HOW TO COMPLETE THIS APPLICATION

- Please read all materials provided with this application, including the outline of coverage, so that you understand the cost-sharing obligations of the coverage you have selected and to ensure you have selected the health care coverage that is right for you. If at any time you need assistance you may call us at 1-888-323-8832
- On Page 1 and 2, provide all "General Information" and all "Enrollment Information" requested. Provide information about your spouse and dependents only if they are applying for coverage.
- Provide all "Medical Information" requested under Sections A,B,C and D on pages 2 through 5.Provide information about yourself and each dependent who is also applying.
- Read the "Conditions of Enrollment" on page 6. Be sure to sign and date where indicated. If you and your spouse are applying for coverage, both of you must sign and date this application.
- Please **fax** your application back to Low Cost Pa Health Insurance at **412-892-9725** or you may mail your application back to.

Supplemental Benefits Specialists
3401 Provost Rd. Suite 119
Pittsburgh, Pa. 15227

1-888-323-8832 office
412-892-9725 fax

Medically Underwritten
Application and Health Questionnaire

An Independent Licensee of the Blue Cross and Blue Shield Association

How to complete this application

To avoid processing delays, we ask that you take your time to carefully and accurately complete all of the appropriate sections.

Please note that the underwriting process can take several weeks. Therefore, you may want to continue your existing health care coverage while waiting for the response to this application.

1. Read all materials enclosed with this application, including the Outline of Coverage, so that you understand the cost sharing obligations of the coverage you have selected and to ensure that you have selected the health care coverage that is right for you.
2. Tear off this front page along the perforation. **Keep this page for your records.** You may want to refer to it if you have a question about your application or the appeals process.
3. On pages 1 and 2, provide all "General Information" and all "Enrollment Information" requested. Provide information about your spouse and dependents only if they are also applying for coverage.
4. On pages 2 through 5, provide all "Medical Information" requested. Provide information about yourself and each dependent who is also applying.
5. Read the "Conditions of Enrollment" on page 6. Be sure to sign and date where indicated. If both you and your spouse are applying for coverage, both of you must sign and date this application.
6. The "Producer's Certificate" on page 8 should be completed only by a licensed insurance producer acting on your behalf. Do not complete if you are applying on your own.
7. Return your completed application with a check or money order for your initial premium made payable to: "Highmark Blue Cross Blue Shield."

   Mail to:
   Highmark Blue Cross Blue Shield
   P.O. Box 382555
   Pittsburgh, PA 15250-8555

Please Note: Receipt of your initial payment does not constitute enrollment under this program. Your coverage will not begin until this application has been accepted by Highmark Blue Cross Blue Shield and you have been notified that an effective date of coverage has been assigned. If your application is approved by the medical underwriting department on or before the last day of the month, your coverage will become effective on the first day of the following month. Failure to provide all the information requested may result in a delay in the processing of your application.

Keep this page for your records.

Date:____________________Check Number:________________

Amount Paid: ____

Deductible Amount Applied For: ___________________________

Underwriting your application

The basic source of information we use to determine your eligibility for this insurance policy is your application. Experienced underwriters will carefully and promptly review the information you have provided. In addition, we may also obtain information from other sources, including physicians and hospitals, as authorized by you when you complete your application.

A high percentage of our applicants are in good health and meet our underwriting standards. As a result, these applications are quickly approved and insurance policies are issued. Some applicants, however, present a greater insurance risk, usually due to an abnormal physical condition or history of medical problems. By underwriting policies in this way, we try to keep the cost of health care coverage affordable for as many people as possible.

If, due to your medical history, you do not qualify for coverage at the rate for which you apply, you <u>may</u> be eligible for coverage <u>at one of Highmark's high tiered rates</u>, as determined in accordance with our medical criteria ("underwriting guidelines"*). Each application will be reviewed individually, and you will be notified if you are eligible for coverage and at which rate. You will also be notified if your application is denied.

Underwriting guidelines are based on nationally recognized actuarial and clinical criteria.

