

Application for Membership

Thank you for selecting Regence BlueCross BlueShield of Utah or Regence HealthWise BlueSelect for your Medicare Supplement coverage. Please note you must be **age 65 or older** to be covered under these plans.

To assure prompt processing of your application, please be sure to:

1. Print your answers in either BLACK or BLUE ink in all unshaded blanks. Shaded areas are for the use of Regence BlueCross BlueShield of Utah/Regence HealthWise.
2. The Application must be complete. Be sure to **sign** and **date** where requested.
3. Detach the **10-page application** from booklet and remove page 9, Customer Copy. Fold in half and insert the completed application (all pages except Customer Copy, page 9) in the provided envelope addressed to:

Regence BlueCross BlueShield of Utah
P. O. Box 30270
Salt Lake City, Utah 84130-0270

NOTICE TO BUYER: This policy may not cover all of your medical expenses.

SECTION 1. Applicant's Information

APPLICANT (Last)	(First)	(Initial)	GROUP NUMBER	ID NUMBER ASSIGNED
Name:				
Mailing Address/Box No. (if applicable):			Social Security Number:	
City, State, ZIP			Home Phone:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate: Mo/Day/Yr / /	Medicare effective dates (from your Medicare card):		
My Medicare Insurance Number is:		PART A (Hospital) _____		
		PART B (Physician) _____		

Office Use Only	STATUS FILE SPECIAL CODE	PAY METHOD BILLING CYCLE	ADULT CODE	MEMBERSHIP STATUS	PLAN	EFFECTIVE DATE

SECTION 2. Coverage Desired:

Choose **ONE** of the seven standard plans or **ONE** of our Regence HealthWise BlueSelect® Medicare Plans.

Standard Plans:	<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan B	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D	<input type="checkbox"/> Plan E	<input type="checkbox"/> Plan F	<input type="checkbox"/> Plan G
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If you have selected one of the seven standard plans above, please proceed to Section 3.

Regence HealthWise BlueSelect® Plans:

<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan F	(Salt Lake, Weber, Davis, or Utah County only.)
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If you have selected one of the [Regence HealthWise BlueSelect Plans](#), please continue on page 2:

Section 2. Coverage Desired (continued)

If you have selected one of the **Regence HealthWise BlueSelect Plans**, please read the following:

1. An outline of coverage (Refer to the *BlueSelect* brochure);
 - a. Other Medicare Supplement plans offered by Regence BlueCross BlueShield of Utah; (See *Medicare Supplement* brochure)
 - b. Other BlueSelect plans (See *BlueSelect* brochure pages 3 – 4)
2. A Description of the Restricted Network Provisions, including:
 - a. A description (including address, phone number and hours of operation) of current hospital network providers; (See *BlueSelect* brochure pages 5 – 6)
 - b. Payments for deductibles when hospitals other than network hospitals are utilized; (See *BlueSelect* brochure page 7)
 - c. A description of coverage for emergency and urgently needed care and other out-of-service area coverage; (See *BlueSelect* brochure page 7)
 - d. Limitations on referral to restricted network hospitals; (See *BlueSelect* brochure page 7)
 - e. A description of my rights to purchase any other Medicare Supplement plan offered by Regence BlueCross BlueShield of Utah; (See *BlueSelect* brochure page 8)
 - f. A description of BlueSelect's quality assurance statement; (See *BlueSelect* brochure pages 8)
 - g. A description of BlueSelect's grievance procedure. (See *BlueSelect* brochure pages 9 –17)

SECTION 3.

Important Information

Please read and answer the following questions. (To be answered by all applicants)

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy or, if that is no longer available, a substantially equivalent policy, will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (OMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Section 3. Important Information (continued)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with the application.

