

To help us process your application promptly, please remember to:

- Print all answers in blue or black ink. Pencil will not be accepted.
- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid or tape.
- If more space is needed attach a separate page listing section and question numbers, then sign and date each page.

HOME OFFICE USE ONLY

CWA: _____

Please submit application using a method at right. If you have any questions, please call our Customer Service Department toll-free at 1-866-689-1523.	APPLY BY FAX: 1-505-816-5325
	APPLY BY MAIL: Blue Cross and Blue Shield of New Mexico Attn: PAK Enrollment P.O. Box 27838 Albuquerque, NM 87125-9705

SECTION A: PERSON APPLYING FOR NEW COVERAGE

- In addition to having a permanent residence in New Mexico, all persons applying for coverage must be a New Mexico resident at least for 6 months each year. All others are ineligible for coverage.
- Applicants who are not U.S. citizens must have had a complete physical by a physician in the U.S. within the past two years.
- Applicants must be less than 12 years of age, or less than the age of 18 if part of a sibling group that includes a child up to the age of 12.
- You must be the child's parent, trustee, or legal guardian when completing this form for a child. The child's information should be completed in the Primary Applicant section below. Infants are eligible after the first postnatal visit if there are no medical issues.

PRIMARY APPLICANT

FIRST NAME, MIDDLE INITIAL, LAST NAME		SOCIAL SECURITY NO.		SEX M <input type="checkbox"/> F <input type="checkbox"/>	AGE	DATE OF BIRTH (MM / DD / YYYY)	HEIGHT ' "	WEIGHT LBS
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)								
MAILING ADDRESS (STREET, CITY, STATE, ZIP+4) if different than above					MEDICAID ID NUMBER		COUNTY	
HOME PHONE () ()	WORK PHONE () ()	CELL PHONE () ()	FAX (if acceptable contact method) () ()		ETHNICITY <input type="checkbox"/> Caucasian <input type="checkbox"/> Other <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black			
EMAIL (if available and acceptable contact method)		BEST PLACE TO CALL (if necessary) <input type="checkbox"/> Home <input type="checkbox"/> Work		BEST TIME TO CALL (if necessary) <input type="checkbox"/> Morning <input type="checkbox"/> Evening <input type="checkbox"/> Afternoon				
Okay to use listed mailing address for non-billing mail? <input type="checkbox"/> Yes <input type="checkbox"/> No								

SECTION B: SELECT BILLING AND INSURANCE OPTIONS

Section B-1: Effective Date & Billing for Health

The coverage effective date will be the 1st of the month equaling or following BCBSNM's approval for coverage.

Complete the following:

ONGOING PREMIUM MODE: Monthly Bank Draft (complete *Automatic Premium Payment Authorization Agreement*)
 One-Month Direct Bill
 Two-Month Direct Bill

To setup a Monthly Bank Draft, submit an Automatic Premium Payment Authorization Agreement. This premium mode can also be added later.

SUBMITTED PREMIUM DEPOSIT: \$ _____ (check, bank draft)

Cashing of the Premium Deposit does not constitute approval of this Application. If this Application is not approved, the Premium Deposit will be returned to the Primary Applicant and neither the Primary Applicant nor any other person applying for coverage under this Application shall be entitled to benefits or coverage.

BILLING NAME & ADDRESS: _____

SECTION C: HEALTH HISTORY / MEDICAL QUESTIONS

- All health history / medical questions must be completed for the individual child applying for coverage.
- If you answer "Yes" to ANY questions in Section C, please give complete details in Section D. Please note the time frame reference for each question.

1. Within the last 10 years has the individual child applying for coverage been advised, counseled, tested, diagnosed, treated, prescribed medication, hospitalized or recommended for treatment for the following (please mark "Yes" or "No"):

If any boxes are marked "Yes" (☒ Yes), also circle the condition, e.g., migraines, and give complete details in Section D.

A. Migraines; headaches; epilepsy or seizure disorder; head injury or concussion; any neurological disorder; neuropathy; paralysis; multiple sclerosis; or any other central or peripheral nervous system disorder? Yes No

B. Attention deficit disorder; anxiety; depression or chemical imbalance; insomnia; bipolar disorder; mental retardation; any behavioral, emotional or mental disorder; eating disorder; pervasive development disorder or autism spectrum disorder; marital or any form of counseling or therapy? Yes No

C. Chest pain; palpitations; heart murmur; mitral valve prolapse; arrhythmia or irregular heartbeat; heart attack; stroke or TIA; or any other heart or circulatory disorder or condition, or hypertension / high blood pressure (HBP)? Yes No

If "Yes" to HBP, provide 3 readings and their dates within the last year.