Please note: If you, your spouse or any dependent applying for coverage receives medical advice or treatment from a physician or other professional provider for a condition which is incurred *after* this application is signed but *prior* to the effective date of coverage, you must notify the Highmark Blue Cross Blue Shield Underwriting Department immediately at 120 Fifth Avenue, Suite 1224, Pittsburgh, PA 15222-3099. For individuals age 19 or older, change in a medical condition that occurs *prior* to the effective date could result in a denial of coverage if an application has not yet been approved or cancellation of coverage if an application has been approved but coverage is not yet effective. For individuals under age 19, change in a medical condition that occurs *prior* to the effective date could result in movement to one of Highmark's higher tiered rates.

How to appeal a denial for insurance coverage

You have the right to appeal a denial for medical insurance. To do so, complete the following steps within 180 days from your receipt of the denial letter:

1) Ask the attending physician to complete the Attending Physician Statement form or write a letter providing additional medical information about the condition(s) for which coverage was denied. Have the doctor include any pertinent clinical information to support your appeal.

2) Send the physician's letter, clinical information and a copy of the denial letter to:

   Highmark Blue Cross Blue Shield Appeal
   120 Fifth Avenue, Suite 1224
   Pittsburgh, PA 15222-3099

   <u>or</u> fax them to 412-544-4009 (for appeals only).

Your appeal will be reviewed by a physician on our medical staff, and a final decision will be issued to you in writing within 30 days.

For more information or help concerning this application...

If you have questions about this coverage or how to complete this application, please call a Customer Service Representative Monday through Friday between 9:00 a.m. and 9:00 p.m. at 1-800-847-2004.

HIGHMARK Blue Cross Blue Shield

Highmark Blue Cross Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association

Medically Underwritten Application and Health Questionnaire

General Information (check one)

❑ I am applying for new coverage under the Highmark Blue Cross Blue Shield **DirectBlue®** Comprehensive Major Medical Preferred-Provider Subscription Agreement for Individual Members, Utilizing the Keystone Health Plan West Network of Providers, Without a Gatekeeper ("Agreement") (new applicant).	❑ I am applying for new coverage under the Highmark Blue Cross Blue Shield **PPOBlue℠** Comprehensive Major Medical Preferred-Provider High-Deductible Subscription Agreement for Individual Members, Utilizing the Keystone Health Plan West Network of Providers, Without a Gatekeeper ("Agreement") (new applicant).

❑ I am adding dependent(s) to my existing coverage.
For husband/wife or family coverage, applicant must be the older spouse. For children-only coverage, youngest child must be the applicant.

(PLEASE PRINT) Applicant's Last Name	**First Name**	**Middle Initial**	**County**

Address	**City**	**State**	**Zip Code**

Preferred Phone Number		**Alternate Phone Number**		**E-mail**
( )	❑ Home ❑ Work ❑ Other	( )	❑ Home ❑ Work ❑ Other	

When possible, I prefer to be contacted via: ❑ Mail ❑ Phone ❑ E-mail

Enrollment Information

DirectBlue Annual Deductible* You Prefer: ❑ $250 Individual/$750 Family ❑ $500 Individual/$1,500 Family Monthly premium $ ____________ *Please see Conditions of Enrollment (page 7) for explanation of how the Family Deductible works.	**Note:** Deductible level can be **increased** only on the contract anniversary date provided that the request is received one month prior to the contract anniversary date. Deductible level can be **decreased** as of the contract anniversary date only after the member holds a contract for two consecutive years and if the request is received at least one month prior to contract anniversary date.	PPOBlue Annual Deductible* You Prefer: ❑ $1,200 Individual ❑ $2,400 Family ❑ $2,600 Individual ❑ $5,200 Family ❑ $3,500 Individual ❑ $7,000 Family Monthly premium $ ____________ *Please see Conditions of Enrollment (page 7) for explanation of how the Family Deductible works.

Highmark Blue Cross Blue Shield Agreements renew on a month-to-month basis. The premium is payable in advance to Highmark Blue Cross Blue Shield on a monthly basis. Members may, for their convenience, submit amounts in excess of the specific monthly amount. However, such excess amounts will be applied on a monthly basis by Highmark Blue Cross Blue Shield and will be subject to premium increases on the date the increase becomes effective. Once enrolled, you can choose to pay your monthly premium via one of the Highmark electronic payment options.

Please complete the information requested about yourself and any other family members you are enrolling. Failure to provide all information requested may result in a delay in the processing of your application.

