

Application for Blue Shield Individual and Family Health Plans



Blue Shield of California and Blue Shield of California Life & Health Insurance Company

APPLICATION MUST BE COMPLETED IN BLUE OR BLACK INK. Please make sure you answer all questions as completely and accurately as possible and include first month's premium to avoid a delay in processing or possible return of the application. Submit ALL pages, 1 through 26, as your complete application including any other supporting documentation to Blue Shield Attn: I&M -Applications, PO Box 3008, Lodi, CA 95241-9969 or fax: (888) 386-3420. Call Blue Shield at **(800) 431-2809**, or contact your agent for help filling out the application.

(PRODUCER USE ONLY)

MARKET CODE

Please print using BLOCK CAPITAL LETTERS. Boxes should be marked as follows:

Reason for application: New enrollment Plan transfer Add family member to existing coverage

Part 1 – Primary applicant information –

Indicating the younger spouse/domestic partner as the primary applicant may reduce your monthly dues/premiums. You are eligible to apply for a Blue Shield individual and family health plan if you are: a California resident, under the age of 65 and not eligible for Medicare.

Applicant's Social Security number _____ First name _____ MI _____
Last name _____

Male Married: Yes No Date of birth (month/day/year) _____ Height (ft. in.)** _____ Weight (lbs.)** _____
 Female Domestic partner: Yes No _____/_____/_____

Applicant's business phone () _____ Applicant's home phone () _____ Applicant's email address: _____
Applicant's fax No. () _____ Applicant's cell phone () _____

If a current Blue Shield member, provide Subscriber number: _____

Home address (no P.O. Box) _____ Apt. No. _____
City _____ State _____ ZIP code _____

Billing address (if different from above) _____ Apt. No. _____
City _____ State _____ ZIP code _____

Mailing address (if different from home address) _____ Apt. No. _____
City _____ State _____ ZIP code _____

Applicant's occupation** _____ Applicant's employer's ZIP code _____

Spouse/domestic partner's occupation** _____ Spouse/domestic partner's employer's ZIP code _____

List other name(s) used in past _____

Health Plan option (check one box only):

Active Start: <input type="checkbox"/> Plan 25* <input type="checkbox"/> Plan 25 Generic Rx* <input type="checkbox"/> Plan 35* <input type="checkbox"/> Plan 35 Generic Rx*	Essential package: <input type="checkbox"/> Plan 1750* <input type="checkbox"/> Plan 3000* <input type="checkbox"/> Plan 4500*	Shield Spectrum: <input type="checkbox"/> PPO 5000* <input type="checkbox"/> PPO 5500	Vital Shield: <input type="checkbox"/> 900* <input type="checkbox"/> 2900* Vital Shield Plus: <input type="checkbox"/> 400* <input type="checkbox"/> 400 Generic Rx* <input type="checkbox"/> 900* <input type="checkbox"/> 900 Generic Rx* <input type="checkbox"/> 2900* <input type="checkbox"/> 2900 Generic Rx*
Access+ <input type="checkbox"/> HMO package <input type="checkbox"/> Value HMO	Balance: <input type="checkbox"/> Plan 1000* <input type="checkbox"/> Plan 1700* <input type="checkbox"/> Plan 2500*	Shield Savings: <input type="checkbox"/> 1800/3600* <input type="checkbox"/> 3500* <input type="checkbox"/> 4000/8000* <input type="checkbox"/> 5200*	

HMO only (visit blueshieldca.com to find a provider, or for questions call **800-431-2809**)

Personal Physician name: _____ Provider No.: _____ Med Group/IPA No.: _____

Check if current patient Requested effective date (see Part 7(b), Item 4 for information) _____/_____/_____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

** Do not complete if applying only for a HIPAA guaranteed issue plan (see below).

C12900-RD-EXT (10/11)

Part 1 – Primary applicant information (continued):

HIPAA Guaranteed Issue Plans: Please note that HIPAA guaranteed issue plan rates may be higher than those of Blue Shield's underwritten plans. If you are applying for both HIPAA guaranteed issue coverage and an underwritten plan, complete the entire application. If you are applying for HIPAA guaranteed issue coverage only, complete Parts 1-4, 6-8 and 10-11. See Part 8 for more information.

Payment options: First month's dues by credit card (complete pages 25-26) First month's dues by check Automatic payment (complete pages 25-26)
 Monthly direct billing Quarterly direct billing

Note: First month's dues are required at time of application submission.

Have you been a resident of California for the past six months? Yes No If no, where was your last residence? _____
 If no, medical records documenting a complete physical exam by a California physician within the last six months may be required.

Indicate language preference: English Spanish Chinese Vietnamese Other: _____

Preferred method of contact (check one): Home phone Work phone Cell phone Email Standard mail Best time to contact: _____ AM PM

Check here if you have previously had coverage with Blue Shield. If prior coverage, indicate prior Blue Shield ID No., if known: _____

Part 2 – Primary applicant supplemental plan choices

You may also purchase a dental plan and/or life insurance to supplement your medical coverage. Please note: HIPAA guaranteed issue plans are not eligible for supplemental dental plan or life insurance coverage options.

Dental plan option (check one): Dental HMO Dental PPO Value Smile Specialty Duo (dental + vision package)*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809** Dental Provider No. _____
 Dental provider name: _____

Life insurance* option (check one): Applicants under the age of 1 year are not eligible for life insurance. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. Child applicants can apply for up to a \$30,000 life insurance option and spouse/domestic partner can apply for up to a \$100,000 life insurance option below.

\$10,000 (ages 1-64) \$30,000 (ages 1-64) \$60,000 (ages 19-64) \$90,000 (ages 19-49) \$100,000 (ages 19-49)

If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000/8000, and 5200)

Part 3(a) – Spouse/domestic partner dependent applicant information – If a dependent applies for a separate medical plan he/she is considered a primary applicant and is then eligible to select a life insurance plan.

Spouse Domestic Partner Sex: Male Female Social Security number _____ - _____ - _____

First name _____ MI _____

Last name _____

Date of birth (Month/Day/Year) ____/____/____ Height (ft. in.):** _____ Weight (lbs.):** _____

Is this dependent applying for the same plan as the primary applicant? Yes No If no, which plan? (check one): **Active Start Plan***: 25 25 Generic Rx 35 35 Generic Rx **Access+***: Value HMO HMO package **Essential package***: 1750 3000 4500 **Balance Plan***: 1000 1700 2500

Shield Spectrum PPO*: 5000* 5500 **Shield Savings***: 1800 3500 4000 5200 **Vital Shield***: 900 2900

Vital Shield Plus*: 400 400 Generic Rx 900 900 Generic Rx 2900 2900 Generic Rx

HMO only – visit **blueshieldca.com** to find a provider or for questions call **(800) 431-2809**. Check if current patient
 Personal Physician name: _____ Provider No.: _____ Med group/IPA No.: _____

Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200)

Dental plan option (check one): Dental HMO Dental PPO Value Smile Specialty Duo (dental + vision package)*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809**. Dental Provider No. _____
 Dental provider name: _____

Life insurance* option (check one only if applying for a separate medical plan):
 \$10,000 \$30,000 (ages 1-64) \$60,000 (ages 19-64) \$90,000 (ages 19-49) \$100,000 (ages 19-49)

If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

Beneficiary: _____ Relationship _____ Age _____ City/State _____ (%) _____

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** Do not complete if applying only for a HIPAA guaranteed issue plan.

Part 3(b) – Child dependent applicant information – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached.

