Application and Health Questionnaire for

An Individual HMO
from Keystone Health Plan West

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees 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 appropriate sections.

First select a Primary Care Physician (PCP)/Group Practice from the *Physician Directory*. Indicate the name and the PCP number of the physician or practice you have selected for yourself and each of your covered dependents. Each of you can choose a different PCP.

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 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.
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. Provide all the information requested on the Enrollment Form. Provide information about your spouse and dependents only if they are also applying for coverage. Please remember to select a PCP and indicate if you are currently a patient of the PCP you choose.
4. Provide "Medical Information" requested under Sections A, B, C and D. Provide information about yourself and any other applicants.
5. Read the "Conditions of Enrollment" on page 7. 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 an insurance producer acting on your behalf. This section should not be completed 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 "Keystone Health Plan West." Mail to:

   KeystoneBlue Individual HMO
   P.O. Box 382062
   Pittsburgh, PA 15250-8062

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 Keystone Health Plan West 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 information requested may result in a delay in the processing of your application.

Keep this page for your records.

Date: ________________ Check Number: ______________

Amount Paid: ____________________________________

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 may be eligible for coverage at a higher rate, 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 Keystone Health Plan West Underwriting Department immediately at 120 Fifth Avenue, Suite 1224, Pittsburgh, PA 15222-3099. A change in your medical condition that occurs *prior* to your effective date could result in a denial of coverage if your application has not yet been approved or cancellation of coverage if your application has been approved but coverage is not yet effective.

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 60 days of the date shown on the denial letter you receive:

1) Ask the attending physician to 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:

    Keystone Health Plan West Appeal
    Fifth Avenue Place
    120 Fifth Avenue, Suite 1224
    Pittsburgh, PA 15222-3099

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

For more information or help completing this application…

If you have questions about this coverage or how to complete this application, please call a Member Service Representative at 1-800-876-7639.

HIGHMARK
KEYSTONEBLUE
An Individual HMO
from Keystone Health Plan West

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ENROLLMENT FORM

All information must be complete and accurate to process your application without delay. You must select a Primary Care Physician for yourself and dependents you are enrolling. (Eligible children are unmarried children under age 19.) If you have any questions or need additional forms, please call our Member Service Department toll-free at 1-800-544-6679.

If applying for family coverage, applicant must be the older spouse. If children only are applying, youngest child must be applicant.

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. All shaded fields are for Keystone Health Plan West and Producer use only.

☐ One Person ☐ Hus./Wife ☐ Hus./Wife-One Child	Work Phone ( )	Home Phone ( )
☐ Par./Child ☐ Par./Children ☐ Hus./Wife-Two+ Children	Work E-mail	Home E-mail

Home Address	City	State	Zip	County

Monthly premium: $ ____________________

This KeystoneBlue Individual HMO Subscriber Agreement renews on a month-to-month basis. The premium is payable to Keystone Health Plan West on a monthly basis. Once enrolled, you can choose to pay your monthly premium via electronic funds transfer through the Pay It Easy program.

	Applicant	Spouse	Dependent	Dependent	Dependent
Social Security Number					
Name					
Have you smoked or used smokeless tobacco within the past year?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Sex	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female	❑ Male ❑ Female
Membership Status	❑ Single (1) ❑ Married (2)	(2) Spouse	(3) Child	(3) Child	(3) Child
Birth Date (MM/DD/YY)	/ /	/ /	/ /	/ /	/ /
Height / Weight	/	/	/	/	/
Primary Care Phys. Name					
Primary Care Phys. No. Obtain from PCP Directory					
Primary Care Phys. Phone No.	( )	( )	( )	( )	( )
Primary Care Physician Status	❑ Check here if presently a patient of this physician	❑ Check here if presently a patient of this physician	❑ Check here if presently a patient of this physician	❑ Check here if presently a patient of this physician	❑ Check here if presently a patient of this physician
KHPW Use Only					

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 Keystone Health Plan West, Blue Cross and/or Blue Shield policy.
☐ Yes ☐ No – If "yes," please provide the insurance company name and applicable group and identification number(s):

