



# MONTANA YOUTHCARE APPLICATION

PLEASE PRINT IN BLACK INK



Blue Cross Blue Shield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

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<b>Purpose</b>	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Transfer (Current ID Number)  <small>(Example: Changing from ID 000123456789 covered as a dependent child to ID 000234567890)</small>	<b>IMPORTANT</b> <b>The Montana YouthCare Product is for children age 3 months through 18 years. Applicants/Subscribers must be Montana residents.</b>					
<b>Applicant/Subscriber</b>	<b>Applicant/Subscriber (Person to be Covered)</b> Last Name                      First Name                      MI		<b>Social Security Number (SSN)</b> The Applicant/Subscriber SSN may be included in the Subscriber Identification Number.	<b>Date of Birth</b> (mo   day   yr)	<b>Male/Female</b>	<b>Height</b>	<b>Weight</b>
	Applicant/Subscriber Street Address		City	State	ZIP Code		
	Home Phone		Work Phone		<b>Marital Status</b> <input type="checkbox"/> Single <input type="checkbox"/> Married		
	If Applicant/Subscriber, while using a different name than shown above, received care from a physician, indicate below the name under which the care was received. <b>Name(s):</b>						
<b>Parent/Legal Guardian</b>	<b>Parent/Legal Guardian</b> Last Name                      First Name                      MI			<b>Relationship to Applicant/Subscriber</b> If Legal Guardian, this Application must be accompanied by a copy of court documents of legal guardianship or adoption.			
				<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian			
	Parent/Legal Guardian Street Address		City	State	ZIP Code		
	Mailing Address (if different than above)		City	State	ZIP Code		
<b>Employer Information</b>	1. Is the Applicant/Subscriber or Parent/Legal Guardian employed by a firm which, for at least 50 percent of its working days during the preceding calendar year, employed two or more employees?			<b>Applicant/Subscriber</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Parent/Legal Guardian</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
	2a. Will all or part of the premium be paid by an employer?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	b. If yes, will the method of payment be through a salary or wage adjustment in which the employer requires the monies to be used toward the purchase of health insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	3a. Will any portion of the premium be paid through a Medical Savings Account or Section 125 Plan (e.g., Cafeteria or Flex Plan)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		
b. If yes, will any part be funded by the employer?			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Effective Date</b>	<b>Requested Effective Date</b> (Subject to BCBSMT approval) (mo   day   yr)						

<b>OFFICE USE ONLY</b>	Group Number	<b>Effective Date</b> _____ <input type="checkbox"/> Approved as Applied _____ <input type="checkbox"/> Declined _____ <input type="checkbox"/> Modified Approval _____	<b>Date Stamps</b>  Rider # _____ Rider # _____ Rider # _____ Comments _____ _____ _____
	Package Number		
	Medical Notes		
	7   8   10   11		

Applicant/Subscriber Name: \_\_\_\_\_

**BILLING INFORMATION** (Complete this section for the payment method selected)

<b>Billing Frequency</b>	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually			
<b>Payment Information</b>	Billing Name and Address (If different from Parent/Legal Guardian mailing address)	City	State	ZIP Code
<b>Electronic Funds Transfer (EFT) Authorization</b>	<b>IMPORTANT</b> This Electronic Funds Transfer (EFT) Authorization section needs to be completed only if this is the payment method you have selected.		<input type="checkbox"/> Selecting Electronic Funds Transfer (EFT) payment method (Indicate billing frequency above)	
	To _____ <small>(Name, City, and State of Bank)</small>			
	You are hereby authorized to honor Electronic Funds Transfer (EFT) drawn by Blue Cross and Blue Shield of Montana on my account, in payment of Blue Cross and Blue Shield of Montana dues at the prevailing rate. This authorization is to remain in force until revoked by me in writing through the Office of Blue Cross and Blue Shield of Montana, Helena, Montana.			
	Date <small>(mo   day   yr)</small>		Subscriber ID	
	Type of Account		Account Number	
	⊖ Checking Account      ⊖ Savings Account			
	PRINT Account Owner's Name		Account Owner's Signature <small>DO NOT PRINT</small>	
	<b>***** ATTACH A DEPOSIT SLIP OR A VOIDED CHECK *****</b>			
	Blue Cross and Blue Shield of Montana agrees to pay to any bank or banker all sums of money, which said bank or banker shall become legally obligated to pay because of any deduction of money for Blue Cross and Blue Shield of Montana as herein authorized by the bank customer whose signature appears above.			

