BlueCross BlueShield of Oklahoma
A member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

P.O. BOX 3283 • TULSA, OKLAHOMA 74102-3283

HEALTH CHECK
Select Care and Children's Major Medical

Member Service Life Insurance Company

REQUEST FOR CHANGE IN MEMBERSHIP

PLEASE PRINT IN INK OR TYPE

MEMBER NAME (LAST) (FIRST) (MIDDLE)	RESIDENCE TELEPHONE A/C	BUSINESS PHONE A/C
RESIDENTIAL ADDRESS (STREET OR BOX NO.) (CITY) (STATE) (ZIP CODE)		
SUBSCRIBER IDENTIFICATION NUMBER S	HEALTH CHECK GROUP NUMBER	

REQUEST YOUR CHANGE(S) BELOW (CHECK APPROPRIATE BOXES AND PROVIDE REQUESTED INFORMATION)

☐ NAME CHANGE:
NEW NAME (LAST) (FIRST) (MIDDLE)

☐ ADDRESS CHANGE:
NEW RESIDENTIAL ADDRESS (STREET OR BOX NO.) (CITY) (STATE) (ZIP CODE)

☐ SPOUSE CHANGE:

☐ ADD *
NAME OF SPOUSE (FIRST, MIDDLE, LAST) | DATE OF BIRTH MO. DAY YR. | SPOUSE'S SOCIAL SECURITY NO. | MARRIAGE DATE MO. DAY YR.

☐ DROP
NAME OF SPOUSE (FIRST, MIDDLE, LAST)
CHECK BOX FOR REASON DROPPED AND COMPLETE DATES
☐ DIVORCE DATE MO. DAY YR. ☐ DECEASED DATE MO. DAY YR. ☐ OTHER (Please explain)

☐ DEPENDENT CHANGE:
(IF ADDITIONAL SPACE IS NEEDED, COMPLETE ANOTHER FORM)

TO ADD DEPENDENTS COMPLETE THIS SECTION

☐ ADD *
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO MEMBER | DATE OF BIRTH MO. DAY YR. | SOCIAL SECURITY NUMBER
IS THIS DEPENDENT UNMARRIED, UNDER AGE 19, AND LIVING WITH YOU IN A PARENT/CHILD RELATIONSHIP? ☐ YES ☐ NO
IF "NO", IS IT STATED IN A COURT DECREE THAT YOU ARE TO PROVIDE HEALTH COVERAGE FOR THEM? ☐ YES ☐ NO
IF "YES", ATTACH A COPY OF THE COURT DECREE.

☐ ADD *
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO MEMBER | DATE OF BIRTH MO. DAY YR. | SOCIAL SECURITY NUMBER
IS THIS DEPENDENT UNMARRIED, UNDER AGE 19, AND LIVING WITH YOU IN A PARENT/CHILD RELATIONSHIP? ☐ YES ☐ NO
IF "NO", IS IT STATED IN A COURT DECREE THAT YOU ARE TO PROVIDE HEALTH COVERAGE FOR THEM? ☐ YES ☐ NO
IF "YES", ATTACH A COPY OF THE COURT DECREE.

☐ ADD *
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO MEMBER | DATE OF BIRTH MO. DAY YR. | SOCIAL SECURITY NUMBER
IS THIS DEPENDENT UNMARRIED, UNDER AGE 19, AND LIVING WITH YOU IN A PARENT/CHILD RELATIONSHIP? ☐ YES ☐ NO
IF "NO", IS IT STATED IN A COURT DECREE THAT YOU ARE TO PROVIDE HEALTH COVERAGE FOR THEM? ☐ YES ☐ NO
IF "YES", ATTACH COPY OF THE COURT DECREE.

* If requesting to add spouse or dependents the back of this form must be completed. No change on the membership will be made until approved by Blue Cross and Blue Shield of Oklahoma.

DOES ANYONE APPLYING FOR THIS COVERAGE HAVE BLUE CROSS AND BLUE SHIELD COVERAGE? ☐ YES ☐ NO	IF YES, NAME OF THE POLICY HOLDER	MEMBER'S I.D. NO.	GROUP NO.	GROUP NAME
DOES ANYONE APPLYING FOR THIS COVERAGE HAVE OTHER GROUP HEALTH INSURANCE OR MEDICARE? ☐ YES ☐ NO	IF YES, NAME OF OTHER GROUP INSURER	NAME OF POLICY HOLDER	POLICY NUMBER	TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY

TO DROP DEPENDENTS COMPLETE THIS SECTION

☐ DROP
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO MEMBER | DATE AND REASON FOR DROPPING DEPENDENT MO. DAY YR.

☐ DROP
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO MEMBER | DATE AND REASON FOR DROPPING DEPENDENT MO. DAY YR.

☐ DROP
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) | RELATIONSHIP TO MEMBER | DATE AND REASON FOR DROPPING DEPENDENT MO. DAY YR.