<input type="checkbox"/> Son <input type="checkbox"/> Daughter		Social Security number _____-_____-_____	
First name _____			MI _____
Last name _____			
Date of birth (Month/Day/Year) ____/____/____		Height (ft. in.)**	Weight (lbs.)**
Is this dependent applying for the same plan as the primary applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, which plan? (check one): Active Start Plan* : <input type="checkbox"/> 25 <input type="checkbox"/> 25 Generic Rx <input type="checkbox"/> 35 <input type="checkbox"/> 35 Generic Rx Access+: <input type="checkbox"/> Value HMO <input type="checkbox"/> HMO package Essential package* : <input type="checkbox"/> 1750 <input type="checkbox"/> 3000 <input type="checkbox"/> 4500 Balance Plan* : <input type="checkbox"/> 1000 <input type="checkbox"/> 1700 <input type="checkbox"/> 2500 Shield Spectrum PPO: <input type="checkbox"/> 5000* <input type="checkbox"/> 5500 Shield Savings*: <input type="checkbox"/> 1800 <input type="checkbox"/> 3500 <input type="checkbox"/> 4000 <input type="checkbox"/> 5200 Vital Shield*: <input type="checkbox"/> 900 <input type="checkbox"/> 2900 Vital Shield Plus*: <input type="checkbox"/> 400 <input type="checkbox"/> 400 Generic Rx <input type="checkbox"/> 900 <input type="checkbox"/> 900 Generic Rx <input type="checkbox"/> 2900 <input type="checkbox"/> 2900 Generic Rx Consider my child for a separate plan <input type="checkbox"/>			
HMO only – visit blueshieldca.com to find a provider or for questions call (800) 431-2809 .			<input type="checkbox"/> Check if current patient
Personal Physician name:		Provider No.:	Med group/IPA No.:
Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200) <input type="checkbox"/>			
Dental plan option (check one): <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental PPO <input type="checkbox"/> Value Smile <input type="checkbox"/> Specialty Duo (dental + vision package)*			
Dental HMO only – visit blueshieldca.com to find a dental provider or for questions call (800) 431-2809 .			Dental Provider No.
Dental provider name: _____			
Life insurance* option for child applicants age 1 year or older: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000			
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.			
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____

Part 3(c) – Child dependent applicant information – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached.

<input type="checkbox"/> Son <input type="checkbox"/> Daughter		Social Security number _____-_____-_____	
First name _____			MI _____
Last name _____			
Date of birth (Month/Day/Year) ____/____/____		Height (ft. in.)**	Weight (lbs.)**
Is this dependent applying for the same plan as the primary applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, which plan? (check one): Active Start Plan* : <input type="checkbox"/> 25 <input type="checkbox"/> 25 Generic Rx <input type="checkbox"/> 35 <input type="checkbox"/> 35 Generic Rx Access+: <input type="checkbox"/> Value HMO <input type="checkbox"/> HMO package Essential package* : <input type="checkbox"/> 1750 <input type="checkbox"/> 3000 <input type="checkbox"/> 4500 Balance Plan* : <input type="checkbox"/> 1000 <input type="checkbox"/> 1700 <input type="checkbox"/> 2500 Shield Spectrum PPO: <input type="checkbox"/> 5000* <input type="checkbox"/> 5500 Shield Savings*: <input type="checkbox"/> 1800 <input type="checkbox"/> 3500 <input type="checkbox"/> 4000 <input type="checkbox"/> 5200 Vital Shield*: <input type="checkbox"/> 900 <input type="checkbox"/> 2900 Vital Shield Plus*: <input type="checkbox"/> 400 <input type="checkbox"/> 400 Generic Rx <input type="checkbox"/> 900 <input type="checkbox"/> 900 Generic Rx <input type="checkbox"/> 2900 <input type="checkbox"/> 2900 Generic Rx Consider my child for a separate plan <input type="checkbox"/>			
HMO only – visit blueshieldca.com to find a provider or for questions call (800) 431-2809 .			<input type="checkbox"/> Check if current patient
Personal Physician name:		Provider No.:	Med group/IPA No.:
Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200) <input type="checkbox"/>			
Dental plan option (check one): <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental PPO <input type="checkbox"/> Value Smile <input type="checkbox"/> Specialty Duo (dental + vision package)*			
Dental HMO only – visit blueshieldca.com to find a dental provider or for questions call (800) 431-2809 .			Dental Provider No.
Dental provider name: _____			
Life insurance* option for child applicants age 1 year or older: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000			
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.			
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____

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C12900-RD-EXT (10/11)

Part 3(d) – Child dependent applicant information – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached.

<input type="checkbox"/> Son <input type="checkbox"/> Daughter		Social Security number _____ - _____ - _____	
First name _____			MI _____
Last name _____			
Date of birth (Month/Day/Year) ____/____/____		Height (ft. in.)** _____	Weight (lbs.)** _____
Is this dependent applying for the same plan as the primary applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, which plan? (check one): Active Start Plan* : <input type="checkbox"/> 25 <input type="checkbox"/> 25 Generic Rx <input type="checkbox"/> 35 <input type="checkbox"/> 35 Generic Rx Access+: <input type="checkbox"/> Value HMO <input type="checkbox"/> HMO package Essential package* : <input type="checkbox"/> 1750 <input type="checkbox"/> 3000 <input type="checkbox"/> 4500 Balance Plan* : <input type="checkbox"/> 1000 <input type="checkbox"/> 1700 <input type="checkbox"/> 2500 Shield Spectrum PPO: <input type="checkbox"/> 5000* <input type="checkbox"/> 5500 Shield Savings*: <input type="checkbox"/> 1800 <input type="checkbox"/> 3500 <input type="checkbox"/> 4000 <input type="checkbox"/> 5200 Vital Shield*: <input type="checkbox"/> 900 <input type="checkbox"/> 2900 Vital Shield Plus*: <input type="checkbox"/> 400 <input type="checkbox"/> 400 Generic Rx <input type="checkbox"/> 900 <input type="checkbox"/> 900 Generic Rx <input type="checkbox"/> 2900 <input type="checkbox"/> 2900 Generic Rx Consider my child for a separate plan <input type="checkbox"/>			
HMO only – visit blueshieldca.com to find a provider or for questions call (800) 431-2809 .			<input type="checkbox"/> Check if current patient
Personal Physician name: _____		Provider No.: _____	Med group/IPA No.: _____
Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200) <input type="checkbox"/>			
Dental plan option (check one): <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental PPO <input type="checkbox"/> Value Smile <input type="checkbox"/> Specialty Duo (dental + vision package)*			
Dental HMO only – visit blueshieldca.com to find a dental provider or for questions call (800) 431-2809 .			Dental Provider No. _____
Dental provider name: _____			
Life insurance* option for child applicants age 1 year or older: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000			
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.			
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____

Part 3(e) – Child dependent applicant information – Dependent children must be under age 26. Life insurance is only available to the primary applicant; however, a dependent who applies for a separate medical plan is considered a primary applicant and is then eligible to select their own life insurance plan below. If more than one child dependent is applying for coverage, please attach a supplemental page providing all information listed below, your signature and date. Check here if a supplemental page is attached.

