BlueCross BlueShield of New Mexico

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

Home Office Use Only

CWA:	

APPLY & SUBMIT ONLINE *(Internet)*
bcbsnm.com

SUBMIT BY MAIL
Blue Cross and Blue Shield of New Mexico
Attn: Underwriting and Individual Enrollment
PO Box 3236
Naperville IL 60566-7236

SUBMIT BY FAX
1-800-625-5916

Application for Individual Medical Insurance, and Individual Dental Insurance

To help us process your application promptly, complete and submit your application as follows:

1. *If you have questions, call Customer Service toll-free at 1-866-236-1702 or call your broker.*
2. Please print clearly in **blue or black ink**. Pencil will not be accepted.
3. To correct any errors, cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid or tape.
4. If more space is needed, attach a separate page(s) and list section(s), question numbers, and answers. Then sign and date each sheet.
5. The Primary Applicant must personally sign the application. If the Primary Applicant's spouse and/or any dependent children age 18 or over are also applying, each must personally sign the appropriate signature line.
6. If applicable, be sure Broker section on the last page is completed.
7. Make a copy of your completed application for your records.
8. Please submit all application materials together using one of the methods listed at the top of this page.
9. DO NOT CANCEL any current coverage you may have until your new policy is approved and in force.

Primary Applicant Name_____

SELECT HOW YOU ARE USING THIS APPLICATION FORM

Mark Box(es): ☐ Apply for New Policy ☐ Add Spouse and/or Dependent(s) to Current Policy ☐ Upgrade Current Policy (increase benefits)

SECTION A – PERSON(S) APPLYING FOR NEW COVERAGE (or Change in Coverage)

- In addition to having a permanent residence in New Mexico, all persons applying for coverage must reside in New Mexico a minimum of 6 months each year. All others are ineligible for coverage.
- All 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.

PRIMARY APPLICANT

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NO.	SEX M F	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*	OCCUPATION / DUTIES (optional)

HOME PHONE	WORK PHONE	CELL PHONE	FAX (if acceptable contact method)	SPOUSE'S PHONE NO.'S (if applying)
( )	( )	( )	( )	WORK: ( ) CELL: ( )

EMAIL (if available and acceptable contact method)	BEST PLACE AND TIME TO CALL (if necessary)
	☐ HOME ☐ WORK ☐ MORNING ☐ AFTERNOON ☐ EVENING

SPOUSE and/or DEPENDENT CHILDREN* TO BE COVERED (dependent children must be under age 26)

First Name, Middle Initial, Last Name	Relationship	Sex	Height	Weight lbs	Date of Birth (MM/DD/YYYY)	Social Security No.
		M ☐ F ☐	' "			
		M ☐ F ☐	' "			
		M ☐ F ☐	' "			
		M ☐ F ☐	' "			
		M ☐ F ☐	' "			

*If a CHILD is to be covered, are ALL children listed above your natural children, stepchildren or adopted children?. . . . . ☐ Yes ☐ No

If "No," 1) List name(s) of applicable child(ren): _____

2a) Are you (or your spouse) legally and financially responsible for this/these dependent(s)?. . . . . ☐ Yes ☐ No

2b) If "Yes" in 2a, please submit a copy of the signed court decree.

SECTION B – SELECT HEALTH INSURANCE PLAN

Select a box for one of the five health insurance plans and then select a box for the desired deductible level (individual amounts listed):

☐ BlueDirect® Basic *Choose a deductible below – individual amounts listed:*
☐ $1,000 ☐ $2,000 ☐ $3,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

☐ BlueDirect Enhanced *Choose a deductible below – individual amounts listed:*
☐ $500 ☐ $1,000 ☐ $2,000 ☐ $3,500 ☐ $5,000 ☐ $7,500

☐ BlueDirect Premier *Choose a deductible below – individual amounts listed:*
☐ $500 ☐ $1,000 ☐ $2,000 ☐ $3,500 ☐ $5,000

☐ BlueEdge℠ Individual HSA (An HSA-eligible plan)
*Choose a deductible below – individual amounts listed:**
☐ $2,600 (Basic) ☐ $1,700 (Enhanced) ☐ $1,250 (Premier)

☐ BlueEdge 100 HDHP (An HSA-eligible plan)
*Choose a deductible below – individual amounts listed:**
☐ $3,500 ☐ $5,000

*The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.