PLEASE ANSWER ALL QUESTIONS

Please mark Yes or No below with an "X"

To the best of my knowledge,

- 1. a) Did you turn age 65 in the last 6 months? Yes No
b) Did you enroll in Medicare Part B in the last 6 months? Yes No
c) If yes, what is the effective date _____
- 2. Are you covered for medical assistance through the state Medicaid program?
[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.] Yes No
a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes No
b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No
- 3. a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days, for example, a Medicare Advantage plan, or a Medicare HMO or PPO, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ____/____/____ END ____/____/____
b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No
c) Was this your first time in this type of Medicare plan? Yes No
d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No
- 4. a) Do you have another Medicare supplement policy in force? Yes No
b) If so, with what company, and what plan do you have? _____
c) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No
- 5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes No
a) If so, with what company and what kind of policy? _____
b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank. START ____/____/____ END ____/____/____
- 6. Have you ever received a copy of the Regence BlueCross BlueShield of Utah Medicare Supplement Program brochure? Yes No
- 7. Have you received the Medicare Supplement Buyer's Guide? Yes No

TO BE COMPLETED BY THE AGENT

- 1. List all health insurance policies sold to this applicant which are still in force. _____

- 2. List all health insurance policies sold to this applicant in the past five years which are no longer in force. _____

If you answered "Yes" to question #4.A. and 4.C. above, and an agent is assisting you in purchasing this plan, be sure that **Section 7**. (pages 9 and 10) is completed.

SECTION 4.

Underwriting Information

Regence BlueCross BlueShield of Utah and Regence HealthWise **do not** sell Medicare Supplement plans to applicants who will be under the **age of 65** when their policies go into effect:

1. Is today's date within 6 (six) months of your Part B effective date? **Yes** **No**

If you answered "**Yes**" please proceed to **Section 5 - Certification, Authorization and Signature.**

If you answered "**No**" please continue to Question 2.

2. Are you on Medicare for the disabled, and is today's date within 6 (six) months of your 65th birthday? **Yes** **No**

If "**Yes**" **proceed to Section 5 - Certification, Authorization and Signature.**

If "**No**" **YOU MUST COMPLETE QUESTIONS 3-8 BELOW.**

3. In the space provided below, please list any prescription drugs and the dosage you have been requested to take, you are currently taking, and/or you have taken during the last year. If "none" write "none." (Use additional sheet if necessary.)

Name of Drug	Condition Being Treated	Date of Onset

4. In the last **five years** have you been diagnosed, treated (including prescription drugs and/or injections), or seen by a physician for any of the following: (**Please check all that apply**)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Blood Related Disorders including AIDS/HIV | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Neurological Disorders including Alzheimer's, Dementia, Parkinson's, Sclerosis, and Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease/Renal Failure | <input type="checkbox"/> Major Intestinal Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disorders including Cirrhosis, and Hepatitis | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Heart Disease | | <input type="checkbox"/> Muscular Disorders including Rheumatoid Arthritis and Dystrophies | |

5. If you checked any of the conditions above or answered yes to any of the questions, please provide the following information:

Diagnosis	Treatment	Date of Onset

6. Are you currently using or have you been advised to use oxygen? **Yes** **No**

7. Do you have any condition for which your doctor has advised confinement in a nursing home or hospital within the next 12 months? **Yes** **No**

8. Do you have any condition for which your doctor has advised future treatment or surgery? **Yes** **No**
 If you answered "**Yes**" what was advised? _____

SECTION 5.

Certification, Authorization and Signature

Be sure to sign and date the application at the end of this section. Signature applies to “Certification of Completeness and Correctness,” “Regence HealthWise BlueSelect Plan Acknowledgement” and “Medicare Supplement Authorization for my Protected Health Information:”

CERTIFICATION OF COMPLETION AND CORRECTNESS

I, the undersigned, hereby make application for membership in Regence BlueCross BlueShield of Utah or Regence HealthWise, 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.

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.

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.

REGENCE HEALTHWISE BLUESELECT PLAN ACKNOWLEDGEMENT (if applicable)

I acknowledge I have received and understand information regarding restrictions and limitations, which apply to the Regence HealthWise BlueSelect® Plans.

