tested positive for the presence of antibodies to the AIDS virus (HIV)? YES NO

If the answer is "Yes" to questions 8 and/or 9, please provide full details below, including the onset and ending dates. Use extra paper if needed.

NAME OF PERSON		DESCRIPTION, i.e. SYMPTOMS DIAGNOSIS, CONDITION, ILLNESS	TYPES OF TREATMENT, TESTING, MONITORING, SURGERY, OR MEDICATION	NAME AND ADDRESS OF PAST & PRESENT PHYSICIANS, HOSPITALS, ETC.
NAME				
ONSET DATE (MM/YY) /	END DATE (MM/YY) /			
NAME OF PERSON		DESCRIPTION, i.e. SYMPTOMS DIAGNOSIS, CONDITION, ILLNESS	TYPES OF TREATMENT, TESTING, MONITORING, SURGERY, OR MEDICATION	NAME AND ADDRESS OF PAST & PRESENT PHYSICIANS, HOSPITALS, ETC.
NAME				
ONSET DATE (MM/YY) /	END DATE (MM/YY) /			

10 Please list all medications being taken (regularly or as needed). Use extra paper if needed. Fill in this oval if no medications are being taken by any applicant:

NAME OF PERSON	NAME OF DRUG	REASON FOR TAKING	DATE OF LAST REFILL (MM/YY)



APPLICANT'S SSN _____

APPLICANT'S NAME _____

(For child-only applications, enter the parent or legal guardian's name.)

11. Is any male or female applicant currently expecting a child? YES NO (If yes, the applicant(s) expecting a child are not eligible for coverage at this time.)

12. Females only: All females age 13 or older listed on this application must complete this section.

List Female	Do you menstruate? <input type="radio"/> YES <input type="radio"/> NO	If yes: Have you had a menstrual period in the last 30 days? <input type="radio"/> YES <input type="radio"/> NO	Please provide dates that your last 3 periods began MM/DD/YY			If you do not menstruate, please explain.
			#1 Most Recent	#2	#3	
1.	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	/ /	/ /	/ /	
2.	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	/ /	/ /	/ /	
3.	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	/ /	/ /	/ /	

Important: If any menstruating females listed on this application miss a menstrual period after this application has been submitted, it is considered to be a change in health status and must be reported to Medical Risk Assessment.

IF ANY PART OF QUESTIONS 1-12 IS NOT COMPLETED, THIS APPLICATION WILL BE RETURNED TO THE APPLICANT, RESULTING IN PROCESSING DELAYS.

13. Have you or any member of your family ever had Blue Cross Blue Shield of Arizona insurance before? YES NO

NAME	CITY AND STATE	PREVIOUS ID NUMBER	FROM (YEAR) TO (YEAR)
NAME	CITY AND STATE	PREVIOUS ID NUMBER	FROM (YEAR) TO (YEAR)

14. Is any applicant currently receiving any type of physical or mental disability insurance benefits? YES NO

NAME	NATURE OF DISABILITY (IF APPLICABLE, SPECIFY PART OF BODY AFFECTED)	% DISABILITY
NAME	NATURE OF DISABILITY (IF APPLICABLE, SPECIFY PART OF BODY AFFECTED)	% DISABILITY

15. Has any application for a policy of life or health insurance on any applicant ever been declined, postponed, modified or required an extra premium? YES NO

NAME	TYPE OF INSURANCE	DATE / /	INSURANCE COMPANY	REASON
NAME	TYPE OF INSURANCE	DATE / /	INSURANCE COMPANY	REASON

16. **IF APPLYING FOR BlueSelect:** Do any dependents (including those attending school) listed on this application live in a county that is different that the one indicated for the contract holder? If yes, list dependent's name and county of residence below.

NAME	COUNTY

17. Are any dependents listed on this application full time students age 19-25? If yes, list below. (Please note that children over age 19 who are not students are not eligible for coverage on BluePreferred or BlueClassic as dependents.)

NAME	SCHOOL NAME	CITY AND STATE	EXPECTED DATE OF GRADUATION
			/ /
			/ /

18. Is contract holder or any dependents listed on this application eligible for Medicare benefits? YES NO If yes, that person is not eligible for this coverage.

Name(s) of person(s) receiving Medicare _____

19. Will this coverage for which you are applying replace any other coverage you have?

NO YES – Temporary Coverage (E.G. Option One) YES – Other (Specify): _____

If this coverage will replace current BCBSAZ group or any current coverage from another Blue Cross Blue Shield plan, you may be eligible for conversion coverage. Conversion coverage does not require medical underwriting, but is has higher premiums and different benefits from your previous coverage. If you are interested in such coverage, please contact your current Plan or BCBSAZ for more details.

20. If your insurance is expiring, what is the expiration date? (Mo/ Day/ Year) ____/____/____

IMPORTANT: UNTIL THIS APPLICATION IS APPROVED, DO NOT CANCEL ANY INSURANCE YOU MAY HAVE. SIGNATURES REQUIRED ON NEXT PAGE.



APPLICANT'S SSN _____

APPLICANT'S NAME _____

(For child-only applications, enter the parent or legal guardian's name.)