Optional BlueCare Dental PPO

Select the box below to apply **(you must be enrolled in a BCBSNM health plan in order to apply for dental coverage)**:

☐ Dental Insurance Coverage – I (We) hereby apply for Dental coverage and understand that all Applicants and Dependents approved for health coverage will be covered under the Dental coverage. If any covered health individual is cancelled from the health coverage or if health coverage is cancelled in its entirety, I understand the same action will be applied to Dental coverage. **I understand I only have until 31 days after the effective date of my health insurance policy to purchase dental insurance, and that there will not be a later opportunity to do so.**

Primary Applicant Name_____

SECTION C – HEALTH HISTORY / MEDICAL QUESTIONS

Please Complete the Following Health Questions: For this insurance to be in force, you must answer the following health questions fully and truthfully and provide all of the health information asked for; including routine physical examinations, and Blue Cross and Blue Shield of New Mexico must approve this application. No one may change this requirement for you in any way. An act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission means the cancellation or discontinuance of coverage retroactive to the effective date. Rescission does not include the cancellation or discontinuance of coverage attributable to a failure to timely pay required premiums or contributions toward the cost of coverage, a voluntary termination by a covered person, or cancellation due to a covered person becoming ineligible for coverage. You be will provided with at least 30 days advance written notice before you or your dependent's coverage may be rescinded. **Please do not mark over or strike out any signature, date or health question information.**

- **All health history/medical questions must be completed for all individuals (including adults and children) applying for coverage.**
- **If "Yes" to ANY questions in Section C – Health History / Medical Questions, please give complete details in Section D – Details of Health History. Please note the timeframe reference for each question.**

1. Within the last 10 years has any person 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 – Details of Health History.

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:*

Reading/Date:_____Reading/Date:_____Reading/Date:_____

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 Cholesterol: _____

High-Density Lipoprotein (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 and location:* _____

J. Acne; keratosis; psoriasis; basal cell carcinoma; malignant melanoma; lesions of the skin or mouth; hemangiomas; or any other skin disorder? . . . . . ☐ Yes ☐ No

Questions continue at right

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. <u>For all Male persons applying (adults and children)</u>
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. <u>For all Female persons applying (adults and children)</u>
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 any female person had a C–section?. . . . . ☐ Yes ☐ No
c) Has any female person had a Pap smear?. . . . . ☐ Yes ☐ No
If "Yes" for Pap, provide date and results of each person's last 2 Paps:

Name _____ Date _____ ☐ Normal ☐ Abnormal

Name _____ Date _____ ☐ Normal ☐ Abnormal

Name _____ Date _____ ☐ Normal ☐ Abnormal

Name _____ Date _____ ☐ Normal ☐ Abnormal

Primary Applicant Name_____

SECTION C – HEALTH HISTORY / MEDICAL QUESTIONS *continued*

All health history/medical questions must be completed for all individuals (including adults and children) applying for coverage.

2. **For EACH person applying for coverage (adults and children),** complete the following information regarding their last physical exam, including checkup:

   Person's Name: _____ Exam Date (Month / Year): _____ / _____ Exam Results: ☐ Normal ☐ Abnormal*

   Person's Name: _____ Exam Date (Month / Year): _____ / _____ Exam Results: ☐ Normal ☐ Abnormal*

   Person's Name: _____ Exam Date (Month / Year): _____ / _____ Exam Results: ☐ Normal ☐ Abnormal*

   Person's Name: _____ 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 any person 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 any person 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 your physician.* . . . . . ☐ Yes ☐ No