MEDICARE SUPPLEMENT AUTHORIZATION FOR MY PROTECTED HEALTH INFORMATION

I authorize any physician, health-care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Regence or its representatives my health information (excluding health

information relating to alcohol or chemical dependency, mental treatment, genetic testing, HIV treatment, or sexually transmitted diseases). I 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).

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

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

NAME OF APPLICANT

(Please Print): _____

SIGNATURE*: _____ **DATE:** ___/___/___

* If signed by a Personal Representative of the member/enrollee, please complete the following:

✓ Personal Representative’s Name: _____

✓ Relationship to Individual:
 Legal Guardian** Holder of Power of Attorney**

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

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.

Agent/Agency Agreement (If applicable)

(To be completed by Insurance Agent when applicable. **In order to receive proper credit for business written and policy communications, please complete all applicable areas.**)

Agent/Agency Name _____

Producer Name _____

Business Address _____

City, State, Zip _____

Telephone Number _____

Tax ID No. _____

Regence BCBSU Agent No. _____

Utah Lic. No. _____

FBL Membership No. (if applicable) _____

FBL Producer No. (if applicable) _____

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/Regence HealthWise (Regence BCBSU/Regence HW), or (2) waive any of the terms or conditions of the contract.
- D. I have no authority to assign effective dates or to affect membership changes.
- E. If the attached application is accepted, subsequent termination of the resulting contract will terminate this Agent/Agency Agreement.
- F. I have been appointed by Regence BlueCross BlueShield of Utah/Regence HealthWise or its subsidiaries.
- G. If you have sold prior health insurance to this applicant, please complete the "to be completed by the agent" in section 3.

Signature of Agent/Producer _____ Date of Signature _____

THIS SECTION IS TO BE COMPLETED BY REGENE BLUECROSS BLUESHIELD OF UTAH

Effective Date _____ Contract No. _____

Group No. _____

SECTION 6.**Billing Options** (choose **ONE** option)**SUREPAY** **Monthly Checking Account Deduction**

- Complete the “SUREPAY Authorization Form” on **page 8**

 Monthly Savings Account Deduction

- Please see “**Special Note**” below
- Complete the “SUREPAY Authorization Form” on **page 8**

QUARTERLY BILL **Every 3 Months****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 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 or Regence HealthWise health insurance, the premiums will be deducted automatically from your account on or about the 5th day of the month.

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. COMPLETE**, date and sign the SUREPAY Authorization Form.
- 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. 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 **voided** 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).

Attach **voided** check for checking account or **voided** deposit slip for savings account.

Name O. Person 12345 Street City, State 88888	24-242 2424	813
Pay to the Order of _____	Date _____	\$ <input type="text"/>
First Bank of Cash 2222 Commerce City, State 88888		Dollars
Memo _____		
: 123123123 : 12 31231 2		

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 whenever you change your address. We need your current address to notify you of rate, policy or procedure changes, and claims information.

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 or Regence HealthWise, 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)

CUSTOMER COPY

SECTION 7.

Notice to Applicant

Regarding Replacement of Medicare Supplement Insurance — Customer Copy

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage plan and replace it with a policy to be issued by **Regence BlueCross BlueShield of Utah or Regence HealthWise** (Independent Licensees of the Blue Cross and Blue Shield Association). Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep this policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage.

You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, PRODUCER (AGENT OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason. **Check one:**

- Additional benefits
- Fewer benefits and lower premiums
- No change in benefits, but lower premiums
- My plan has outpatient prescription coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- Other (please specify) _____

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If 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 application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Printed Name and Address of Issuer, Producer (Agent or other Representative) (if applicable)

Signature of Producer (Agent or other Representative)

Date

I, the Producer (Agent or other Representative), have given a copy of this section to the applicant.

Signature of Applicant

Date

Customer Copy

Please keep page 9 for your personal records. Complete and return all remaining pages in provided postage paid envelope for Regence BlueCross BlueShield of Utah.

Thank you.

OFFICE COPY

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Signature of Applicant

Date

Office Copy

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