☐ DEDUCTIBLE CHANGE:
I AM REQUESTING A CHANGE TO: ☐ $200 ☐ $500 ☐ $1000 ☐ $1500 ☐ $5000
NOTE: If you are requesting a change to a lower deductible than you currently have, complete the back of this form for each person currently enrolled and those applying for coverage (if any).

☐ SMOKER CHANGE:
☐ MEMBER STOPPED SMOKING OR USING TOBACCO PRODUCTS ON: Date:
☐ SPOUSE STOPPED SMOKING OR USING TOBACCO PRODUCTS ON: Date:
☐ MEMBER STARTED SMOKING OR USING TOBACCO PRODUCTS ON: Date:
☐ SPOUSE STARTED SMOKING OR USING TOBACCO PRODUCTS ON: Date:

IMPORTANT:
COMPLETE QUESTIONS 17 AND 18 ON REVERSE SIDE OF THIS FORM.
NON-SMOKER'S DISCOUNT NOT AVAILABLE UNTIL 12 MONTHS FOLLOWING CESSATION.

☐ MATERNITY COVERAGE CHANGE:
☐ DELETE MATERNITY COVERAGE ☐ ADD MATERNITY COVERAGE (FOR FEMALE MEMBER OR SPOUSE AGE 19 OR OVER)

☐ FINANCIAL INSTITUTION OR ACCOUNT NO. CHANGE:
NEW FINANCIAL INSTITUTION NAME | TRANSIT ROUTING NO. | ACCOUNT NO.
SIGNATURE OF ACCOUNT HOLDER (AUTHORIZES DEDUCTION FROM NEW ACCOUNT) X
PLEASE ENCLOSE A VOIDED CHECK FROM ACCOUNT

I understand that my membership as ammended will not become effective until approved by Blue Cross and Blue Shield of Oklahoma. I have read all the statements on this application and represent that they are true and complete to the best of my knowledge and belief. I understand that any false or incomplete information can result in retroactive cancellation of membership and coverage for all persons under the membership.

SIGNATURE OF MEMBER X	TODAY'S DATE MO. DAY YR.	SIGNATURE OF SPOUSE X	TODAY'S DATE MO. DAY YR.

FOR OFFICE USE ONLY

GROUP NO.	INVOICE NO.	MSC	MSC DATE	LINCS POLICY NO.	NEW SMK IND	APPROVED BY	DATE APPROVED	CHG.PROC. BY	DATE INPUT

STATEMENT OF HEALTH

IMPORTANT:
THE STATEMENT OF HEALTH MUST BE COMPLETED FOR EACH PERSON TO BE ADDED TO THE MEMBERSHIP, AND IF REQUESTING A LOWER DEDUCTIBLE, COMPLETE FOR ALL PERSONS CURRENTLY ENROLLED ON THE MEMBERSHIP.

ANSWER THESE HEALTH QUESTIONS

ALL HEALTH QUESTIONS MUST BE ANSWERED "YES" OR "NO"

ATTACH ADDITIONAL SHEET IF NECESSARY

		YES	NO
1.	HAS ANYONE LISTED HEREIN HAD LIFE, ACCIDENT, OR HEALTH INSURANCE POSTPONED, RATED UP, RIDERED, DECLINED OR CANCELLED?	☐	☐
2.	HAS ANYONE EVER HAD AIDS, AIDS RELATED COMPLEX OR IMMUNE SYSTEM DISORDER (HIV)?	☐	☐
3.	ANY DISEASE OR DISORDER OF THE HEART OR THE CIRCULATORY SYSTEM, HIGH BLOOD PRESSURE, HEART ATTACK, PHLEBITIS?	☐	☐
4.	DIABETES, THYROID, OTHER GLANDULAR DISORDER?	☐	☐
5.	ANY TYPE OF CANCER, TUMOR, CYST, GROWTH OR SKIN DISORDER?	☐	☐
6.	HAS ANYONE EVER HAD ANY DISEASE OR DISORDERS OF THE STOMACH OR INTESTINES, GALLBLADDER, LIVER, PANCREAS, OR RECTUM?	☐	☐
7.	ANY DISEASE OR DISORDER OF THE LUNGS OR RESPIRATORY SYSTEM, ASTHMA, TUBERCULOSIS, EMPHYSEMA?	☐	☐
8.	HAS ANYONE EVER HAD DISEASE OR DISORDER OF THE BACK, SPINE, BONES, JOINTS,ARTHRITIS?	☐	☐
9.	ANY DISEASE OR DISORDER OF THE BRAIN OR NERVOUS SYSTEM, EPILEPSY, CONVULSIONS, MIGRAINE HEADACHES, STROKES OR PARALYSIS?	☐	☐
10.	ANY DISEASE OR DISORDER OF THE BLOOD OR LYMPH GLANDS?	☐	☐
11.	ANY DISORDER OF THE MALE OR FEMALE GENITAL AND/OR URINARY SYSTEMS?	☐	☐
12.	HAS ANYONE LISTED HEREIN RECEIVED TREATMENT FOR ALCOHOL OR DRUG ABUSE?	☐	☐
13.	IS THERE ANY ABNORMALITY, DEFORMITY, OR DISORDER NOT ALREADY SPECIFIED , OR ANY CONDITION THAT MAY REQUIRE TREATMENT?	☐	☐
14.	HAS ANYONE LISTED HEREIN CONSULTED A PHYSICIAN OR HEALTH PRACTITIONER, FOR ANY REASON, IN THE PAST THREE YEARS?	☐	☐
15.	HAS ANYONE LISTED HEREIN BEEN A PATIENT IN A HOSPITAL WITHIN THE LAST THREE YEARS?	☐	☐
16.	ARE ANY FEMALES TO BE COVERED NOW PREGNANT? IF YES, EXPECTED DELIVERY DATE (MO/DAY/YR) AND PATIENT'S NAME.	☐	☐