List spouse and/or eligible dependent child(ren) who are applying for coverage. **(Eligible dependent children are the applicant's and/or spouse's dependent children who are under age 26.)**

	Applicant	**Spouse**	**Dependent**	**Dependent**	**Dependent**
Name					
Have you smoked or used any form of tobacco within the last year?	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
Social Security Number (If no SSN, write N/A)					
Birth Date (MM/DD/YY)	/ /	/ /	/ /	/ /	/ /
Gender	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Height/Weight	/	/	/	/	/
Current Physician					
Physician's Phone Number	( )	( )	( )	( )	( )

Payment Enclosed	**Group Number**	**Applicant's Social Security Number**
$	**039000-00**	

Mail to Highmark Blue Cross Blue Shield, P.O. Box 382555, Pittsburgh, PA 15250-8555

Enrollment Information (continued)

1. Is this coverage for which you are applying intended to replace any other accident or health insurance you or any family members applying currently have in force? This includes any current Highmark Blue Cross Blue Shield policy.

❑ No – If "no," proceed to question 2. ❑ Yes – If "yes," proceed to 1 (a) and (b).

1 (a). If you answered "yes" to question 1, please provide the insurance company name and applicable group and identification number(s):

Company Name: ______________________________

Group No: ____________________ Agreement or I.D. No.: ____________________

1 (b). If you answered "yes" to question 1, please complete the enclosed Notice to Applicant Regarding Replacement of Accident and Sickness Coverage form and mail it with your application.

2. Has any person applying ever been turned down for any health reasons for:

		Name of Person(s) Turned Down and Reason
Medical policies	❑ No ❑ Yes	
Life Insurance policies	❑ No ❑ Yes	

3. Is any person applying for this coverage enrolled in or eligible for Medicare due to age and/or disability? ❑ No ❑ Yes

EXCEPT FOR DEPENDENT CHILDREN UNDER THE AGE OF 26, ANY PERSON ELIGIBLE FOR MEDICARE OR MEDICARE DISABILITY BENEFITS IS NOT ELIGIBLE FOR THIS COVERAGE.

Medical Information

Please note: You must include information on all conditions for which you have been diagnosed, treated, advised, counseled, tested, hospitalized or recommended treatment by a licensed health care practitioner. **However, please DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe that you may be at risk.** Please answer each question completely. **If it is found that you have performed an act or practice that constitutes fraud, or have made an intentional misrepresentation of a material fact, in completing this Application, your Agreement may be voided.**

1. Has any person applying used any medical equipment (such as a walker, wheelchair, cane, hospital bed, CPAP, BiPAP or oxygen)? Has any person applying ever had an implant (e.g., breast, chin or penile implant), internal fixation (e.g., pins, plates, or screws), prosthesis, pacemaker, defibrillator, valve replacement, shunt or monitoring device (e.g., electrical stimulation device) or any other device? If "Yes," please provide details on the "**Details of Health History**" chart on page 4. . . . . ❑ No ❑ Yes

2. Is any person applying currently receiving home health care? If "Yes," please provide details on the "**Details of Health History**" chart on page 4. ❑ No ❑ Yes

3. Give date of last menstrual period for each female family member applying.

Name of Person	Date of Last Period	If none or more than a month ago, please explain

4. Has any person applying been recently (i.e., within the past 9 months) medically diagnosed or treated for pregnancy? . . . . ❑ No ❑ Yes

Name of Pregnant Person	Diagnosis or Treatment	Date (mm/dd/yyyyy)

5. Has any person applying gained or lost more than 20 pounds over the past 6 months? . . . . ❑ No ❑ Yes

If "Yes," provide person's name, amount gained or lost and reason for gain/loss.

Name of Person	Weight Gained	Weight Lost	Reason

6. Is each person (age 18 and below) applying current on his/her childhood immunizations? If "No," please explain. . . . . ❑ No ❑ Yes

Name of Person	Reason

Medical Information (continued)

7. Has any person applying received occupational, physical, or speech therapy or chiropractic treatments in the past 5 years? If "Yes," please provide number of visits and dates on the **"Details of Health History"** chart on page 4 . . . . ❑ No ❑ Yes

8. Has any person applying been advised by a licensed health care practitioner of any abnormal lab results, X-rays, diagnostic studies, or physical exam results within the last 5 years? If "Yes," please provide details on the "**Details of Health History"** chart on page 4 . . . . ❑ No ❑ Yes

9. Has any person applying been advised by a licensed health care practitioner to have treatment, testing, counseling, therapy, or surgery which has not yet been performed? If "Yes," please provide details on the "**Details of Health History"** chart on page 4 . . . . ❑ No ❑ Yes

10. Has any person applying been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment by a licensed health care practitioner for the following? Please check "Yes" or "No". **Conditions listed are examples only. All known health conditions must be disclosed.** If any boxes are checked "Yes", please provide details on the "**Details of Health History"** chart on page 4.