5. **During the last 12 months,** have you or your spouse (if to be insured) or any dependent child age 18 and over (if to be insured) smoked or used any tobacco product – such as cigarettes, pipes, cigars, snuff, chewing tobacco or used any smoking cessation aid or nicotine substitution product?
   APPLICANT . . . . . ☐ Yes ☐ No
   SPOUSE . . . . . ☐ Yes ☐ No
   CHILD *(dependent who is age 18 or over)* **(If "Yes," list name(s) in Section D – Details of Health History).** . . . ☐ Yes ☐ No

6. A. **Question for all FEMALE persons applying (including dependents):**
   Is any female applying for coverage currently pregnant or now an expectant parent? . . . . . ☐ Yes ☐ No
   B. **Question for all MALE persons applying (including dependents):**
   Is any male applying for coverage now an expectant parent? . . . . . ☐ Yes ☐ No

For policies with an initial effective date prior to March 23, 2010, if you answered either question "Yes", coverage cannot be offered. For policies with an initial effective date on or after March 23, 2010, if you answered "Yes" and the applicant is age 19 and over, coverage cannot be offered.

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

8. A. Does any person 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

   ***If "Yes" to breast implants**, please complete the following:*

   B. Indicate reason(s) for breast implants: ☐ Cosmetic reasons ☐ Disease / Illness / Injury / Congenital Anomaly

   C. Have there been any complications or have the breast implants been replaced? . . . . . ☐ Yes ☐ No

9. A. Does any person applying for coverage drink beer or alcohol? . . . . . ☐ Yes ☐ No

   If "Yes", please complete the following:

   Person's Name: _____ Average Number of Drinks Per Week: _____

   Person's Name: _____ Average Number of Drinks Per Week: _____

   Person's Name: _____ 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 any person 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 any person 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 any person 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 any person 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 "Yes" to ANY questions in Section C – Health History / Medical Questions, please give complete details in Section D – Details of Health History.

Primary Applicant Name_____

SECTION D – DETAILS OF HEALTH HISTORY

If you answered "Yes" to ANY question in Section C – Health History / Medical Questions OR have had an abnormal exam or test, please provide further information in the spaces below. Be sure to use the "correct" example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

	QUESTION NUMBER	PERSON AFFECTED	CONDITION, INJURY, SYMPTOM, OR DIAGNOSIS			WAS RECOVERY COMPLETE?	TYPES OF TREATMENT, ADVICE GIVEN AND MEDICATIONS PRESCRIBED	DATE LAST TREATED (if applicable)	NAME, ADDRESS & PHONE NUMBER OF DOCTORS AND HOSPITALS
			DESCRIPTION (specify left or right, if applicable)	DATE THAT IT STARTED	DATE OF RECOVERY (if applicable)				
CORRECT	1C	JOE SMITH	HIGH BLOOD PRESSURE	6/95	NONE	NO, ONGOING	40 MG ATENOLOL, ONCE DAILY	TODAY, (STILL USING MEDICINE)	DR. JONES ST. MARY'S ANYTOWN, NM (505) 222-2222

SECTION E – OTHER INSURANCE

1. Does any person applying for coverage currently have, or did they previously have within the last 5 years, Blue Cross and Blue Shield of New Mexico coverage, either as a primary insured, spouse, or as a dependent? . . . . . ☐ Yes ☐ No
   If "Yes", please complete the following:

   Applicant Name: _____ Name on Current or Previous Policy *(if applicable):* _____ Member Number and Group Number *(optional)*_____

   Applicant Name: _____ Name on Current or Previous Policy *(if applicable):* _____ Member Number and Group Number *(optional)*_____

   Applicant Name: _____ Name on Current or Previous Policy *(if applicable):* _____ Member Number and Group Number *(optional)*_____

2. Has any person applying for coverage had, **within the last 5 years**, any health or major medical insurance coverage with any other Insurer, including other Blue Cross and Blue Shield plans? . . . . . ☐ Yes ☐ No
   If "Yes", please complete the following:

   Name(s) of all individuals covered:_____

   Insurer Name(s): _____ Location / State: _____

   Policy Effective Date:_____ Anticipated Policy Termination Date:_____

3. Has any person applying for coverage ever been declined, postponed, charged an extra premium for or had a rider applied to health or disability insurance, or had any such insurance rescinded or cancelled? . . . . . ☐ Yes ☐ No

   If "Yes", provide name(s): _____ Explanation:_____

NOTE: DO NOT CANCEL ANY CURRENT COVERAGE YOU MAY HAVE UNTIL YOUR NEW POLICY IS APPROVED AND IN FORCE.