MEMBER	EXACT HEIGHT FEET _____ INCHES _____	EXACT WEIGHT _____ LBS.	17. MEMBER: HAVE YOU SMOKED OR USED TOBACCO PRODUCTS IN THE LAST 12 MONTHS? SIGNATURE OF MEMBER X	☐	☐
SPOUSE	EXACT HEIGHT FEET _____ INCHES _____	EXACT WEIGHT _____ LBS.	18. SPOUSE: HAVE YOU SMOKED OR USED TOBACCO PRODUCTS IN THE LAST 12 MONTHS? SIGNATURE OF SPOUSE X	☐	☐

COMPLETE THIS SECTION FOR EACH QUESTION ANSWERED "YES" Attach additional sheet if necessary.

QUESTION NUMBER(S)	PERSON AFFECTED	TYPE OF AILMENT, SYMPTOM, OR DIAGNOSIS OF CONDITION	DEGREE OF RECOVERY	ONSET DATE	DATE OF LAST TREATMENT OR SURGERY	PRESCRIPTION DRUGS (LIST DATES TAKEN)	NAME(S) AND ADDRESS OF PHYSICIAN, PRACTITIONER, HOSPITAL OR INSTITUTION
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		
			☐ NONE ☐ PARTIAL ☐ FULL		TREATMENT SURGERY		

BENEFICIARY DESIGNATION INFORMATION (COMPLETE IF ADDING SPOUSE TO THE MEMBERSHIP)

SPOUSE: I, on behalf of myself only, hereby apply for $5,000 of your guaranteed renewable term life insurance and $5,000 of guaranteed renewable accidental death and dismemberment benefits with Member Service Life Insurance Company.

IS THIS LIFE INSURANCE TO REPLACE ANY OTHER POLICY? ☐ YES ☐ NO

IF YES, GIVE COMPANY NAME AND POLICY NUMBER

BENEFICIARY NAME (FIRST) (MIDDLE) (MAIDEN) (LAST)

RELATIONSHIP TO APPLICANT

IMPORTANT: BENEFITS WILL BE PAYABLE TO INSURED'S ESTATE IF NO BENEFICIARY IS NAMED AND SPOUSE IS NOT LIVING.

BENEFICIARY ADDRESS (STREET OR BOX NO.) (CITY) (STATE) (ZIP CODE)

AGREEMENT AND SIGNATURES I understand and agree to the items listed below:

This is a Request for Change in Membership and I should not cancel any existing coverage unless and until I am notified in writing by Blue Cross and Blue Shield of Oklahoma of acceptance.

I have read all the statements on this Request for Change in Membership and represent that they are true and complete to the best of my knowledge and belief. I understand that any false or incomplete information can result in retroactive cancellation of my membership and coverage for all persons under the membership, and I will be obligated to repay promptly any benefit payments to which persons covered under the membership were not entitled. Blue Cross and Blue Shield of Oklahoma may also recoup any monies paid as benefits prior to a determination by the Plan that medical condition(s) or other information required to be reported was not correctly represented.

Any insurance agent, examining physician, or other person who knowingly and willfully makes a false or fraudulent statement or representation in or relative to any application for insurance, or who makes any such statement to obtain a fee, commission, or money or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.

I authorize any physician, practitioner, hospital or other institution to release,disclose and furnish Blue Cross and Blue Shield of Oklahoma and Member Service Life Insurance Company for their review and retention in connection with this request for health and life coverage, all information, records, or copies of records relating to medical history and conditions, including, but not limited to, diagnosis, treatment, care, surgery, and the dates thereof.

I understand that if this Request for Change in Membership is accepted, no benefits will be provided for any pre-existing condition or complication of a pre-existing condition for a period of twelve (12) months after coverage becomes effective. This provision applies to any condition existing during the twelve (12) months immediately before the coverage effective date.

This application when processed may result in denial, exclusion, or limitation of coverage.

SIGNATURE OF MEMBER	TODAY'S DATE MO. / DAY / YR.	SIGNATURE OF SPOUSE	TODAY'S DATE MO. / DAY / YR.
X		X	

REMINDER: ARE ALL QUESTIONS ANSWERED? IS THIS DOCUMENT SIGNED AND DATED?