   A. Behavioral Health/Psychiatric/Substance Abuse: Current addiction/substance abuse; History of addiction/substance abuse; Psychosis; Eating disorder; Sleep disorders/sleeping medications; Any condition requiring psychiatric/psychological counseling or medications such as: Depression, Manic depression, Bipolar disorder, Anxiety, Panic disorder, Obsessive/Compulsive disorder, and Schizophrenia, Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity disorder (ADHD) . . . . ❑ No ❑ Yes

   B. Heart/Blood/Circulation: Irregular heart beat; Pacemaker, angina/chest pain;, Congestive heart failure; Abnormality/anemia blood disorders; Heart attack; Problems with veins and arteries/blood clotting disorder/Deep Vein Thrombosis; Hypertension/hypotension; Cholesterol/ hyperlipidemia; Stroke/cerebrovascular accident; Cardiomyopathy; Enlarged heart; Heart valve problems or replacement . . . . ❑ No ❑ Yes

   C. Eyes/Ears/Nose/Throat: Glaucoma; Macular degeneration; Cataracts; Visual Impairment; Enucleated/removed eye; Iritis; Retinal/corneal problems; Frequent ear infections; Cochlear implants; Deviated septum; Jaw or Temporomandibular Joint problems; Excessive snoring; Frequent throat infections . . . . ❑ No ❑ Yes

   D. Endocrine/Hormones/Metabolic/Glandular: Adrenal gland problems; Diabetes (insulin or diet controlled); Thyroid (Hypothyroid or Hyperthyroid); Goiter/nodule/other; Pituitary or pineal gland problems; Chronic fatigue . . . . ❑ No ❑ Yes

   E. GI – Gastrointestinal/stomach/intestines: Abscess/infection; Constipation or diarrhea-frequent; Cirrhosis/liver disease; Ulcerative colitis/ Crohns; Diverticulitis/diverticulosis/frequent abdominal pain; Nutritional disorder; Fistula/fissure; Bariatric surgery; Hemorrhoids; Hernia; Hepatitis; Irritable Bowel Syndrome; Pancreatitis; Cancer; Gastritis/ulcer/esophagitis/Gastroesophageal Reflux Disease; Polyps . . . ❑ No ❑ Yes

   F. GU – Urinary/Kidney/Bladder: BPH/enlarged prostate; Incontinence; Kidney cysts; Kidney failure/renal failure/CRF/ESRD; Kidney stones; Pyelonephritis/cystitis/frequent infections; Strictures or narrowing; Cancer . . . . ❑ No ❑ Yes

   G. Immune System/Infections: AIDS/HIV; Allergies; Current infections; Lupus; Scleroderma; Lyme disease; Viral infections; Chronic Fatigue/ Epstein Barr Virus/Mononucleosis . . . . ❑ No ❑ Yes

   H. Skin/Nails/Hair/Cosmetic: Cellulitis; Hair loss; Psoriasis; Skin lesions/skin cancer/pre-cancer; Other skin conditions requiring treatment (acne, fungal infections, rosacea, rashes, dermatitis, warts, eczema, keratosis); Cosmetic problems . . . . ❑ No ❑ Yes

   I. Muscles/Bones: Amputations; Arthritis; Fracture/joint replacements/pins/screws; Bunion/foot conditions/plantar fasciitis; Carpal Tunnel Syndrome; Fibromyalgia; Osteopenia/osteoporosis; Recurrent pain; Physical therapy, Chiropractic; Spine problems/disc problems/ scoliosis/kyphosis; Tendonitis/bursitis/myositis . . . . ❑ No ❑ Yes