<b>Other Coverage or Creditable Coverage</b>	Has the Applicant had health coverage within the last 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach verification of creditable coverage to this form, OR complete the following information for the Applicant/Subscriber. Creditable coverage: <ul style="list-style-type: none"> <li>◆ <b>Includes</b> Medicare, Medicaid, employer-based insurance, or an individual policy.</li> <li>◆ <b>Does not include</b> limited benefit plans such as a cancer policy, a hospital indemnity plan, or a life insurance policy.</li> </ul> This coverage has a 12-month waiting period for preexisting conditions. Credit toward fulfilling this waiting period is allowed based on health coverage the Applicant had during the past 12 months. In order to receive credit, an application for coverage must be received by BCBSMT within 63 days from the date of cancellation of the previous coverage.					
	Applicant/Subscriber Name	Full Name, Address, and Telephone Number of Insurance Company or Carrier	Check Type of Coverage	Enrollment Date <small>(mo   day   yr)</small>	Cancel Date <small>(mo   day   yr)</small>	Will this coverage be continued?
	Name: ID #:		<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Name: ID #:		<input type="checkbox"/> Medical <input type="checkbox"/> Dental			<input type="checkbox"/> Yes <input type="checkbox"/> No
*ID # is the identification number under previous or current insurance company or carrier.						

Applicant/Subscriber Name:

**If additional space is necessary to give complete information, use a separate sheet of paper, signed and dated.**

**A. Within the last three (3) years, have medications (except antibiotics) been prescribed for or been provided for (e.g., samples, injections) and/or been taken by the person to be covered?**  
 Yes  No If yes, please explain below.

Name of Medication, Daily Dosage, and How Often Refilled	Condition for Which Medication Was Prescribed or Taken	Dates		Complete Provider Name (First and Last) Address City State ZIP Code
		From (mo   day   yr)	To (mo   day   yr)	

**B. Does the person to be covered have reason to believe that they are an expectant mother or father (by positive result of a home pregnancy test, provider test, laboratory results, etc.)?**  
 Yes  No If yes, due date:  
 Explain any signs of complications:

**C. Has the person to be covered EVER had or been diagnosed with any of the following?**  
 Yes  No If yes, please explain below.

- |  |  |  |   |
|--|--|--|---|
| 1. <input type="checkbox"/> AIDS or AIDS-Related Complex | 5. <input type="checkbox"/> Heart Murmur   | 8. <input type="checkbox"/> Liver Disorder             | 11. <input type="checkbox"/> Rheumatic Fever                |
| 2. <input type="checkbox"/> Cancer                       | 6. <input type="checkbox"/> Heart Problems | 9. <input type="checkbox"/> Mental Disease or Disorder | 12. <input type="checkbox"/> Seizure Disorder/Epilepsy      |
| 3. <input type="checkbox"/> Congenital Defect            | 7. <input type="checkbox"/> HIV Positive   | 10. <input type="checkbox"/> Nervous System Disorder   | 13. <input type="checkbox"/> Stroke or Circulatory Problems |
| 4. <input type="checkbox"/> Diabetes                     |  |  |   |

Condition Number (1-13)	Diagnosis/Condition	Treatment Dates		Hospitalized?	Complete Provider Name (First and Last) or Facility Name Address City State ZIP Code
		From (mo   day   yr)	To (mo   day   yr)		
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**D. Has the person to be covered been diagnosed with, or treated or counseled for, any complaint, condition, illness, disorder, or disease relating to any of the following in the past five (5) years?**  Yes  No If yes, please explain below.

- |   |  |  |  |
|---|--|--|--|
| 14. <input type="checkbox"/> Alcohol or Drug Use              | 21. <input type="checkbox"/> Back                | 28. <input type="checkbox"/> Thyroid       | 35. <input type="checkbox"/> GERD                |
| 15. <input type="checkbox"/> Anxiety/Depression               | 22. <input type="checkbox"/> Colon or Intestines | 29. <input type="checkbox"/> Urinary Tract | 36. <input type="checkbox"/> Headaches/Migraines |
| 16. <input type="checkbox"/> Eating                           | 23. <input type="checkbox"/> Joints              | 30. <input type="checkbox"/> Allergy       | 37. <input type="checkbox"/> Hernia              |
| 17. <input type="checkbox"/> Suicide Attempt                  | 24. <input type="checkbox"/> Kidneys             | 31. <input type="checkbox"/> Arthritis     | 38. <input type="checkbox"/> High Blood Pressure |
| 18. <input type="checkbox"/> Attention Deficit Disorder (ADD) | 25. <input type="checkbox"/> Lungs               | 32. <input type="checkbox"/> Asthma        | 39. <input type="checkbox"/> Infertility         |
| 19. <input type="checkbox"/> Hyperactivity                    | 26. <input type="checkbox"/> Prostate            | 33. <input type="checkbox"/> Digestive     | 40. <input type="checkbox"/> Ulcer               |
| 20. <input type="checkbox"/> Breasts                          | 27. <input type="checkbox"/> Reproductive Organs | 34. <input type="checkbox"/> Fracture      |  |