Company Name: Agreement or I.D. No.: ________________________________

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

Have you or any applicants ever applied and been rejected for any: Name of Person(s) Rejected and Reason

Medical policies ☐ Yes ☐ No ____

Life Insurance policies ☐ Yes ☐ No ____

Are you or any of your dependents who are applying for this coverage enrolled in or eligible for Medicare due to age and/or disability?
☐ Yes ☐ No

ANY PERSON ELIGIBLE FOR MEDICARE OR MEDICARE DISABILITY BENEFITS IS NOT ELIGIBLE FOR THIS COVERAGE.

I request this coverage to become effective____________________

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

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. To avoid delays in processing your application, this form must be received by Keystone Health Plan West within fifteen (15) days of the date of your signature.

Payment Enclosed	Group Number		Applicant's Social Security Number
$	058908-00	Box 382062	

Medical Information:

Section A.

Please answer each question completely. If it is found that you have supplied fraudulent information, or made fraudulent statements or omissions with the intent to deceive, your Agreement may be terminated.

1. Do you – or any family member applying – use any medical equipment (such as a walker, wheelchair, cane, hospital bed, C-PAP, Bi-PAP or oxygen)? ☐ Yes ☐ No
2. Are you – or any family member applying – currently receiving home health care? ☐ Yes ☐ No
3. If you answered "YES" to question 1 or 2, please provide the name(s) of the affected person(s) and specifics about the condition:

Name of Person ____________________ Condition/Reason ____________________

____________________ ____________________

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

Name of Person ____________________ Date of Last Period ____________________

____________________ ____________________

5. Have you — or any family member applying — been recently (i.e., within the past nine (9) months) medically diagnosed or treated for pregnancy? ☐ Yes ☐ No

   Name(s) of pregnant person(s): ____________________ Date medically diagnosed or treated: ____________________

6. Have you – or any family member applying – gained or lost more than 20 pounds over the past 3 months? ☐ Yes ☐ No If "YES," provide person's name and amount gained or lost.

Name of Person ____________________ Weight Gained/Lost ____________________

____________________ ____________________

Section B.

For each person listed on this application, please check the block and enter the most recent date of diagnosis, treatment, monitoring or medical consultation by a physician or other health care provider for any condition, illness, injury or surgery.

			List Dependent(s) by Name			
Conditions	**Applicant**	**Spouse**				
7. AIDS or Positive Test for HIV, HTLV-III/LAV Antibodies						
8. Alcoholism						
9. Alzheimer's Disease						
10. Amputation of Limb (Specify) ____________						
11. Arterio-Venous Malformation (AVM)						
12. Arthritis (Specify type) ____________						
13. Other Musculoskeletal Conditions (Specify - for example: osteoporosis or osteopenia) ____________						
14. Asthma						
15. Back Disabilities						
16. Back Pain - Chronic						
17. Brain Tumor						
18. Cancer						
19. Cataract(s) right ________ left ________						
20. Chest Pain or Angina						
21. Chiropractic or Therapy Visits (**Required** - Specify type and number of visits) ________						
22. High Cholesterol (**Required** - Specify total cholesterol) ________						
23. Cirrhosis						
24. Other Liver Disease (Specify) ____________						
25. Congenital Anomalies and Conditions (Specify) ____________						
26. Dementia, "Senility" or Increasing Forgetfulness with Age						
27. Diabetes – Controlled with Diet (**Required** - Specify current Hemoglobin A1c or Fasting Blood Sugar) ________						
28. Diabetes – Controlled with Medication (**Required** - Specify current Hemoglobin A1c or Fasting Blood Sugar) ________						

Medical Information (Continued)