**PLEASE READ CAREFULLY. UPON ACCEPTANCE,
THIS APPLICATION BECOMES PART OF YOUR CONTRACT
ACKNOWLEDGMENT AND AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

- A. I have carefully read all of this application and understand its terms and conditions. On behalf of myself and the persons listed on this application, I hereby apply for enrollment subject to all of its terms and conditions. I also understand that, if accepted for coverage, this application becomes part of my contract with Blue Cross Blue Shield of Arizona (BCBSAZ), and, if applicable, with CPIC Life Insurance Company (CPIC Life).
- B. I acknowledge and agree that coverage shall become effective only when a) this application has been accepted by BCBSAZ and/or CPIC Life, after its review of the health history I have furnished, and b) a contract has been issued by BCBSAZ and/or CPIC Life. Such contract, if issued, shall have an effective date assigned by the Corporation and its coverage shall be subject to its own waiting periods, limitations, medical waivers and other provisions, regardless of any prior coverage.
- C. I acknowledge that the information I have provided on this application is material to the medical underwriting process and that BCBSAZ will rely on the accuracy of such information to make a determination about each applicant's eligibility for coverage.

I represent that, to the best of my knowledge, the information provided on this application is complete and accurate. I understand that if I have misstated or omitted any information on this application, any contract issued covering me and my dependents may be rescinded, that is, declared null and void as of the effective date of coverage, and that such misstatement or omission may subject me to criminal or civil penalties. I also understand that failure to cooperate with an investigation concerning information disclosed or omitted on this application will result in rescission of the contract.

I understand and acknowledge that I alone am responsible for any information stated or omitted on this application, regardless of whether any other person advised me or assisted me in filling out this application, or if they filled out some or all of the application for me.

I further understand that, in the event of rescission, BCBSAZ will seek reimbursement for claims or expenses paid on my behalf and/or on behalf of my dependents. The amount of the paid claims or expenses will be deducted from the premium refund due to me, if any. If the amount of paid claims or expenses exceed the premiums paid, BCBSAZ will seek payment from me for the difference. I understand I may be responsible to pay reasonable attorney's fees and court costs BCBSAZ may incur in collecting amounts due under this contract.
- D. BCBSAZ, CPIC Life, its reinsurers, and their authorized representatives may obtain medical information in order to evaluate this application. Any cost for obtaining medical records is the responsibility of the applicant. Personal information may be collected from someone other than myself, or one of the proposed covered persons.
- E. Upon being presented this authorization, any physician, practitioner, hospital, clinic, other medical or medically-related facility, the Veteran's Administration, or any other government-supported facility, who possesses information about care, treatment, or advice about me shall furnish information to BCBSAZ, CPIC Life, or its reinsurers, or its authorized representatives. This authorization includes information about drugs, alcoholism and mental illness. This authorization also permits the release of confidential HIV-related information, genetic-related information, and information derived from genetic testing, including the test results.
- F. For purposes of collecting information as to this application or reinstating or revising the contract, this authorization will continue for 30 months. For collection as to claims or expenses, this authorization will continue for the term of the contract. I have a right to access and make corrections to personal information collected by BCBSAZ.
- G. BCBSAZ will not disclose confidential information from my file to third parties without my specific written consent, except as permitted by applicable law in certain limited circumstances. A more detailed notice and the general business circumstances which may require disclosure without prior authorization are available upon my request to BCBSAZ.

If you are applying for child-only coverage:

On behalf of the named child(ren), I hereby apply for enrollment subject to all of the contract terms and conditions. I understand that if this application is accepted by BCBSAZ and/or CPIC Life, I will be the contract holder on behalf of the child(ren) named on this application. I also understand that this application becomes part of any contract issued by BCBSAZ and/or CPIC Life on behalf of the named child(ren). I further understand that, in the event of rescission, BCBSAZ will seek reimbursement from the contract holder for claims paid on behalf of the child(ren).

BCBSAZ will not disclose confidential information from the child's file without the contract holder's specific written consent, or when applicable, the consent of the child(ren), except as permitted by applicable law. I understand that both parents are entitled to have equal access to medical and other records of a child directly from the custodian of the records, unless otherwise provided by court order or law, and a copy of such court order or law has been provided to BCBSAZ (A.R.S. § 25-403, 25-408).

APPLICANT SIGNATURES	All persons named on this application age 18 and older MUST sign and date, acknowledging their understanding of and their agreement to the conditions listed above. A copy of the Acknowledgement and Authorization To Obtain And Disclose Information is available to you or your authorized representative upon request.																						
	Individual/Family Coverage:	Child-only Coverage:																					
	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)																					
X _____ Contract holder	<table border="1" style="width: 100px; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											X _____ Parent or legal guardian designated as contract holder	<table border="1" style="width: 100px; height: 20px;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>										
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		*Co-parents or legal guardians who want authority to make changes to the child's contract must sign the application.																					

Note: This application must be received by BCBSAZ within 15 days from the date of applicant's signature(s) and will become VOID 90 days from that date, requiring submission of a new, updated application.



APPLICANT'S SSN _____

APPLICANT'S NAME _____

(For child-only applications, enter the parent or legal guardian's name.)

Before you mail this application, please check the following:

- If you selected BlueSelect coverage, did each person named on the application provide a Personal Physician I.D. Number on the first page? (This information is not applicable to BluePreferred or BlueClassic.)
- Did all persons named on this application (*age 18 and older*) sign and date application above? (If applying for child-only coverage, did the parent(s) or legal guardian(s) sign and date application above?)
- Important:** Have all questions been answered? If not, the application will be returned to applicant, resulting in processing delays.
- If you indicated you would like to make your monthly payment with Sure Pay (*electronic bank draft*), then be sure to fill out the separate Sure Pay application. Don't forget to attach a voided check.
- Did you attach the \$20.00 application fee payable to Blue Cross Blue Shield of Arizona? (Please note: If you are applying for child-only coverage, or if you are a current BCBSAZ customer and you are applying for coverage change, adding a dependent or lowering your deductible, the \$20 application fee is not necessary.)
- Please return this application to:

BROKER ADDRESS

Thank you for choosing Blue Cross Blue Shield of Arizona

ATTACH CHECK HERE