1) _____ 2) _____

3) _____

D. Elevated cholesterol, triglycerides or other lipids (including if controlled by diet or exercise)? Yes No

If "Yes", provide the date and results of most recent testing:

Date: _____ Total Chol.: _____ HDL: _____ Triglycerides: _____

E. Varicose veins; spider veins; varicosities; blood clot; anemia; or any other blood disorder? Yes No

F. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; breathing difficulty; or any other lung or respiratory disease, disorder or condition? Yes No

G. Acid reflux; gastroesophageal reflux (GERD); Barrett's or any other disorder of the esophagus; irritable bowel syndrome (IBS); colitis; diverticular disease; chronic diarrhea or intestinal problem; ulcer; hernia; hemorrhoids or rectal disorder; or any other digestive disorder or condition? Yes No

If "Yes" to hernia, indicate type: _____

H. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; or hepatitis? Yes No

If "Yes" to hepatitis, indicate type: _____

I. Cancer; tumor; growth; cyst; polyp; enlarged lymph node(s); or leukemia? Yes No

If "Yes", indicate diagnosis & location: _____

J. Acne; keratosis; psoriasis; basal cell carcinoma; malignant melanoma; lesions of the skin or mouth; hemangioma(s); or any other skin disorder? Yes No

K. Kidney stones; urinary reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? Yes No

L. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? Yes No

M. Back or spinal disorder; herniated, bulged, protruded, ruptured or slipped disc; degenerative disc disorder; or any other injury to, disease or disorder of the back or spine? ... Yes No

N. Arthritis (e.g. osteoarthritis, rheumatoid, psoriatic, etc.); gout; bursitis; carpal tunnel syndrome; pinched nerve; bunion; temporomandibular joint syndrome (TMJ); or any injury to, disease or disorder of the knees, shoulders, jaw, bones, muscles or joints; joint replacement; or received chiropractic adjustments or manipulation therapy? Yes No

O. Hypothyroidism; hyperthyroidism; Graves' disease; goiter; nodule or any other thyroid disorder; diabetes; elevated blood sugar; glucose intolerance; insulin resistance or any other metabolic, endocrine, pituitary or adrenal disorder; lupus; chronic fatigue syndrome; connective tissue or autoimmune disorder? Yes No

P. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any other eye, ear, nose, speech or throat disorder? Yes No

Q. Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex (ARC); HIV positive or other immune disorder? Yes No

R. For MALE child applicant
Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; erectile dysfunction; or any other disease or disorder of the genital or reproductive system? Yes No

S. For FEMALE child applicant
a) Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele; rectocele; sexually transmitted disease; genital warts; herpes; HPV; or any other disease or disorder of the genital or reproductive system? Yes No

b) Has the child applicant ever had a C-section? Yes No

c) Has the child applicant ever had a pap smear? Yes No

If "Yes" for pap, provide date and results of the applicant's last 2 paps:

Date _____ Normal Abnormal

Date _____ Normal Abnormal

Applicant Name _____

SECTION C: HEALTH HISTORY / MEDICAL QUESTIONS *continued*

All health history/medical questions must be completed for the individual child applying for coverage.

2. For the individual child applicant applying for coverage, complete the following information regarding their last physical exam, including checkup:

Exam Date (Month/Year): _____ \ _____ Exam Results: Normal Abnormal*

***Abnormal exam results include any recommendation for additional testing, medication or follow-up visit(s).**

3. **During the last 5 years**, has the child applying for coverage had an **abnormal** result from a physical exam, blood test, urinalysis, lab or diagnostic test? Yes No

4. **During the last 12 months**, has the child applying for coverage been prescribed or advised to take medication (other than for the common cold or flu) that is not indicated elsewhere on this application? *If unsure of the reason for any ongoing medication use, please verify with the child's physician* Yes No

5. **During the last 12 months**, has the child applying for insurance smoked or used any tobacco product – such as cigarettes, pipes, cigars, snuff, chewing tobacco – or used any smoking cessation aid or nicotine substitution product? Yes No

6. A. Question for female child applicant:
Is any female applying for coverage currently pregnant or now an expectant parent? Yes No
If "Yes," coverage cannot be offered.

B. Question for male child applicant:
Is any male applying for coverage now an expectant parent? Yes No
If "Yes," coverage cannot be offered.