Conditions	Applicant	Spouse	List Dependent(s) by Name			
29. Disease/Surgery of the Esophagus, Stomach or Intestine (for example, Crohn's Disease, Ulcerative Colitis or weight loss procedures) (Specify) ________						
30. Drug Dependency						
31. Ear Conditions (including frequent ear infections) (Specify) ________						
32. Emphysema/COPD						
33. Other Lung Disease (Specify - for example work-related conditions or chronic bronchitis) ________						
34. Gynecological (Specify - for example, polycystic ovaries) ________ If recent delivery, please provide date of medical release (post-partum check-up) from Obstetrician/Gynecologist: ________						
35. Heart Attack						
36. Other Heart Disease/Irregular Heart Rate (Specify) ________						
37. Hepatitis						
38. High Blood Pressure (**Required** - Specify last blood pressure reading) ________						
39. Infertility (Specify) ________						
40. Immunization for Children Name and address of pediatrician: ________ ________ ________						
41. Kidney/Renal Failure						
42. Other Kidney Disorder (Specify - for example, kidney stones or cysts) ________						
43. Leukemia						
44. Other Hematologic (Blood) Disorder (Specify) ________ ________						
45. Musculoskeletal (pertaining to muscle or bone) Injury or Illness (Specify) ________ ________						
46. Neurologic Deficit or Disorder, including headaches, epilepsy (**Required** - Specify date of last seizure), head or spinal injury or paralysis (Specify) ________						
47. Psychiatric Disorder/Behavioral Health						
48. Severe Injury or Burns (Specify) ________ ________						
49. Severe Visual Impairment/Blindness						
50. Spinal Injuries						
51. Stroke						
52. Surgery of any kind (Specify) ________ ________						
53. Temporomandibular Joint Syndrome (TMJ)						
54. Transient Ischemic Attacks (TIA's)						
55. Urological/Prostate/Bladder						
56. Please describe 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 and for which you or your eligible dependents are receiving ongoing evaluation, treatment or monitoring by a physician or other health care provider. For example: • Thyroid Condition • Sleep Disorder • Hormone Therapy • Skin Condition (Psoriasis, Dermatitis) • Polyps (Specify) ________	________ ________ ________ ________ ________					

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)

Section C.

If any of the conditions in Section B are checked, please explain below. Use additional paper if necessary. Please provide details of the condition.

	Name/Condition/ Treatment	Most Recent Date of Treatment, Monitoring or Medical Consultation by a Physician or Health Care Provider	Attending Physician	Dates of Illness
57.		☐ Inpatient ☐ Outpatient Date ____/____/____	Name: ____ Address: ____ Phone: ( ) ____ Hospital Name: ____	From: ____ To: ____
58.		☐ Inpatient ☐ Outpatient Date ____/____/____	Name: ____ Address: ____ Phone: ( ) ____ Hospital Name: ____	From: ____ To: ____
59.		☐ Inpatient ☐ Outpatient Date ____/____/____	Name: ____ Address: ____ Phone: ( ) ____ Hospital Name: ____	From: ____ To: ____

60. When was the last time each person applying for coverage visited a doctor (other than at an emergency room)? Include date of visit, name and address of physician or other provider (gynecologist/obstetrician, osteopath, chiropractor, etc.) and reason for visit. Use additional paper if necessary. **This question must be answered.** If it is not answered, the application will be considered incomplete and returned to your for additional information.

Applicant: ______________________ Date of Exam ______________________

Provider's Name and Address ______________________

____

____

Reason ______________________

Spouse: ______________________ Date of Exam ______________________

Provider's Name and Address ______________________

____

____

Reason ______________________

Dependent Child: ______________________ Date of Exam ______________________

Provider's Name and Address ______________________

____

____

Reason ______________________

Dependent Child: ______________________ Date of Exam ______________________

Provider's Name and Address ______________________

____

____

Reason ______________________

Medical Information (Continued)

61. When was the last time each person applying for coverage visited an emergency room at a hospital or other medical facility? Include date of visit, name and address of emergency room, attending physician's name and reason for visit. Use additional paper if necessary.