<input type="checkbox"/> Son <input type="checkbox"/> Daughter		Social Security number _____ - _____ - _____	
First name _____			MI _____
Last name _____			
Date of birth (Month/Day/Year) ____/____/____		Height (ft. in.)** _____	Weight (lbs.)** _____
Is this dependent applying for the same plan as the primary applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, which plan? (check one): Active Start Plan* : <input type="checkbox"/> 25 <input type="checkbox"/> 25 Generic Rx <input type="checkbox"/> 35 <input type="checkbox"/> 35 Generic Rx Access+: <input type="checkbox"/> Value HMO <input type="checkbox"/> HMO package Essential package* : <input type="checkbox"/> 1750 <input type="checkbox"/> 3000 <input type="checkbox"/> 4500 Balance Plan* : <input type="checkbox"/> 1000 <input type="checkbox"/> 1700 <input type="checkbox"/> 2500 Shield Spectrum PPO: <input type="checkbox"/> 5000* <input type="checkbox"/> 5500 Shield Savings*: <input type="checkbox"/> 1800 <input type="checkbox"/> 3500 <input type="checkbox"/> 4000 <input type="checkbox"/> 5200 Vital Shield*: <input type="checkbox"/> 900 <input type="checkbox"/> 2900 Vital Shield Plus*: <input type="checkbox"/> 400 <input type="checkbox"/> 400 Generic Rx <input type="checkbox"/> 900 <input type="checkbox"/> 900 Generic Rx <input type="checkbox"/> 2900 <input type="checkbox"/> 2900 Generic Rx Consider my child for a separate plan <input type="checkbox"/>			
HMO only – visit blueshieldca.com to find a provider or for questions call (800) 431-2809 .			<input type="checkbox"/> Check if current patient
Personal Physician name: _____		Provider No.: _____	Med group/IPA No.: _____
Bridge Plan* (hospital insurance indemnity rider available for Shield Savings 3500, 4000, and 5200) <input type="checkbox"/>			
Dental plan option (check one): <input type="checkbox"/> Dental HMO <input type="checkbox"/> Dental PPO <input type="checkbox"/> Value Smile <input type="checkbox"/> Specialty Duo (dental + vision package)*			
Dental HMO only – visit blueshieldca.com to find a dental provider or for questions call (800) 431-2809 .			Dental Provider No. _____
Dental provider name: _____			
Life insurance* option for child applicants age 1 year or older: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$30,000			
If you do not identify a beneficiary, and the policy is issued, benefits will be paid in accordance with the policy. The percentage indicated must total 100%.			
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____
Beneficiary: _____		Relationship _____	Age _____ City/State _____ (%) _____

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C12900-RD-EXT (10/11)

Part 4 – Prior medical coverage: must be completed.

1a. Did you or any applying family member have other health coverage (insurance) within the last 63 days? Yes No

1b. Did any applying child under age 19 have other continuous health coverage within the last 90 days? Yes No

If NO, go to question 3.

If YES, submit evidence of prior coverage, such as a certificate of creditable coverage from your previous health carrier and complete the following:

2. Name(s)	Type of coverage	Effective date	Cancel date	Health plan carrier and/or COBRA administrator
Primary applicant	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other	___/___/___	___/___/___	
Spouse/domestic partner dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other	___/___/___	___/___/___	
Child dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other	___/___/___	___/___/___	
Child dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other	___/___/___	___/___/___	
Child dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other	___/___/___	___/___/___	
Child dependent	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other	___/___/___	___/___/___	

3. If you or any applying family member currently has coverage, it will need to be cancelled if this application for coverage is approved by Blue Shield. Will you cancel your other coverage if this coverage is approved by Blue Shield? Yes No

4. If you or any applying family member are applying for a plan other than an HMO and had other health coverage within the last 63 days, submit a certificate of creditable coverage from your previous health carrier (this document is sent to you by your previous carrier and discloses when your coverage ended and how long you were covered). You can obtain a copy of your certificate of creditable coverage by contacting your previous health carrier. If this application is approved, Blue Shield will apply the individual's creditable coverage to reduce any waiting period on their pre-existing condition exclusion with this plan. The pre-existing condition exclusion does not apply to dependents under the age of 19 unless you are adding an applicant under 19 to a grandfathered plan (coverage issued prior to March 23, 2010). See the EOC /Policy booklet for more on pre-existing conditions. You can obtain a copy of the EOC /Policy by contacting Blue Shield at **(800) 431-2809**.

Part 5 – Health questionnaire

Answer all questions accurately and completely for each applicant. Blue Shield relies upon the information you provide in your application to determine whether you are eligible for coverage. While we may review your medical records in certain instances, do not assume we will review your medical records before issuing coverage. Blue Shield has the right to rescind your coverage if your answers are intentionally and materially inaccurate or incomplete. If coverage is rescinded, this means that you may lose coverage back to the original effective date. If your coverage is lawfully rescinded, Blue Shield may have the right to seek repayment from you for medical expenses that we already paid. You should be aware that we can and do review medical records in certain situations after a health services contract/policy has been issued to determine whether material facts were misrepresented or omitted on the application. It is therefore very important that you make every effort to answer all questions accurately and completely. Please note that even if you currently have coverage, or had prior coverage, with Blue Shield you must answer all questions in this health questionnaire. Your obligation to disclose medical information includes the obligation to disclose to Blue Shield any new or changed medical information arising after submission of this Application but before your enrollment date. Any failure to disclose new or changed information may result in rescission of your contract/policy, if that information would have been material to the issuance of coverage.

HIPAA Guaranteed Issue Plans: If you are applying for both HIPAA guaranteed issue coverage and an underwritten plan, complete the entire application. If you are applying for HIPAA guaranteed issue coverage only, complete parts 1-4, 6-8, and 10-11 (do not complete this Part 5). See Part 8 for more information.

Part 5(a) – Medical history

All questions must be answered. Check (✓) "Yes" or "No." Complete details of any "Yes" answer must be given in Part 5(b). **Where indicated below for questions 1 through 15, please print the first name of each individual applying for coverage.** Initial any changes/corrections you may make. If you do not understand a medical term being used, or are not sure whether you have or had a medical condition listed on this application, do not answer "No." Speak to your doctor or otherwise take steps to understand what the question means before answering. If you otherwise need help filling out the application, call Blue Shield at **(800) 431-2809**, or contact your agent. If you still aren't sure or don't recall if you have or had a listed medical condition, answer "Don't know" and then explain the answer in Part 5(b). **NOTE** – Each "Yes" or "Don't know" answer must be explained in Part 5(b) or the application will be deemed to be incomplete. If more than four child dependents are applying for coverage, please attach supplemental pages providing all information listed below for Section 5(a) and Sections 5(b), 5(c) and 5(d) if applicable, your signature and date. Check here if a supplemental page is attached.

1. In the past 10 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
Aortic or Mitral Valve Regurgitation or Stenosis, other Heart Valve condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Abnormality of the Veins or Arteries of the Brain, such as Aneurysm, AV Malformation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Acquired Immune Deficiency Syndrome (AIDS) or AIDS – Related Complex (ARC), Kaposi's Sarcoma (KS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Alzheimer's Disease or Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bi-polar Disorder, Manic Depression, Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cancer, Malignant Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Connective Tissue Disorder, Scleroderma, Systemic Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Coronary Artery Disease (CAD), Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Disorder(s) of the blood vessels or heart, Heart Enlargement, Heart Failure, Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hepatitis If yes, please specify Type (B, C, D, other?)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Joint Replacement (such as hip, knee, shoulder), Amputation, Prosthetic Limb	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Leukemia, Hodgkin's Disease, Lymphoma, Organ or bone marrow transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Stroke or Transient Ischemic Attack (TIA), Bruit, or Carotid Stenosis (narrowing or stiffness of the arteries)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

2. In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
Abnormal or Irregular Menstrual/Uterine Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Alcohol Abuse, Dependence or Addiction; Drug Use or Abuse, Dependence or Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Allergies, Asthma, Reactive Airway Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Angina, Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Anorexia, Bulimia or other eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Apnea or Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Arthritis, Osteoarthritis, Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?

