Independence Blue Cross

INDIVIDUAL COVERAGE PERSONAL CHOICE APPLICATION FORM

PLEASE TYPE OR PRINT BOLD

Personal CHOICE®

1. ENROLLMENT INFORMATION

FOR OFFICE USE ONLY		
IDENT. No.		
GR NO	TR DT	REAS
BC EFF	PR ST	ORIG
BS EFF	TC	

Last Name First Name MI

Street Address

City State Zip Code

HOME PHONE: ( ) - If current member, please provide Identification Number:

2. COVERAGE INFORMATION

Please check the coverage you want: ☐ Personal Choice High Option ☐ Personal Choice Standard Option

3. PERSONS TO BE COVERED

Please complete the following information regarding yourself and dependents to be covered. Dependents include your spouse, dependent children (under age 19) and eligible handicapped children over age 19. **Attach a separate list for additional dependents, if needed.**

NAME (include last name if different from applicant) Last First MI	SEX	DATE OF BIRTH Mo.	Day	Yr.	SOCIAL SECURITY NUMBER	HANDICAPPED Children (Over Age 19)
Self	☐ M ☐ F					N/A
Spouse	☐ M ☐ F					N/A
	☐ M ☐ F					
	☐ M ☐ F					
	☐ M ☐ F					

Please answer the questions below:

A. Do any of the persons listed above have health insurance with a Blue Cross®, or any other insurance company? ☐ Yes ☐ No

If YES, do you wish to replace this coverage with Independence Blue Cross?
(Please see reverse side Section 1) ☐ Yes ☐ No

If NO, do you understand that the Company will not pay benefits during the first 12 months of the policy for any medical condition or illness for which medical advice or treatment was recommended or received within the 12 month period preceding the effective date of coverage? ☐ Yes ☐ No

B. Do any of the persons listed above have any other health insurance? ☐ Yes ☐ No

If you answered Yes to questions A or B above, please provide:

Name of Insured | Name of Plan | Location of Plan (City, State) | Identification or Policy No.

Please indicate if you or your spouse are enrolled in Medicare Part A or Part B:

	PART A	EFFECTIVE DATE	PART B	EFFECTIVE DATE	MEDICARE CLAIM NUMBER
SELF	☐ Yes ☐ No	- -	☐ Yes ☐ No	- -	
SPOUSE	☐ Yes ☐ No	- -	☐ Yes ☐ No	- -	

4. PRIOR INSURER

☐ No Prior Insurance ☐ Horizon Blue Cross ☐ Travelers ☐ Oxford ☐ Aetna ☐ CIGNA ☐ Prudential ☐ Greater Atlantic ☐ Other

5. IMPORTANT! READ THE REVERSE SIDE OF THIS FORM, BEFORE SIGNING AND DATING BELOW:

The information supplied on the application is accurate and complete to the best of my knowledge and I have read and agree to the terms set forth on the reverse side of this form.

Sign Here → SIGNATURE OF APPLICANT: DATE:

IMPORTANT --- Please read carefully

6. NOTICE OF PRE-EXISTING CONDITION(S) EXCLUSION

Independence Blue Cross will not pay benefits during the first 12 months of the policy for charges related to any medical condition or illness for which medical advice or treatment was recommended or received within a 12-month period preceding the effective date of coverage, unless you and your dependents have been enrolled in a Blue Cross, or an affiliate of Independence Blue Cross for a period of 12 months and are transferring directly without a break in coverage.

7. DECLARATION

I elect coverage under the plan specified on this application for the persons listed on the reverse side and agree to abide by the conditions of the agreement and pay required premiums for the plan as selected. I and my listed eligible dependent(s) authorize any hospital, physician, or other health care provider to furnish Independence Blue Cross, its assignee or designee, with such medical information about the applicant and dependent(s) listed on the application as Independence Blue Cross may require for claims payment, utilization review, quality assurance or in fulfillment of obligations imposed by applicable state or federal law. I understand that my coverage(s) will become effective upon the approval of my Application. I understand and agree that: (1) the agreement may contain(s) certain waiting periods; (2) the agreement(s) shall be binding on Independence Blue Cross only if all of my statement(s) are complete and true.

8. NOTICE REGARDING FRAUDULENT INFORMATION

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.

9. CONDITIONS OF ENROLLMENT

- I understand that if I and my dependents receive care from Non-Network Providers (Non-Participating Health Care Facilities and Non-Participating Professional Providers), except for emergencies, I will be responsible for higher Non-Network deductibles and coinsurance, and in some cases, the entire cost of the care.

10. SUBSCRIBER INFORMATION

- ***PLEASE NOTE:*** Most elective admissions require Pre-Admission Certification. Services that are rendered by Non-Network Providers are subject to deductible and coinsurance provisions. See your contract for details about your coverage, its limitations and exclusions, or call Personal Choice Customer Service at **1-215-557-7577 or 1-800-626-8144** (for calls outside the local area). Inquiries about your coverage should include your name, identification number, group number and home address.

11. PLEASE NOTE

If you must provide coverage for a child not living with you due to a court order please contact us for the appropriate paperwork.

Mail to: Independence Blue Cross, attn: Direct Pay
P.O. Box 41452, Philadelphia, PA 19101-8822

Send No Money Now - *We Will Bill You Later.*

Independence Blue Cross

1901 Market Street, Philadelphia, PA 19103-1480