Primary Applicant Name_____

SECTION F – REPRESENTATIONS, ACKNOWLEDGEMENTS AND AUTHORIZATIONS

Conditions of Health Statement: I understand that the purpose of the Health Statement is to provide BCBSNM with information for determining the qualifications of myself (individual) and/or my dependents for BCBSNM health benefits coverage, and I agree that this Health Statement shall become part of the contract 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 the broker/producer has no authority to approve this Application or to issue coverage, and I acknowledge that no such representations have been made to me by the broker/producer.

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 (this limitation does not apply to persons under 19 years of age) and that I may provide proof of prior creditable coverage to reduce or eliminate this pre-existing period.

Authorization: I understand that BCBSNM may, in its discretion, 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 and/or my dependents. 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 understand that an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission means the cancellation or discontinuance of coverage retroactive to the effective date. I will be provided with at least 30 days advance written notice before my or my dependent's coverage may be rescinded. In the event of such cancellation, BCBSNM may deduct from the premium refund any amounts made in claim payments during this period and you may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which cancellation is effected. At any time when BCBSNM is entitled to rescind coverage already in force, BCBSNM may, at its option, make an offer to reform the policy already in force. This reformation could include, but not be limited to, the addition of exclusion riders (this limitation does not apply to members under 19 years of age) and a change in the rating category/level. In the event of reformation, the policy will be reissued retroactive in the form and premium it would have been issued had the misstated or omitted information been known at the time of application.

I acknowledge that I have read and verified the above. I understand the foregoing answers and certify and warrant that they are true. They shall be the basis for the issuance of the coverage applied for.

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.

The undersigned acknowledges that any broker/producer is acting on behalf of Health Care Service Corporation (HCSC) for purposes of purchasing the insurance, and that if HCSC accepts this application and issues an Individual Policy, HCSC may pay the broker/producer a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if additional information is needed regarding any commissions or other compensation paid the broker/producer by HCSC in connection with the issuance of the Individual Policy, they should contact the broker/producer.

Primary Applicant Name_____

SECTION G – REQUIRED SIGNATURES

IMPORTANT: Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) 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.

Primary Applicant's Name (Please print):_____

Primary Applicant's Signature: X_____ **Date:**_____ /_____ /_____
Month Day Year

Spouse's Name (If applying, please print):_____

Spouse's Signature (If applying): X_____ **Date:**_____ /_____ /_____
Month Day Year

Parent's Name (Please print): _____

Parent's Signature: X_____ **Date:**_____ /_____ /_____
Month Day Year

Trustee or Legal Guardian's Name (Please print):_____

Trustee or Legal Guardian's Signature: X_____ **Date:**_____ /_____ /_____
Month Day Year

Dependent's Signature (ONLY if 18 or over and to be insured): X_____ **Date:**_____ /_____ /_____
Month Day Year

Dependent's Signature (ONLY if 18 or over and to be insured): X_____ **Date:**_____ /_____ /_____
Month Day Year

SECTION H – 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 (300 E. Randolph St., Chicago, IL 60601) 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.

Primary Applicant's Proxy Signature (Optional) **YOU MUST ALSO SIGN IN "SECTION G" ABOVE:**

X_____

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

SECTION I – EFFECTIVE DATE & BILLING FOR HEALTH AND DENTAL

REQUESTED EFFECTIVE DATE **(Mo./Day/Yr.) ____ / ____ / ____ (Note: Date cannot be 29th, 30th or 31st)**

BILLING DATE

Billing for health (medical) and optional dental insurance is combined – one payment covers both products (if applicable). Enrollment in Dental coverage depends on acceptance and enrollment in Health Insurance.