	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma, other Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bleeding or Blood Disorder (except HIV test)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Birth Marks (Hemangioma)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bladder Disorder, Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bone, Ligament, Tendon, Joint Injury or Disorder, Carpal Tunnel Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bronchitis, Pneumonia, Breathing or other Lung Disorder(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cataracts, Glaucoma, Strabismus (crossed eyes), other Eye Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cerebral Palsy, Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Chronic (or recurrent) Muscle/Limb Weakness, Fatigue, or Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Chronic (or recurrent) Pain, including back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Congenital (Birth) Defect or Abnormality, Cleft Lip, Cleft Palate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Curvature of the Spine, Scoliosis, other Spine Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Depression, Anxiety, Panic Attack(s), Obsessive Compulsive Disorder (OCD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Deviated Nasal Septum, Sinusitis, Excessive Snoring or other Sinus Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Diabetes or other Endocrine (Glandular) Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Ear Infections, other Ear or Hearing Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Epilepsy, Convulsions, Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Fibrocystic Breasts, Micro-Calcifications, other Breast Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Fractures, Retained Hardware (pins, screws, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Gastric Bypass, Stapling, Banding or other weight loss surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Heartburn or Reflux (recurrent), other Digestive Tract Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Headaches or Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Heart Murmur, Palpitations, Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Herniated or Bulging Disk, Sciatica	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
High Blood Pressure (Hypertension)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
High Cholesterol and/or high Triglycerides	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hormone or Growth Hormone Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hyperactivity, Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hypothyroidism, other Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Implant(s), Prosthesis (other than breast)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Infertility, male or female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
In-vitro Fertilization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Kidney Infection, Bladder Infection, Kidney or Bladder Stones, Interstitial Cystitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Miscarriage (Spontaneous Abortion)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Multiple Sclerosis, Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Osteoporosis or Osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Ovarian Cyst(s), Polycystic Ovaries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
Phlebitis, Blood Clots, Embolism, Varicose Veins, Peripheral Artery Disease (PAD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Premature Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Prostatitis, Enlarged Prostate (BPH), other Disorder of the male Reproductive (sex) Organs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Psoriasis, Keratosis, Acne, Herpes, Shingles, other Skin Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Severe Burns	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Syphilis, Gonorrhea, Chlamydia, Genital Warts, Herpes, other Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Temporal Mandibular Joint Disorder (TMJ)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Tumor, Mass, Polyp, Cyst (other than ovarian)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Ulcerative Colitis, other Bowel or Rectal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Uterine Fibroid(s), Endometriosis, other Disorders of the Female Reproductive (sex) Organs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

3. In the past 5 years, have you:	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
(a) Been an inpatient or outpatient in a hospital, surgical center, emergency room, or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Had any kind of surgery, including biopsy, angioplasty, bypass or cosmetic/reconstructive surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Had any application for health or life insurance rescinded, declined, deferred, postponed, or restricted in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Had abnormal test results (Blood Test (except HIV test), X-Ray, CT Scan, MRI)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

4. In the past 12 months have you had, or do you currently have:	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
(a) Any illness or infection lasting more than a week, not mentioned elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) A physical injury requiring medical attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Any medical diagnosis by a licensed health practitioner, not mentioned elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5. In the past 12 months have you been advised or referred by a licensed health practitioner to have a medical exam, further testing, treatment, or surgery which has not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
6. Have you taken prescription medication(s) or been written a prescription for medication(s) in the past 12 months? If Yes or Don't know, please complete Part 5(c) below.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
7. Are you currently receiving scheduled doses of medication administered by self-injection or through IV therapy in a physician's office or hospital setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you currently receiving insurance or workers' compensation benefits due to a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

	Write in name of:		
	Primary applicant	Spouse/domestic partner	Child dependent
9. Do/did you regularly smoke cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Average number of packs per day?	_____	_____	_____
(b) How many years?	_____	_____	_____
(c) Have you stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If yes, when?	_____	_____	_____
10. Do/did you regularly drink alcoholic beverages? (one drink equals 1 oz. liquor, 4 oz. wine, or 12 oz. beer)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Average number of drinks per week?	_____	_____	_____
(b) How many years?	_____	_____	_____
(c) Have you stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If yes, when?	_____	_____	_____
11. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of alcohol or substance use (including if court ordered)? If Yes, please complete (a) and (b) below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Type?	_____	_____	_____
(b) How long?	_____	_____	_____
12. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of mental, emotional, or behavioral disorder(s)? If Yes, please complete (a) and (b) below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Type?	_____	_____	_____
(b) How long?	_____	_____	_____
13. Are you expecting a child with anyone, even if the expecting mother is not listed on the application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
14. Male and females:			
(a) Are you, or your spouse, domestic partner or dependent (whether or not listed on the application), in the process of adoption or surrogate pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Within the last 90 days have you, or your spouse, domestic partner or dependent performed a home pregnancy test, or had a pregnancy test performed at a clinic or a lab, which was positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Females only:			
(a) Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) If you are between the ages of 14-55, do you menstruate (have monthly periods)? (If no, please explain).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) If yes to (b) above, has it been more than 40 days since your last menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If you are 18 years of age or older, have you had a Pap test? (If yes, please provide date of last test & results in Part 5(b))	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) If you are 18 years of age or older, do you have breast implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type? (check one) Implant Surgery Date: _____	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

Part 5 – Health questionnaire

Answer all questions accurately and completely for each applicant. Blue Shield relies upon the information you provide in your application to determine whether you are eligible for coverage. While we may review your medical records in certain instances, do not assume we will review your medical records before issuing coverage. Blue Shield has the right to rescind your coverage if your answers are intentionally and materially inaccurate or incomplete. If coverage is rescinded, this means that you may lose coverage back to the original effective date. If your coverage is lawfully rescinded, Blue Shield may have the right to seek repayment from you for medical expenses that we already paid. You should be aware that we can and do review medical records in certain situations after a health services contract/policy has been issued to determine whether material facts were misrepresented or omitted on the application. It is therefore very important that you make every effort to answer all questions accurately and completely. Please note that even if you currently have coverage, or had prior coverage, with Blue Shield you must answer all questions in this health questionnaire. Your obligation to disclose medical information includes the obligation to disclose to Blue Shield any new or changed medical information arising after submission of this Application but before your enrollment date. Any failure to disclose new or changed information may result in rescission of your contract/policy, if that information would have been material to the issuance of coverage.

HIPAA Guaranteed Issue Plans: If you are applying for both HIPAA guaranteed issue coverage and an underwritten plan, complete the entire application. If you are applying for HIPAA guaranteed issue coverage only, complete parts 1-4, 6-8, and 10-11 (do not complete this Part 5). See Part 8 for more information.

Part 5(a) – Medical history

All questions must be answered. Check (✓) "Yes" or "No." Complete details of any "Yes" answer must be given in Part 5(b). **Where indicated below for questions 1 through 15, please print the first name of each individual applying for coverage.** Initial any changes/corrections you may make. If you do not understand a medical term being used, or are not sure whether you have or had a medical condition listed on this application, do not answer "No." Speak to your doctor or otherwise take steps to understand what the question means before answering. If you otherwise need help filling out the application, call Blue Shield at (800) 431-2809, or contact your agent. If you still aren't sure or don't recall if you have or had a listed medical condition, answer "Don't know" and then explain the answer in Part 5(b).

NOTE – Each "Yes" or "Don't know" answer must be explained in Part 5(b) or the application will be deemed to be incomplete. If more than four child dependents are applying for coverage, please attach supplemental pages providing all information listed below for Section 5(a) and Sections 5(b), 5(c) and 5(d) if applicable, your signature and date. Check here if a supplemental page is attached.

1. In the past 10 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Child dependent	Child dependent	Child dependent
Aortic or Mitral Valve Regurgitation or Stenosis, other Heart Valve condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Abnormality of the Veins or Arteries of the Brain, such as Aneurysm, AV Malformation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Acquired Immune Deficiency Syndrome (AIDS) or AIDS – Related Complex (ARC), Kaposi's Sarcoma (KS)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Alzheimer's Disease or Dementia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bi-polar Disorder, Manic Depression, Schizophrenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cancer, Malignant Tumor	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Connective Tissue Disorder, Scleroderma, Systemic Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Coronary Artery Disease (CAD), Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Disorder(s) of the blood vessels or heart, Heart Enlargement, Heart Failure, Heart Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hepatitis If yes, please specify Type (B, C, D, other?)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Joint Replacement (such as hip, knee, shoulder), Amputation, Prosthetic Limb	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Leukemia, Hodgkin's Disease, Lymphoma, Organ or bone marrow transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Stroke or Transient Ischemic Attack (TIA), Bruit, or Carotid Stenosis (narrowing or stiffness of the arteries)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
2. In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Child dependent	Child dependent	Child dependent
Abnormal or Irregular Menstrual/Uterine Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Alcohol Abuse, Dependence or Addiction; Drug Use or Abuse, Dependence or Addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Allergies, Asthma, Reactive Airway Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Angina, Chest pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Anorexia, Bulimia or other eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Apnea or Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Arthritis, Osteoarthritis, Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?