   J. Brain/Spine/Nervous System: Neuro/muscular disorders/Guillain-Barrē/Multiple Sclerosis; Headaches/migraines; Memory loss/ cognitive problems/physical development delays; Narcolepsy; Parkinson's Disease; Pinched nerve/numbness/tingling/paralysis; Seizure disorder; Dizziness/Meniere's Disease/fainting; Head or spinal injury; Tremors; Stroke/Cerebral Vascular Accident; Transient Ischemic Attack . . . . ❑ No ❑ Yes

   K. Reproductive System – Female: Breast augmentation; Breast problems/fibrocystic breast/mastitis/lumps/lumpectomy/mastectomy; Childbirth; Miscarriage; Infertility; Abnormal PAP test; Infectious disease/Sexually Transmitted Disease/genital warts/chlamydia/HPV/ syphilis/gonorrhea/herpes; Menstrual problems; fibroids/endometriosis; Ovarian cysts; Sexual issues/transgender/dysfunction . . . ❑ No ❑ Yes

   L. Reproductive System – Male: Prostate problems/Benign prostatic hypertrophy; Epididymitis; Erectile dysfunction; Sexual issues/ transgender/ dysfunction; Infectious disease/Sexually Transmitted Disease/genital warts/chlamydia/HPV/syphilis/gonorrhea/herpes . . . . ❑ No ❑ Yes

   M. Respiratory: Asthma; Bronchitis/pneumonia/upper respiratory infections; Chronic cough; Shortness of breath; Pleurisy/pneumothorax; Pulmonary embolism/blood clots; Tuberculosis, Emphysema/COPD/other lung disease/work-related breathing problems . . . . ❑ No ❑ Yes

   N. Other Conditions: Accident/injury; Birth conditions/congenital abnormalities; Surgery; Cancer; Leukemia . . . . ❑ No ❑ Yes

Please note: Any physician charges or other fees incurred during the process of completing this application are the responsibility of the applicant.

Medical Information (continued)

11. Does any person applying have any other conditions, illnesses or injuries not specifically mentioned on this application for which you or your eligible dependents have been diagnosed, treated or monitored or for which ongoing evaluation, treatment or monitoring has been recommended? If "Yes," please specify condition and provide details on the "**Details of Health History**" chart below . . . . ❑ No ❑ Yes

Details of Health History

Question number	Person affected	Condition, Injury, Symptom, Diagnosis or Other: What condition is it?	Date that it started	Date of recovery (if applicable)	Was person affected released from care?	Required: • Readings, levels, lab results • Types of treatment/advice given • Number of visits and date range for therapy and chiropractic	Name, address and phone number of doctors and hospitals
Incorrect example: ~~10~~	~~Mark~~	~~blood pressure~~	~~2008~~	~~N/A~~	~~N/A~~	~~get regular readings~~	~~Dr. Wilson 3 Rivers Hospital~~
Correct example: 10 B	Mark Jones	high blood pressure or hypertension	6/2008	none	no, ongoing	Blood pressure readings: 140/80 — 7/6/2008 138/77 — 2/2/2009	Dr. Wilson, 3 Rivers Hospital, 127 Main St., Pgh., PA 15222 412-000-0000

Medical Information (continued)

12. If any person applying has taken prescribed drugs in the past 12 months, please list drug(s) taken and reason:

Name of Person	Medication	Dosage	Frequency	Condition/Reason	Dates of Use (mm/yyyy)
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:
					From: To:

13. Please indicate the last physician office or clinical visit for each applicant. If additional space is needed, please attach a separate piece of paper.

Name of Person	Physician's Name		Physician's Phone Number ( )
Physician's Address	City	State	Zip Code
Reason			Date
Name of Person	Physician's Name		Physician's Phone Number ( )
Physician's Address	City	State	Zip Code
Reason			Date

14. If not provided on previous pages, please indicate the last emergency room and/or hospital visit and specific results.

Name of Person	Reason	Results	Date (mm/dd/yyyy)

15. If any person applying drinks alcoholic beverages, please indicate frequency of use. If you drink less than one drink per week, please indicate "Less than one." If you do not drink, write "0." (Serving size per drink equals 1½ oz. liquor, 12 oz. beer, 5 oz. wine)

Name of Person	Number of Drinks per Week	Name of Person	Number of Drinks per Week

16. If any person applying, within the last year, used tobacco products, please indicate amount of cigarettes, cigars, pipes or smokeless tobacco (snuff, chewing tobacco, etc.) used and length of use. If you use tobacco less than once per day, please indicate "Less than once." If you do not use tobacco products, write "0."