7. Has the child applying for coverage **ever** been seen, tested, prescribed or taken medication, or treated for infertility or to assist in becoming pregnant? Yes No

8. Does the child applying for coverage **have or ever had** an implant (e.g., breast, chin, or penile implant, etc.), internal fixation (e.g., pins, plates, rods, screws or spinal cage), prosthesis, pacemaker, heart valve replacement, shunt or monitoring device other than indicated elsewhere on this application? Yes No

9. For Child Applicants Age 13 or Older:
A. Does the individual applying for coverage drink beer or alcohol? Yes No
If "Yes," please complete the following:
Average Number of Drinks per Week: _____ (NOTE: 1 drink is equivalent to one 12 oz. beer, or one 5 oz. glass of wine, or 1.5 oz. of hard liquor)

B. Has the individual applying for coverage **ever** been advised to seek treatment for alcohol use or been advised to reduce alcohol intake or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism? .. Yes No

10. Has the individual applying for coverage **ever** used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use (prescription, non-prescription, or illegal), or dependency? Yes No

11. Has the individual applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery **which has not yet been performed?** Yes No

12. Has the individual applying for coverage **ever** been seen, treated, hospitalized, or had surgery for a bypass, angioplasty, stent, aneurysm, valve replacement, cancer, stroke, gastric or weight loss surgery, congenital abnormality, or organ transplant **other than indicated elsewhere on this application?** Yes No

If you answered "YES" to any questions in Section C, please give complete details in Section D.

Applicant Name _____

SECTION E: REPRESENTATIONS, ACKNOWLEDGEMENTS, and AUTHORIZATIONS

Conditions of Health Statement: I understand that the purpose of the Health Statement is to provide Blue Cross Blue Shield of New Mexico (BCBSNM) with information for determining the qualifications of the individual child applying for BCBSNM health benefits coverage and I agree that this Health Statement shall become part of the contracts between BCBSNM and myself.

I understand that this Application may be declined and that no temporary binder of insurance arises from my completion of this Application and payment of the premium deposit.

I understand that if my Application for health insurance is approved, there is no coverage for pre-existing conditions for six months from the effective date of coverage and that I may provide proof of prior creditable coverage to reduce or eliminate this pre-existing period.

Other Insurance: For purposes of Premium Assistance for Kids (PAK) eligibility, an applicant cannot be covered by a commercial health insurance product, Medicare, or Medicaid. The applicant must be ineligible for Medicaid or SCHIP due to countable income, not on the basis of failure to provide the necessary documentation to establish eligibility for Medicaid or SCHIP. An individual with access to health care at Indian Health Services, Veteran’s Administration, or through worker’s compensation, is not considered to be insured by having such access.

I understand that I am not eligible for the Premium Assistance for Kids (PAK) if I am covered by a commercial health insurance product, Medicare, or Medicaid and acknowledge that I (child applicant) have no other insurance coverage.

Authorization: I understand that BCBSNM must obtain information for the purpose of evaluating my application for insurance and that my authorization is voluntary. Therefore I authorize any medical professional, hospital, clinic, or other organization or person to disclose to BCBSNM medical records or other information about advice, care or treatment provided to me. In addition, I authorize BCBSNM to review and research its own records for information.

I understand that I must sign this authorization for BCBSNM to consider my application and to determine whether or not to offer coverage and that no action will be taken on my application without my signed authorization. I understand that information obtained with my authorization may be re-disclosed by BCBSNM as permitted or required by law and this information may no longer be protected by the federal privacy laws.

I understand this authorization is valid from the date signed and terminates on whichever date is later, when my application is denied or twenty-four months from the date of my application. I may revoke this authorization in writing, which I may do at any time. A revoked authorization does not affect BCBSNM’s activities prior to receipt of the revocation. I should retain one duplicate of this authorization as my copy.

In no event shall BCBSNM incur any liability before a policy is effective or with respect to an application that has been declined.

I acknowledge that I have read and verified the above. I understand the foregoing answers and certify and warrant that they are true and shall be the basis for the issuance of the coverage applied for, and that the omission or misstatement of any material information in answer to the foregoing questions shall void my coverage and may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of BCBSNM.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties

IMPORTANT: Your application must be signed and dated by the individual(s) indicated below. Missing signatures or dates will cause a delay in processing. Must be signed within 60 days of desired effective date.

We must receive your application *within 30 days of the earliest signature date*, so please return the application promptly. Applications received after 30 days will not be accepted, and a new application will be required.

Signature

Primary Applicant’s Signature (Age 15 and over): _____

Date: _____ / _____ / _____
Mo Day Year

Parent/Legal Guardian Signature: _____
Signature of Parent, Trustee or Legal Guardian is required

Date: _____ / _____ / _____
Mo Day Year

Applicant Name _____

Proxy

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Parent/Legal Guardian Signature: _____

Print Your Name as You Signed It: _____ **Date Signed:** _____ / _____ / _____
Mo Day Year

Thank you for applying. Please include all materials when submitting this application.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an independent Licensee of the Blue Cross and Blue Shield Association