	Write in name of:		
	Child dependent	Child dependent	Child dependent
Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma, other Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bleeding or Blood Disorder (except HIV test)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Birth Marks (Hemangioma)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bladder Disorder, Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bone, Ligament, Tendon, Joint Injury or Disorder, Carpal Tunnel Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Bronchitis, Pneumonia, Breathing or other Lung Disorder(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cataracts, Glaucoma, Strabismus (crossed eyes), other Eye Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cerebral Palsy, Parkinson's	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Chronic (or recurrent) Muscle/Limb Weakness, Fatigue, or Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Chronic (or recurrent) Pain, including back pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Congenital (Birth) Defect or Abnormality, Cleft Lip, Cleft Palate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Crohn's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Curvature of the Spine, Scoliosis, other Spine Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Depression, Anxiety, Panic Attack(s), Obsessive Compulsive Disorder (OCD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Deviated Nasal Septum, Sinusitis, Excessive Snoring or other Sinus Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Diabetes or other Endocrine (Glandular) Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Ear Infections, other Ear or Hearing Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Epilepsy, Convulsions, Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Fibrocystic Breasts, Micro-Calcifications, other Breast Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Fractures, Retained Hardware (pins, screws, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Gastric Bypass, Stapling, Banding or other weight loss surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Heartburn or Reflux (recurrent), other Digestive Tract Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Headaches or Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Heart Murmur, Palpitations, Irregular Heart Beat	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Herniated or Bulging Disk, Sciatica	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
High Blood Pressure (Hypertension)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
High Cholesterol and/or high Triglycerides	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hormone or Growth Hormone Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hyperactivity, Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Hypothyroidism, other Thyroid Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Implant(s), Prosthesis (other than breast)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Infertility, male or female	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
In-vitro Fertilization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Kidney Infection, Bladder Infection, Kidney or Bladder Stones, Interstitial Cystitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Miscarriage (Spontaneous Abortion)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Multiple Sclerosis, Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Osteoporosis or Osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Ovarian Cyst(s), Polycystic Ovaries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

2. (continued) In the past 5 years, have you been diagnosed with or sought or received any professional consultation or treatment (including prescription medications) from a licensed health practitioner for any of the following?	Write in name of:		
	Child dependent	Child dependent	Child dependent
Phlebitis, Blood Clots, Embolism, Varicose Veins, Peripheral Artery Disease (PAD)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Premature Birth	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Prostatitis, Enlarged Prostate (BPH), other Disorder of the male Reproductive (sex) Organs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Psoriasis, Keratosis, Acne, Herpes, Shingles, other Skin Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Severe Burns	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Syphilis, Gonorrhea, Chlamydia, Genital Warts, Herpes, other Sexually Transmitted Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Temporal Mandibular Joint Disorder (TMJ)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Tumor, Mass, Polyp, Cyst (other than ovarian)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Ulcerative Colitis, other Bowel or Rectal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Uterine Fibroid(s), Endometriosis, other Disorders of the Female Reproductive (sex) Organs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

3. In the past 5 years, have you:	Write in name of:		
	Child dependent	Child dependent	Child dependent
(a) Been an inpatient or outpatient in a hospital, surgical center, emergency room, or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) Had any kind of surgery, including biopsy, angioplasty, bypass or cosmetic/reconstructive surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Had any application for health or life insurance rescinded, declined, deferred, postponed, or restricted in any way?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(d) Had abnormal test results (Blood Test (except HIV test), X-Ray, CT Scan, MRI)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

4. In the past 12 months have you had, or do you currently have:	Write in name of:		
	Child dependent	Child dependent	Child dependent
(a) Any illness or infection lasting more than a week, not mentioned elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) A physical injury requiring medical attention?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(c) Any medical diagnosis by a licensed health practitioner, not mentioned elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
5. In the past 12 months have you been advised or referred by a licensed health practitioner to have a medical exam, further testing, treatment, or surgery which has not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
6. Have you taken prescription medication(s) or been written a prescription for medication(s) in the past 12 months? If Yes or Don't know, please complete Part 5(c) below.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
7. Are you currently receiving scheduled doses of medication administered by self-injection or through IV therapy in a physician's office or hospital setting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you currently receiving insurance or workers' compensation benefits due to a disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

	Write in name of:		
	Child dependent	Child dependent	Child dependent
9. Do/did you regularly smoke cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Average number of packs per day?	_____	_____	_____
(b) How many years?	_____	_____	_____
(c) Have you stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If yes, when?	_____	_____	_____
10. Do/did you regularly drink alcoholic beverages? (one drink equals 1 oz. liquor, 4 oz. wine, or 12 oz. beer)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Average number of drinks per week?	_____	_____	_____
(b) How many years?	_____	_____	_____
(c) Have you stopped?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If yes, when?	_____	_____	_____
11. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of alcohol or substance use (including if court ordered)? If Yes, please complete (a) and (b) below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Type?	_____	_____	_____
(b) How long?	_____	_____	_____
12. In the past 12 months have you been, or are you presently, a member of a therapy, counseling, or support group for history of mental, emotional, or behavioral disorder(s)? If Yes, please complete (a) and (b) below.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) Type?	_____	_____	_____
(b) How long?	_____	_____	_____
13. Are you expecting a child with anyone, even if the expecting mother is not listed on the application?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
14. Male and females:			
(a) Are you, or your spouse, domestic partner or dependent (whether or not listed on the application), in the process of adoption or surrogate pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Within the last 90 days have you, or your spouse, domestic partner or dependent performed a home pregnancy test, or had a pregnancy test performed at a clinic or a lab, which was positive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Females only:			
(a) Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
(b) If you are between the ages of 14-55, do you menstruate (have monthly periods)? (If no, please explain).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(c) If yes to (b) above, has it been more than 40 days since your last menstrual period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(d) If you are 18 years of age or older, have you had a Pap test? (If yes, please provide date of last test & results in Part 5(b))	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
(e) If you are 18 years of age or older, do you have breast implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what type? (check one) Implant Surgery Date: _____	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline	<input type="checkbox"/> Silicone <input type="checkbox"/> Saline

Please provide complete details of any "Yes" or "Don't Know" answer in Part 5(b).

Part 5(b) – Medical history and condition details

If you or any family member applying for coverage answered Yes or Don't Know to any question in Part 5(a), please provide complete details below. If you do not recall dates, specify "unknown." If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached.

Name

List Part 5(a) question number: _____

If you answered "Don't Know", please explain:

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: ____/____ (month/year) Ended: ____/____ (month/year)
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Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?
------------------------------------------------------------------------------------------	-----------------

Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
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Other comments/details:

Full name of physician, clinic or hospital:	Specialty:
---------------------------------------------	------------

Phone number: ()	Medical group (if applicable):
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Address:	Suite
City	State ZIP code

Name

List Part 5(a) question number: _____

If you answered "Don't Know", please explain:

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: ____/____ (month/year) Ended: ____/____ (month/year)
------------------------------	------------	---------------------------------------------------------------------------------------

Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?
------------------------------------------------------------------------------------------	-----------------

Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
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Other comments/details:

Full name of physician, clinic or hospital:	Specialty:
---------------------------------------------	------------

Phone number: ()	Medical group (if applicable):
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Address:	Suite
City	State ZIP code

Name

List Part 5(a) question number: _____

If you answered "Don't Know", please explain:

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: ____/____ (month/year) Ended: ____/____ (month/year)
------------------------------	------------	---------------------------------------------------------------------------------------

Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?
------------------------------------------------------------------------------------------	-----------------

Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
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Other comments/details:

Full name of physician, clinic or hospital:	Specialty:
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Phone number: ()	Medical group (if applicable):
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Address:	Suite
City	State ZIP code

Part 5(b) – Medical history and condition details

If you or any family member applying for coverage answered Yes or Don't Know to any question in Part 5(a), please provide complete details below. If you do not recall dates, specify "unknown." If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached.