Name of Person	Amount per Day	Type	Dates of Use (mm/yyyy)
			From: To:
			From: To:

17. Is there anything else you want to tell us?

IMPORTANT: PLEASE READ AND SIGN ON PAGE 7

I, the undersigned, hereby apply for coverage for myself and all my listed eligible dependents.

I represent, to the best of my knowledge and belief, that:

1. I have read and have supplied all the requested information on this form with regard to myself and any family members applying for coverage (If not, I have attached a letter which explains why.);
2. All applicants for this policy are in good health except for those conditions listed in the Medical Information portion of the application; and
3. No material information has been withheld or omitted about the past or present state of my health or any family member(s) applying.

I understand and agree that:

1. Except for dependent children under the age of 26, any person eligible for Medicare or Medicare disability benefits is **not** eligible for this coverage;
2. This coverage does not begin until this application is accepted by Highmark Blue Cross Blue Shield and an Effective Date of coverage is assigned;
3. Initial payment must be submitted with the application;
4. Receipt of my money (check or money order) does not constitute enrollment under any program;
5. This coverage is provided only to residents of the geographical area of western Pennsylvania served by Highmark Blue Cross Blue Shield. We reserve the right to investigate and confirm your residence from time to time; and
6. If applicant is under age 18, the signature of a parent or guardian is required on this application.

I also understand and agree that Highmark Blue Cross Blue Shield may:

1. Require me and any family member(s) applying to provide upon request medical history or to have a medical examination, blood test or other applicable medical test prior to acceptance of the application (Highmark Blue Cross Blue Shield may choose to specify the provider);
2. Require me or any family member(s) applying to notify the Highmark Blue Cross Blue Shield Underwriting Department immediately if I, my spouse or any of my dependents applying for coverage receive medical advice or treatment from a physician or other professional provider for a condition which occurs after the application is signed, but prior to the Effective Date of coverage. I understand that, for individuals age 19 or older, change in a medical condition could result in a denial of coverage if my application has not yet been approved or cancellation of coverage if my application has been approved but coverage is not effective, and that, for individuals under age 19, change in a medical condition that occurs prior to the Effective Date could result in movement to one of Highmark's higher tiered rates;
3. Deny this application, in which case any premium submitted will be refunded and accepted by me;
4. Void this Agreement (health insurance policy) or deny a claim for loss incurred or disability (as defined in the Agreement) if the applicant has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the Agreement.

I also understand and agree that the Agreement will not provide benefits for any applicant (including dependents) age 19 or older during the 12-month pre-existing condition period following the Effective Date on which I and any dependents become enrolled under the Agreement. A pre-existing condition is any condition, including normal pregnancy, for which medical advice, care, treatment or diagnosis has been recommended by or received from a health care provider within a five-year period prior to the Effective Date of the Agreement.

I understand and agree that the terms and conditions of our coverage will be controlled by the written Agreement with Highmark Blue Cross Blue Shield and that it may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that Agreement, to administer the program. I recognize that our coverage will only apply to admissions that occur and services that are provided on or after the Effective Date of our coverage.

Authorization for Disclosure of Health Information for Coverage Eligibility and Underwriting

I hereby authorize Highmark to request for those who are enrolling for coverage under this application information and/or medical records relating to past, present and future health care examinations, prescription drugs, treatment and diagnosis, including copies of records concerning advice, care or treatment provided to me and/or my dependents, including, without limitation, information involving mental health (excluding psychotherapy notes, unless specifically and separately authorized), substance abuse and HIV/AIDS.

I further authorize any physician, medical practitioner, hospital, medical or medically related facility, insurer, pharmacy benefits manager, or any other health care organization to release the information described above to Highmark and its subsidiaries.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

Highmark • P.O. Box 70 • Pittsburgh, PA 15230-0700

I understand that revocation of this authorization will *not* affect any action Highmark or any other person/entity took in reliance on this authorization before it received my written notice of revocation. Unless otherwise revoked, this authorization will expire one (1) year from the date of signature.

I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization. However, Highmark may condition my enrollment and determine my eligibility or risk rating from information obtained through this signed authorization. I may print and retain a copy of this application.

In the event of enrollment, I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose protected health information for payment, treatment and health care operations.