Condition Number (14-40)	Diagnosis/Condition	Treatment Dates		Hospitalized?	Complete Provider Name (First and Last) or Facility Name Address City State ZIP Code
		From (mo   day   yr)	To (mo   day   yr)		
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**E. Has the person to be covered received or been recommended to receive any medical treatment that has not been listed above? This includes counseling, follow-up for abnormal laboratory results, examinations/tests, or care recommended by physicians, other medical practitioners, or a legal authority.**  
 Yes  No If yes, please indicate whether the treatment has been received or recommended, and provide date(s) and detailed explanation(s).

**F. Has the person to be covered been fitted with any implants or orthopedic device (including pins, screws, plates, or braces) or does any person regularly use durable medical equipment (e.g., a wheelchair, splints, or crutches)?**  
 Yes  No If yes, please provide date(s) and detailed explanation(s). Also note whether orthopedic devices are temporary or permanent.

Medical History

**If additional space is necessary to give complete information, use a separate sheet of paper, signed and dated.**

Medical History (cont.)	G. Within the past five (5) years, has the person to be covered been declined for medical coverage or been offered medical coverage on a restricted basis? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain below.		
	Name of Company	Date of Decision (mo   day   yr)	Reason for Decision

Conditions of Enrollment	<p>I/We hereby apply for coverage with Blue Cross and Blue Shield of Montana. I/We certify and understand the following:</p> <ol style="list-style-type: none"> <li>I/We personally completed the Medical History section of this form, filling in all requested information.</li> <li>I/We understand that I/we have a continuing obligation to update this Application so that it reflects an accurate and current record of the health of the Applicant/Subscriber until the date the application has been accepted by Blue Cross and Blue Shield of Montana.</li> <li>I/We understand that if this Application does not contain an accurate record of information, the entire policy may be denied or subject to cancellation from its beginning. Acceptance of dues (premiums) does not constitute a waiver of the right of Blue Cross and Blue Shield of Montana to cancel coverage retroactive to its effective date for misrepresentations, omissions, concealment of facts, and incorrect statements in accordance with applicable law.</li> <li>All of the statements made are true and complete for the Applicant/Subscriber applying for coverage.</li> <li>The Applicant/Subscriber is in good health, except for those conditions listed.</li> <li>This is an application only. No right is conferred to me or the Applicant/Subscriber listed on this Application until Blue Cross and Blue Shield of Montana accepts the Applicant/Subscriber and dues (premiums) are paid.</li> <li>I/We understand that waiting periods may apply.</li> <li>I/We, the undersigned, am/are applying for membership with Blue Cross and Blue Shield of Montana. I/We agree to the terms and conditions of any contract issued to the Applicant/Subscriber and/or Parent/Legal Guardian by Blue Cross and Blue Shield of Montana.</li> <li>I/We understand that Blue Cross and Blue Shield of Montana maintains contracts with certain providers of medical services. I/We understand that Blue Cross and Blue Shield of Montana will pay those providers and any other provider it chooses directly.</li> <li>I/We have received the Notice of Insurance Information/Privacy Practices.</li> </ol>
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Signature(s)	I/We understand and agree that the coverage applied for is subject to eligibility requirements and the effective date will be assigned by Blue Cross and Blue Shield of Montana. I/We have read the Conditions of Enrollment. I/We understand and agree to them.			
	Must have signature of Applicant/Subscriber, if age 18, and/or signature of Parent/Legal Guardian			
	Applicant/Subscriber Signature <small>DO NOT PRINT</small>	Signature Date <small>(mo   day   yr)</small>	Parent/Legal Guardian Signature <small>DO NOT PRINT</small>	Signature Date <small>(mo   day   yr)</small>

Representative Information	<b>To be completed by the Blue Cross and Blue Shield of Montana Representative</b>		
	1. Have you advised the Applicant/Subscriber and/or Parent/Legal Guardian to read, complete, and sign this Application to the best of their knowledge and ability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2. Have you advised the Applicant/Subscriber and/or Parent/Legal Guardian that coverage will not commence until this Application has been received and has been accepted by Blue Cross and Blue Shield of Montana?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3. Have you advised the Applicant/Subscriber and/or Parent/Legal Guardian that if this Application does not contain an accurate record of the Applicant/Subscriber's health, coverage may be subject to rejection or termination retroactive to its effective date?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4. Have you explained the waiting periods to the Applicant/Subscriber and/or Parent/Legal Guardian?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Signature of Representative	Date <small>(mo   day   yr)</small>	
Representative Name	Representative Number	Telephone Number	



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