Name

List Part 5(a) question number: _____

If you answered "Don't Know", please explain:

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: ____/____ (month/year) Ended: ____/____ (month/year)
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Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?
------------------------------------------------------------------------------------------	-----------------

Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
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Other comments/details:

Full name of physician, clinic or hospital:	Specialty:
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Phone number: ()	Medical group (if applicable):
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Address:	Suite
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City	State	ZIP code
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Name

List Part 5(a) question number: _____

If you answered "Don't Know", please explain:

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: ____/____ (month/year) Ended: ____/____ (month/year)
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Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?
------------------------------------------------------------------------------------------	-----------------

Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
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Other comments/details:

Full name of physician, clinic or hospital:	Specialty:
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Phone number: ()	Medical group (if applicable):
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Address:	Suite
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City	State	ZIP code
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Name

List Part 5(a) question number: _____

If you answered "Don't Know", please explain:

Medical condition/diagnosis:	Treatment:	Dates of treatment: Began: ____/____ (month/year) Ended: ____/____ (month/year)
------------------------------	------------	---------------------------------------------------------------------------------------

Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?
------------------------------------------------------------------------------------------	-----------------

Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
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Other comments/details:

Full name of physician, clinic or hospital:	Specialty:
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Phone number: ()	Medical group (if applicable):
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Address:	Suite
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City	State	ZIP code
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Part 5(c) – Current or recent prescription medications

If you or any family member applying for coverage answered Yes or Don't know to question 6 in Part 5(a) regarding prescription medications, please provide complete details below. If you do not recall dates specify "unknown." If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached.

Name			
Medication	Dates from: ___/___/___ to: ___/___/___		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name	Specialty		
Medical group (if applicable)	Phone number ()		
Address			Suite
City	State	ZIP code	
Name			
Medication	Dates from: ___/___/___ to: ___/___/___		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name	Specialty		
Medical group (if applicable)	Phone number ()		
Address			Suite
City	State	ZIP code	
Name			
Medication	Dates from: ___/___/___ to: ___/___/___		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name	Specialty		
Medical group (if applicable)	Phone number ()		
Address			Suite
City	State	ZIP code	
Name			
Medication	Dates from: ___/___/___ to: ___/___/___		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name	Specialty		
Medical group (if applicable)	Phone number ()		
Address			Suite
City	State	ZIP code	
Name			
Medication	Dates from: ___/___/___ to: ___/___/___		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name	Specialty		
Medical group (if applicable)	Phone number ()		
Address			Suite
City	State	ZIP code	
Name			
Medication	Dates from: ___/___/___ to: ___/___/___		
Reason for prescription	Still on medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dosage	Frequency
Prescribing physician's name	Specialty		
Medical group (if applicable)	Phone number ()		
Address			Suite
City	State	ZIP code	

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Part 5(d) – Recent health practitioner visit(s)

Have you or any family member applying for coverage visited a physician, mental health practitioner, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health practitioner in the past 2 years? Yes No **If Yes, please provide complete details below.**

Medical records may be requested for all children up to 7 months of age. For children under 6 years of age, be sure to include the date and results of the most recent well child exam. If additional space is needed to provide complete information, please attach a supplemental page providing your name, all information requested below, your signature and date. Check here if a supplemental page is attached.

Name		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: ____/____ (month/year) Ended: ____/____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ()	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: ____/____ (month/year) Ended: ____/____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ()	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

Name		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: ____/____ (month/year) Ended: ____/____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ()	Medical group (if applicable):	
Address:		Suite
City	State	ZIP code

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Part 5(d) – Recent health practitioner visit(s) (continued)

Name		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: ____/____ (month/year) Ended: ____/____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ()		Medical group (if applicable):
Address:		Suite
City		State ZIP code
Name		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: ____/____ (month/year) Ended: ____/____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ()		Medical group (if applicable):
Address:		Suite
City		State ZIP code
Name		
Diagnosis/reason for visit:	Treatment:	Dates of treatment/exam: Began: ____/____ (month/year) Ended: ____/____ (month/year)
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Present status?	
Medical ID card number (if available):	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of hospitalizations? _____ Dates from: ____/____/____ to: ____/____/____ Dates from: ____/____/____ to: ____/____/____	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, number of ER visits? _____ Date(s): ____/____, ____/____, ____/____
Other comments/details:		
Full name of physician, clinic or hospital:		Physician specialty:
Phone number: ()		Medical group (if applicable):
Address:		Suite
City		State ZIP code

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Part 6 – Authorization for release of information

By signing this form you are authorizing the release of your and/or your dependents' healthcare information by a healthcare provider, insurer, insurance support organization (which includes consumer reporting agencies, MIB Group Inc and Milliman Inc), health plan, or your insurance agent, to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, Blue Shield) for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing this form you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization (which includes consumer reporting agencies, MIB Group Inc and Milliman Inc), health plan, or your insurance agent for the purpose of investigating or evaluating any claim for benefits. In addition, Blue Shield may make a brief report to MIB Group Inc regarding information received in the underwriting process. The healthcare information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under the federal health information privacy laws.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your and/or your dependents' eligibility for coverage and enrollment determinations upon receipt of this signed authorization.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid: 1) for thirty (30) months from the date of this authorization for the purposes of processing your application and reporting information, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

_____ Applicant/parent or legal guardian	_____ Today's date
_____ Applicant's spouse/domestic partner	_____ Today's date
_____ Applicant age 18 or over	_____ Today's date
_____ Applicant age 18 or over	_____ Today's date
_____ Applicant age 18 or over	_____ Today's date
_____ Applicant age 18 or over	_____ Today's date

Continue to Part 7 - your signature and today's date are required in that section.

Part 7(a) - Applicant verification of accuracy

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature. Keep a copy of this application for your records.

I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application, including all information provided in the medical history section of this application, is accurate, true and complete. If Blue Shield determines that information on this application is materially inaccurate, not true or incomplete, I understand that coverage may be cancelled or, if the inaccuracy, untruthfulness, or incompleteness was intentional, coverage may be rescinded. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

For applicants with a language preference other than English: If I indicated in Part 1 that I have a language preference other than English and have completed the English-version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.

_____ Signature of applicant/parent or legal guardian	_____ Today's date	_____ Print name (and relationship if applicant is a minor)
_____ Signature of applicant's spouse/domestic partner (if applying)	_____ Today's date	_____ Print name
_____ Signature of family member age 18 and over (if applying)	_____ Today's date	_____ Print name
_____ Signature of family member age 18 and over (if applying)	_____ Today's date	_____ Print name (and relationship if applicant is a minor)
_____ Signature of family member age 18 and over (if applying)	_____ Today's date	_____ Print name (and relationship if applicant is a minor)
_____ Signature of family member age 18 and over (if applying)	_____ Today's date	_____ Print name (and relationship if applicant is a minor)

Continued on the next page

Part 7(b) – Authorizations, terms and conditions

Please read the following terms and conditions carefully. Each applicant age 18 and older is required to review the completed application and provide their own authorization and signature. Keep a copy of this application for your records.