I understand that, if the persons or organizations I authorize to receive and/or use the protected health information described above are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws. *(continued on next page)*

Conditions of Enrollment (continued)

A copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Family Deductible Acknowledgment - Required

Please initial where requested below for the product for which you are applying. If you and your spouse are applying for this coverage, your spouse also must initial where requested below.

DirectBlue

* Family Deductible: For an Agreement covering more than one (1) family member, each covered individual must meet his/her individual deductible (within a benefit period) before Highmark will pay for covered services for that individual. No individual member may satisfy the entire family deductible.

I understand and accept that, under the terms of the DirectBlue Agreement, only after three (3) individual family members have satisfied their deductibles will the deductibles for all remaining family members also be considered to have been satisfied.

Please initial here to indicate that you have read and understand the explanation of the DirectBlue Family Deductible.

Applicant's Initials: ______________________

Spouse's Initials: ______________________

PPOBlue

* Family Deductible: For an Agreement covering more than one (1) family member, the ENTIRE family deductible must be met (within a benefit period) before Highmark will pay for covered services for ANY family member. The family deductible can be satisfied by an individual family member or a combination of one or more family members.

I understand and accept that, under the terms of the PPOBlue Agreement, when more than one (1) family member is covered, one (1) or more family member(s) must satisfy the ENTIRE family deductible (within a benefit period) before Highmark will pay for covered services for ANY family member.

Please initial here to indicate that you have read and understand the explanation of the PPOBlue Family Deductible.

Applicant's Initials: ______________________

Spouse's Initials: ______________________

Applicant Signature(s) - Required

To the best of my knowledge and belief, the information provided on this application is true and correct.

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The PPOBlue High Deductible Health Plan is available to individuals who wish to purchase a qualified high deductible health plan for use with a Health Savings Account as defined by the Internal Revenue Service.

Please sign and date where requested below. If you and your spouse are applying for this coverage, your spouse must also read and understand this "Conditions of Enrollment" and sign and date where requested below.

I request this coverage to become effective ______________.

Your requested Effective Date must be within two (2) months of your date of signature below.

Note: The Effective Date of coverage is usually the first day of the month following medical underwriting approval. However, we cannot guarantee that your requested Effective Date can be met. The Effective Date is in all cases the date on which your coverage begins following medical underwriting approval and assignment of an Effective Date.

Please note: To avoid delays in processing your application, this form must be received by Highmark Blue Cross Blue Shield within fifteen (15) days of the date of your signature.

____
Applicant's Signature Date

____
Spouse's Signature Date

____
Dependent's (age 18 or older) Signature Date

____
Dependent's (age 18 or older) Signature Date

FOR PRODUCER USE ONLY

Producer's Certificate

Attention Producer:

If you have questions concerning the completion of this application, please call the Producer Line at 1-866-602-1248.

If this section is not fully completed, commission will not be paid.

Blue Cross Blue Shield Agency No. ☐☐☐☐☐   Producer No. ☐☐☐☐☐

Agency Name ______________________________

Producer's Name ______________________________
LAST *FIRST* *MI*

Producer's Signature ______________________________

Business Phone (   ) ______________________________
Area Code

Completion of this section is required BY A PRODUCER if the producer wishes to act on the applicant's behalf.

1. Except for the information set forth in the Medical Information Section of this application, are you aware, based on the applicant's responses to your inquiries, of any additional factors impacting the insurability and/or eligibility of the applicant and each of his/her dependents applying for this coverage? ❑ No ❑ Yes

   ____
   Producer Signature   Date

   ____
   Agency

2. Have you provided the applicant with all relevant marketing materials, including the Outline of Coverage? ❑ No ❑ Yes

3. Have you advised the applicant of the features of the product that they have selected, including satisfying their deductible(s)? ❑ No ❑ Yes

4. Is this applicant a current customer of Highmark Blue Cross Blue Shield? ❑ No ❑ Yes

5. Have you attached to this application a Replacement of Coverage form, if necessary? ❑ No ❑ Yes

6. Have you retained a signed copy of this application for your records? ❑ No ❑ Yes

Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the application or policy; or
3. Waive any of Highmark Blue Cross Blue Shield's rights or requirements.

Highmark Inc. d/b/a
Highmark Blue Cross Blue Shield
120 Fifth Avenue
Pittsburgh, PA 15222-3099

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