To setup a Monthly Bank Draft (the health/dental premium is deducted from your bank account), complete the Authorization Agreement on page 8.

Primary Applicant Name_____

SECTION I – *continued*

SELECT PREMIUM OPTION:

(Make check payable to Blue Cross and Blue Shield of New Mexico. Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.)

MONTHLY BANK DRAFT:

☐ Monthly Bank Draft (Payment will be drafted upon receipt of this application. You must complete the Authorization Agreement below.)

- ☐ Deduct initial premium payment only
- ☐ Deduct ongoing monthly premium payments only **(First month premium amount of $_____enclosed)**
- ☐ Deduct both the initial premium payment and ongoing monthly payments

☐ **SEND ME A PAPER BILL: (First month premium amount of $_____enclosed)**

☐ One-Month Direct Bill ☐ Two-Month Direct Bill

NOTE: 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.

☐ **EMPLOYER BILL:** List Bill (Indicate Name of Employer below.)

Billing Name and Address (If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless requested otherwise.)

FIRST NAME, MIDDLE INITIAL, LAST NAME
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)
NAME OF EMPLOYER (if requesting List Bill only)

AUTHORIZATION AGREEMENT

I request and authorize Blue Cross and Blue Shield of New Mexico (BCBSNM) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. As the account holder, by signing below, I also certify, in the event that this draft is being drawn from a company checking account, that I am authorized to approve this transaction, that the company is not paying any portion of the premium for this subscriber, either directly, or through reimbursement, and that the employer/company is not deducting any part of the premium from gross income under section 106 or section 162 of the Internal Revenue Code. I understand that both the financial institution and BCBSNM reserve the right to terminate this payment program and/or my participation therein. I also understand that I may discontinue this payment program at any time with at least 10 days advance notice to Blue Cross and Blue Shield of New Mexico by telephone prior to a scheduled withdrawal date.

PLEASE COMPLETE THE FOLLOWING – PRINT OR TYPE INFORMATION

I authorize BCBSNM to deduct the premium payments from my checking or savings account. If the draft date falls on a non–business day or a holiday, the premium payment will be deducted from my account on the next business day.

PLEASE ENSURE ADEQUATE FUNDS ARE AVAILABLE AT THE TIME OF APPLICATION. BLUE CROSS AND BLUE SHIELD OF NEW MEXICO IS NOT RESPONSIBLE FOR FEES INCURRED DUE TO INSUFFICIENT FUNDS.

PLEASE CHECK ONE: ☐ Checking Account ☐ Savings Account

NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT:_____

NAME AND LOCATION OF BANK WHERE ACCOUNT IS AUTHORIZED:_____

BANK TRANSIT NUMBER:_____ DEPOSITOR'S ACCOUNT NUMBER:_____

I HAVE READ AND ACCEPT THE ABOVE AGREEMENT.

DEPOSITOR'S SIGNATURE: X_____ DATE:_____

RELATIONSHIP TO APPLICANT:_____

SECTION J – BROKER INFORMATION *(if applicable)*

- If you are using an insurance broker, be sure the Broker Information table below is completed (the broker may have already filled it in). If you were instructed to do so, return this application to your broker, and let the broker be responsible for this section.
- If you are not returning this form to an insurance broker, please see page 1 for ways to submit your application.

NAME IN BCBSNM CONTRACT (AGENCY OR INDIVIDUAL)	BROKER NUMBER	MAIL NEW MEMBER PACKET TO: □ BROKER □ MEMBER
BROKER'S NAME	BROKER'S PHONE	BROKER'S FAX

THANK YOU FOR APPLYING. PLEASE INCLUDE ALL NECESSARY MATERIALS WHEN SUBMITTING THIS APPLICATION. IF LEGAL GUARDIAN, PLEASE ENCLOSE SIGNED COURT DECREE.

Changes in state or federal law, or regulations or interpretations thereof, may change the terms and conditions of coverage.