1. **Application for coverage:** It is important to know that Blue Shield of California or Blue Shield of California Life & Health Insurance Company (as applicable) has the right to decline your application for coverage. Note: I understand that Blue Shield may use any medical information in reviewing my application, including any medical condition which occurs after the signature and submission of the application, and before a decision by Blue Shield is communicated. I understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.
2. **First month's dues/premiums:** Blue Shield requires first month's dues/premium at the time of application submission. Attach a personal check or money order to this application in an amount equal to one month's dues/premiums; or to pay by credit card, complete Part 11. Find your estimated monthly dues/premiums in the rate book provided to you. Failure to submit full payment of dues/premiums will delay processing and the effective date of coverage. Please note that processing of your payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If your application is not approved, your check or automatic payment authorization for your credit card or checking account will be destroyed.
3. **Dues/premiums:** Dues/premiums are to be paid by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the *Health Service Agreement/Policy*.
4. **Effective date of coverage:** If your application is approved, Blue Shield will notify you of your effective date of coverage. If Blue Shield cannot honor your requested effective date, or is unable to issue coverage before your requested date, coverage will begin as soon as possible. If additional dues/premiums are owed, payment must be received within the time specified in the notice from Blue Shield to avoid changing the effective date. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Acceptance of Application:** You understand that only Blue Shield can accept your application and approve coverage. Your agent or broker cannot approve this application for coverage or change any terms or conditions of coverage.
6. **Parents/guardians:** If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 7. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach the court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):
 - Parent or legal guardian only: _____ (name) or,
 - My designee _____ (include name and relationship) or,
 - Qualified medical child support order designee _____ (include name and relationship).
 - Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.
7. **Authorization for spouse/domestic partner to make changes:** If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield. Yes No
8. **Authorization for your agent to provide/obtain information:** Check here if you do **not** authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application, including medical information.
9. **Process to authorize Blue Shield to release personal and health information to a third party:** If you would like to authorize your spouse, domestic partner or a third party to access your personal health information, please complete the form titled Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party. To obtain this form go to blueshieldca.com and click on the Privacy link at the bottom of the page, or call **(800) 431-2809**.
10. **Response to requested information:** You agree to cooperate with Blue Shield (or Blue Shield Life, as applicable) by providing, or by providing access to, documents and other information requested to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or information may be cause to rescind or cancel your coverage.
11. **HIV or genetic testing prohibited:** No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits an HIV test from being required or used by a health insurance company or health care service plan as a condition of obtaining health coverage.

I have reviewed all responses pertaining to me in this application. I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature.)

Signature of applicant/parent or legal guardian	Today's date	Print name (and relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name

Important: Return the application within 30 days of your date(s) and signature(s).

Part 8 – Statement of Guaranteed Issue Eligibility if applying for a HIPAA guaranteed issue plan

If you do not qualify for an underwritten plan, Blue Shield offers an alternative that you may want to consider.

The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people in certain instances to maintain coverage if they lose existing group health plan coverage. Depending on your responses to the statements below, you may be eligible for guaranteed issue in accordance with HIPAA, and Blue Shield will automatically accept your application for one of its HIPAA guaranteed issue plans without medical underwriting. Each person on the application must meet HIPAA eligibility requirements to qualify for a HIPAA guaranteed issue plan. Please note that HIPAA guaranteed issue rates may be higher than those of Blue Shield's underwritten plans.

If you are applying individually for coverage on behalf of any dependents who are not eligible for a HIPAA guaranteed issue plan, their coverage will be subject to medical underwriting, except for children who were enrolled under any prior creditable coverage within 30 days of the birth or placement for adoption. A dependent child who is 25 years of age or younger or a dependent spouse applying for HIPAA guaranteed issue must complete a separate Statement of HIPAA Guaranteed Issue Eligibility (Blue Shield will accept copies of the Statement of Guaranteed Issue Eligibility). For additional applications or current HIPAA guaranteed issue plan rates, please contact your insurance agent, or call Blue Shield at **(800) 431-2809**.

Note: Children under the age of 19 are only eligible for a HIPAA guaranteed issue plan if applying as a dependent for family coverage because they are otherwise eligible for guaranteed issue coverage under CA state law.

Statement of Guaranteed Issue Eligibility and checklist if applying for a HIPAA guaranteed issue plan

Name of applicant(s) requesting HIPAA guaranteed issue coverage: _____

Please complete the following questionnaire if you are interested in a HIPAA guaranteed issue policy so that your eligibility for HIPAA guaranteed issue coverage may be verified.

- Yes No 1. I have had a total of at least 18 months of healthcare coverage (including COBRA or Cal-COBRA, if applicable) without a lapse in coverage of more than 63 days (excluding employer-imposed waiting periods).
- Yes No 2. My most recent coverage was through an employer-sponsored health plan (COBRA and Cal-COBRA are considered employer-sponsored coverage).
- Yes No 3. I accepted and exhausted any available COBRA and/or Cal-COBRA coverage (if COBRA/Cal-COBRA were not available, check "yes").
 COBRA/Cal-COBRA coverage dates ____/____/____ through ____/____/____
 COBRA administrator _____ Telephone _____
 Insurance carrier _____ Telephone _____
 If your most recent coverage was employer-sponsored and you were not eligible for COBRA and/or Cal-COBRA coverage, please explain:

- Yes No 4. I am currently eligible for coverage under a group or employer-sponsored health plan, Medicare, or Medicaid.
- Yes No 5. My most recent coverage terminated because of nonpayment of dues/premium or fraud.

If your answers to statements 1, 2, and 3 are "yes," and your answers to statements 4 and 5 are "no," please complete the remaining sections below to apply for a HIPAA guaranteed issue plan. Note: Submit evidence of prior coverage, such as a certificate of creditable coverage from your previous health carrier and/or verification from your previous COBRA/CalCOBRA administrator.

HIPAA guaranteed issue coverage options (please select one)

A. If you know that you will not qualify, or do not want to apply for an underwritten plan, check this box:

- Issue the HIPAA guaranteed issue plan only. Since I have chosen this option, I understand that I will not be considered for an underwritten plan.

B. If you are applying for both HIPAA guaranteed issue and an underwritten plan, select one of the following:

- Issue the HIPAA guaranteed issue plan at the earliest effective date, so that I am covered during the underwriting process of the individual plan. (I understand that if my application for the underwritten plan is approved, I will automatically be transferred to the underwritten plan. If it is not approved, I will continue to receive HIPAA guaranteed issue coverage.)
- Issue the HIPAA guaranteed issue plan only if I am not approved for the underwritten plan. (I understand that I will not have any individual Blue Shield coverage until my application for the underwritten plan is processed and either approved or declined.)

HIPAA guaranteed issue plan options (please select one)

- Access+ HMO package Access+ Value HMO
- Shield Savings 4000/8000* Shield Spectrum PPO 5000*
- Shield Spectrum PPO 5500

By signing this statement, I verify that I have read and understood the eligibility conditions for HIPAA guaranteed issue listed above, and that all of the information I have provided is true and correct.

Signature of applicant or legal guardian _____ Today's date (required) _____ Print name _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Part 9 – Producer information: to be completed by an authorized Blue Shield agent

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely. This attestation must be completed by the producer and submitted with each Blue Shield IFP application.

1. Are you aware of any information not disclosed in this application, which may have a bearing on this risk? Yes (if yes, attach explanation) No
2. Review and select one of the following:
 - I did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice of any kind from me.
 - I assisted the applicant in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to \$10,000.
3. Did you see any of the following applicants sign the application?
 - a. Primary Applicant: Yes No
 - b. Spouse/Domestic Partner: Yes No Not applying
 - c. Family member(s) age 18 or above: Yes No Not applying
 If no to (a), (b), or (c) above, provide details: _____

4. Do you want the health service agreement/policy sent directly to the subscriber? Yes No

Producer name		DAVID J. FLUKER	
E-mail address	dave@davefluker.com	<input type="checkbox"/> Update e-mail	Producer number
Telephone number (408)	847-6139	<input type="checkbox"/> Update phone	Fax number (408) 762-4450
Producer address		767 MARIA WAY	
City		GILROY	State CA
Super producer name		Super producer number	

DAVID J. FLUKER

Producer signature (required) _____ Today's date (required) _____ Print name _____

Producers: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information. IFP applications can be faxed toll-free 24 hours a day, 7 days a week, to **(888) 386-3420**.