Applicant: ______________________ Date of Visit ______________________

Hospital Name and Address______________________

Physician ______________________

Reason ______________________

Spouse: ______________________ Date of Visit ______________________

Hospital Name and Address______________________

Physician ______________________

Reason ______________________

Dependent Child: ______________________ Date of Visit ______________________

Hospital Name and Address______________________

Physician ______________________

Reason ______________________

Dependent Child: ______________________ Date of Visit ______________________

Hospital Name and Address______________________

Physician ______________________

Reason ______________________

Dependent Child: ______________________ Date of Visit ______________________

Hospital Name and Address______________________

Physician ______________________

Reason ______________________

Medical Information (Continued)

Section D.
If you — or any family members applying —

62. — Drink alcoholic beverages, please indicate frequency of use:

Name of Person	Number of Drinks per Week (Serving size per drink equals 1½ oz. liquor, 12 oz. beer, 5 oz. wine)

63. — Have, 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:

Name of Person	Amount per Day/Type	Dates of Use	
		From:	To:
		From:	To:
		From:	To:
		From:	To:
		From:	To:

64. — Have taken prescribed drugs within the last year, please list drug(s) taken and reason:

Name of Person	Medication/Dosage	Dates of Use	Condition/Reason
		From: To:	
		From: To:	
		From: To:	
		From: To:	
		From: To:	
		From: To:	
		From: To:	

Conditions of Enrollment

IMPORTANT: PLEASE READ AND SIGN BELOW:

If you and your spouse are applying for coverage, your spouse also must read and understand the "Conditions of Enrollment," and sign and date this application.

I, the undersigned, hereby apply for coverage for myself and all my listed eligible dependents. I understand and agree that the terms and conditions of our coverage will be controlled by the written Agreement with Keystone Health Plan West 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.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") 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.

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

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.

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.
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. 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 Keystone Health Plan West and an Effective Date of coverage is assigned; and
3. Initial payment must be submitted with the application; and
4. Receipt of my money (check or money order) does not constitute enrollment under any program; and
5. This coverage is provided only to residents of the geographical area of western Pennsylvania served by Keystone Health Plan West. We reserve the right to investigate and confirm your residence from time to time.
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 Keystone Health Plan West 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 (Keystone Health Plan West may choose to specify the provider);
2. Deny this application, in which case any premium submitted will be refunded and accepted by me; or
3. Immediately terminate my coverage if it is found that any material information was omitted by or for me on this questionnaire.

I also understand and agree that the Agreement will not provide benefits for me or any enrolled dependents during the 12-month period following the Effective Date on which I and any dependents become enrolled under the Agreement for 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.

Applicant's Signature ____________________ **Date** ________

Spouse's Signature ____________________ **Date** ________

DO NOT WRITE IN THIS AREA

R FLAG: ____________________

DEC DATE: ____________________

DEPT. CD: ____________________

DEN CD: ____________________

OVR EFF DATE: ____________________

INITIAL RECEIPT DATE: ____________________

CLERK NO: ____________________

C.O. REASON ____________________

C.O. DECISION DATE ____________________

WHO DENIED ____________________

REAPPLY DATE ____________________

REMARKS ____________________

FOR PRODUCER USE ONLY

Producer's Certificate

Attention Producer:

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, I am not aware, based on the applicant's responses to my inquiries, of any additional factors impacting the insurability and/or eligibility of the applicant and each of his/her dependents applying for this coverage.

   Producer Signature: ______________________ Date: ____________

   Agency: ______________________________

2. Have you provided the applicant with all relevant marketing materials, including the Outline of Coverage? ☐ YES ☐ NO

3. Have you advised the applicant of the features of the products that they have selected? ☐ YES ☐ NO

4. Is this applicant a current customer of Highmark Blue Cross Blue Shield or Keystone Health Plan West? ☐ YES ☐ NO

5. Have you attached to this application a replacement of coverage form, if necessary? ☐ YES ☐ NO

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 Keystone Health Plan West's rights or requirements.

KEYSTONE HEALTH PLAN WEST
A HIGHMARK COMPANY

An Independent Licensee of the Blue Cross and Blue Shield Association

120 Fifth Avenue • Pittsburgh, PA 15222

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Blue Cross, Blue Shield and the Cross and Shield symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

KeystoneBlue is a service mark of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.