Part 10 – Billing and payment information

Calculate estimated monthly dues/premiums

- Using the rate book provided to you, calculate your estimated rates or talk to your agent to get estimated rates. You may receive rates higher than your agent quoted you based on Underwriting determination.
- First month's dues/premium are required at the time of application submission. For the first month's dues/premium, staple a personal check or money order to your application in an amount equal to the dues/premiums for one month, payable to Blue Shield. If paying first month's dues/premium by credit card, please fill out the Automatic Payment Authorization Form.

Easy\$Pay and credit card automatic payment options

Subsequent dues/premiums must be paid in advance through one of the following options:

- Easy\$Pay monthly payment – monthly payments are handled automatically, via electronic transfer from your checking or savings account.
- Credit card payment – monthly/quarterly payments are handled automatically, via charge to your credit card.

To sign up for automatic payments, complete the automatic payment authorization form on the next page and return it with your application. If you have selected Easy\$Pay as your payment option, please staple a deposit slip or blank check marked "VOID" to your authorization form in addition to your first month's estimated dues/premiums check. If you prefer not to attach a voided check or deposit slip, you must provide the routing/transit number of your financial institution.

Submit completed applications to:

PO Box 3008
Lodi, CA 95241-9969

Mary Jane Blue	3025
123 First St.	
Anytown, CA 99999	
Pay to	_____ 20
Order of	Dollars
VOID	
Any Bank	
San Francisco Main Office	
P.O. Box 8944	
San Francisco, CA 94126	
Memo _____	
032056884 9 8707228001 0233	

_____ Bank account number
_____ Bank routing/transit number

C12900-RD-EXT (10/11)

Please note that this page has been left intentionally blank.

Part 11 – Automatic payment authorization form

Check all that apply: Paying first month's dues/premium by credit card
 Enrolling in automatic payment for recurring payments
 Changing current automatic payment authorization (processing may take up to 30 days)

Applicant information

Applicant name

Mailing address

Apt. No.

City

State

ZIP code

Applicant's daytime phone number ()

Method of payment

Easy\$Pay debit: Checking account Savings account

Payment date: 1st of month 15th of month (Note: HMO and Dental HMO must use 1st of the month.)

Payment frequency: Monthly

Bank routing/transfer number

Bank account number

Name(s) on bank account

Name of financial institution

Branch address

City

State

ZIP code

Branch telephone number ()

Credit Card (Visa or MasterCard only)

Payment date: 1st of month

Payment frequency: Monthly Quarterly

Cardholder name

Cardholder billing address

Apt. No.

City

State

ZIP code

Credit card number

Card type: Visa MasterCard

Expiration date (mm/yyyy) ___/___/___

If paying first month's dues/premium by credit card, the estimated first month's payment is:* \$ _____

* This is only an estimate of monthly dues/premium. Blue Shield will provide notice of actual monthly dues/premium if my application for coverage is accepted. All dues/premium must be received prior to the original effective date for coverage to be in effect.

Authorization and Signature(s)

Automatic Payment by debit from checking/savings account:

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date (or within 1 to 2 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record and I will be responsible for making my payment by check or money order, along with a return item service charge.

Automatic Payment by credit card:

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to charge (and/or apply credits, if correcting errors to previous charges) the credit card identified on this form on the payment date (or within 1 to 2 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. If the credit card transaction ever fails (e.g., over limit, expired), Blue Shield will mail a bill to me to my address on record and I will be responsible for making my payment by check or money order.

Additional information if paying first month's dues/premium only by credit card:

If only the first month's dues/premium box is checked, this authorization is only valid to charge the first month's dues/premium owed to Blue Shield. I understand my credit card will be charged for the estimated first month's dues/premium immediately upon receipt of my application; however, this payment does not constitute approval of my application, and if my application is accepted, a different rate may apply. If I am accepted at a different rate, the difference in dues/premium must be paid prior to the original effective date of coverage. Blue Shield will not automatically charge the difference in rate owed to the credit card without a separate authorization from the applicant.

Notice to Change/Cancel Required:

I will continue to be debited/charged the amount of dues/premium owed until I cancel this Automatic Payment authorization upon at least 10 calendar days notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 431-2809**. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form (if the bank account is a joint account, all accountholders must sign) and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

Signature

Print Name

_____-_____-_____
Social Security number

____/____/_____
Date

Signature

Print Name

_____-_____-_____
Social Security number

____/____/_____
Date

Part 11 – Automatic payment authorization form

KEEP THIS COPY FOR YOUR RECORDS

- Check all that apply:** Paying first month's dues/premium by credit card
 Enrolling in automatic payment for recurring payments
 Changing current automatic payment authorization (processing may take up to 30 days)

Applicant information

Applicant name _____

Mailing address _____ Apt. No. _____

City _____ State _____ ZIP code _____

Applicant's daytime phone number () _____

Method of payment

Easy\$Pay debit: Checking account Savings account

Payment date: 1st of month 15th of month (Note: HMO and Dental HMO must use 1st of the month.)

Payment frequency: Monthly

Bank routing/transfer number _____

Bank account number _____

Name(s) on bank account _____

Name of financial institution _____

Branch address _____

City _____ State _____ ZIP code _____

Branch telephone number () _____

Credit Card (Visa or MasterCard only)

Payment date: 1st of month

Payment frequency: Monthly Quarterly

Cardholder name _____

Cardholder billing address _____ Apt. No. _____

City _____ State _____ ZIP code _____

Credit card number _____

Card type: Visa MasterCard _____ Expiration date (mm/yyyy) ____/____

If paying first month's dues/premium by credit card, the estimated first month's payment is:* \$ _____

* This is only an estimate of monthly dues/premium. Blue Shield will provide notice of actual monthly dues/premium if my application for coverage is accepted. All dues/premium must be received prior to the original effective date for coverage to be in effect.

Authorization and Signature(s)

Automatic Payment by debit from checking/savings account:

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date (or within 1 to 2 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record and I will be responsible for making my payment by check or money order, along with a return item service charge.

Automatic Payment by credit card:

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to charge (and/or apply credits, if correcting errors to previous charges) the credit card identified on this form on the payment date (or within 1 to 2 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. If the credit card transaction ever fails (e.g., over limit, expired), Blue Shield will mail a bill to me to my address on record and I will be responsible for making my payment by check or money order.

Additional information if paying first month's dues/premium only by credit card:

If only the first month's dues/premium box is checked, this authorization is only valid to charge the first month's dues/premium owed to Blue Shield. I understand my credit card will be charged for the estimated first month's dues/premium immediately upon receipt of my application; however, this payment does not constitute approval of my application, and if my application is accepted, a different rate may apply. If I am accepted at a different rate, the difference in dues/premium must be paid prior to the original effective date of coverage. Blue Shield will not automatically charge the difference in rate owed to the credit card without a separate authorization from the applicant.

Notice to Change/Cancel Required:

I will continue to be debited/charged the amount of dues/premium owed until I cancel this Automatic Payment authorization upon at least 10 calendar days notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 431-2809**. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form (if the bank account is a joint account, all accountholders must sign) and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

Signature

Print Name

_____-_____-_____
Social Security number

____/____/_____
Date

Signature

Print Name

_____-_____-_____
Social Security number

____/____/_____
Date