Application for Membership

HealthCheck *Select*

HealthCheck *Basic*

and Children's Major Medical

BlueCross BlueShield of Oklahoma

www.bcbsok.com

MEMBER SERVICE LIFE
INSURANCE COMPANY

2.363 (07/05)

HEALTH CHECK APPLICATION FOR MEMBERSHIP

To help us process your application promptly, please print all answers in blue or black ink and remember to return this signed application with your voided check attached to:

Blue Cross and Blue Shield of Oklahoma
Attn: Health Check Enrollment
P.O. Box 3283
Tulsa, OK 74102-3283

FINANCIAL INSTITUTION DEBIT AUTHORIZATION

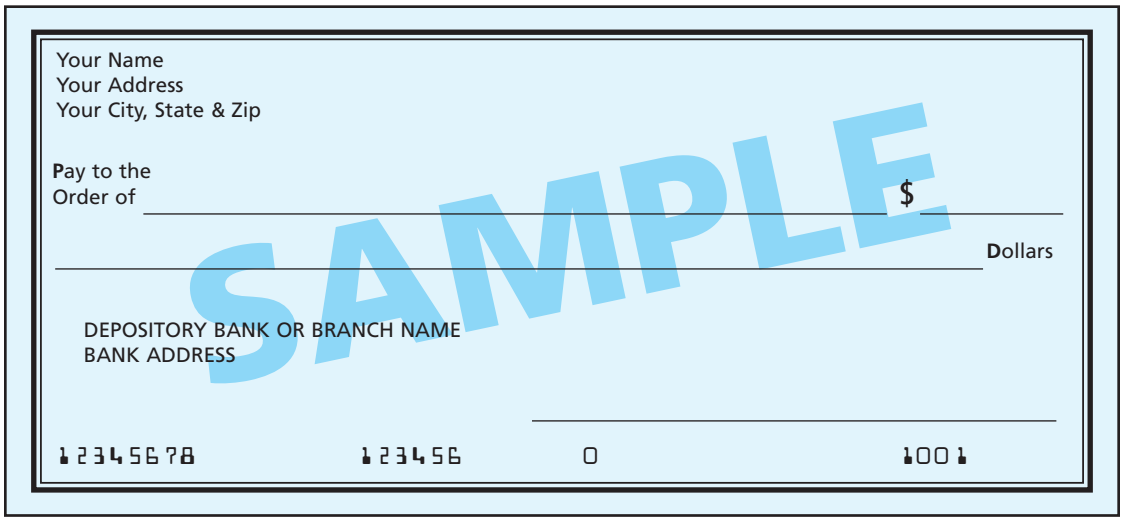
Monthly premiums are deducted automatically from participating Oklahoma banks, credit unions or savings and loans. Please provide the following information and your voided personal check.

PLEASE TAPE CHECK HERE

REMINDER

Your VOIDED CHECK (personal checking) or savings deposit slip from a participating Oklahoma financial institution must be attached here.

Please attach check with TAPE. Do not use glue, staples or paper clips.



- I hereby request and authorize Blue Cross and Blue Shield of Oklahoma to initiate debit entries to my account on or around the date payment is due.
- I understand that this request for coverage in not an employer group health plan and is not intended, in any way, to be an employer-sponsored health insurance plan.
- I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future.
- **PLEASE ENSURE ADEQUATE FUNDS ARE AVAILABLE AT THE TIME OF APPLICATION. BLUE CROSS AND BLUE SHIELD OF OKLAHOMA IS NOT RESPONSIBLE FOR FEES INCURRED DUE TO INSUFFICIENT FUNDS.**

Preference of effective date/monthly withdrawal date (please circle one): 1st only 15th only Either

(Please note that effective date and monthly withdrawal date are the same)

THIS AUTHORITY IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL BLUE CROSS AND BLUE SHIELD OF OKLAHOMA HAS RECEIVED WRITTEN NOTIFICATION FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD IT A REASONABLE OPPORTUNITY TO ACT.

NAME OF ACCOUNT HOLDER (PLEASE PRINT)	TODAY'S DATE
SIGNATURE OF ACCOUNT HOLDER	RELATIONSHIP TO APPLICANT

HOW MAY WE CONTACT YOU?

Additional information may be needed to process your application. Please provide the following information:

APPLICANT NAME: _____

PLEASE INDICATE THE PREFERRED TELEPHONE NUMBER(S) FOR US TO CALL: ☐ RESIDENTIAL ☐ BUSINESS ☐ ALTERNATE

WHEN IS THE MOST CONVENIENT TIME FOR US TO REACH YOU? (INDICATE TIME FRAME. EX: 7–9 AM OR 5–8 PM) ☐ AM _____ ☐ PM _____

MAY WE CONTACT YOU BY E-MAIL? ☐ NO ☐ YES, E-MAIL ADDRESS: _____

MAY WE SEND YOU A FAX? ☐ NO ☐ YES, FAX NUMBER (INCLUDING AREA CODE): _____

PREFERRED LANGUAGE (IF OTHER THAN ENGLISH): _____

WHO DO YOU WANT TO ENROLL? *(check one box below)*

TOTAL NUMBER OF PERSONS APPLYING FOR COVERAGE ☐

☐ APPLICANT ☐ APPLICANT AND SPOUSE ☐ APPLICANT AND UNMARRIED CHILDREN ☐ APPLICANT, SPOUSE AND UNMARRIED CHILDREN

LAST NAME OF APPLICANT	FIRST	MIDDLE	HEIGHT ' "	WEIGHT	RESIDENCE PHONE
MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP+4)					ALTERNATE PHONE
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)		EMPLOYED BY			BUSINESS PHONE
APPLICANT'S SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM / DD / YYYY)	SEX M ☐ F ☐	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED ☐ SEPARATED	EMAIL ADDRESS	FAX NUMBER
LAST NAME OF SPOUSE	FIRST	MIDDLE	HEIGHT ' "	WEIGHT	DATE OF BIRTH (MM / DD / YYYY) / SEX M ☐ F ☐
SPOUSE SOCIAL SECURITY NUMBER	EMPLOYED BY				BUSINESS PHONE

UNMARRIED DEPENDENT'S LAST NAME	FIRST	MIDDLE	DATE OF BIRTH (MM / DD / YYYY)	HEIGHT ' "	WEIGHT	SEX M ☐ F ☐	SOCIAL SECURITY NUMBER
IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? ☐ YES ☐ NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEP-CHILD OR ADOPTED CHILD ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO						RELATIONSHIP TO APPLICANT
UNMARRIED DEPENDENT'S LAST NAME	FIRST	MIDDLE	DATE OF BIRTH (MM / DD / YYYY)	HEIGHT ' "	WEIGHT	SEX M ☐ F ☐	SOCIAL SECURITY NUMBER
IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? ☐ YES ☐ NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEP-CHILD OR ADOPTED CHILD ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO						RELATIONSHIP TO APPLICANT
UNMARRIED DEPENDENT'S LAST NAME	FIRST	MIDDLE	DATE OF BIRTH (MM / DD / YYYY)	HEIGHT ' "	WEIGHT	SEX M ☐ F ☐	SOCIAL SECURITY NUMBER
IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? ☐ YES ☐ NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEP-CHILD OR ADOPTED CHILD ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO						RELATIONSHIP TO APPLICANT
UNMARRIED DEPENDENT'S LAST NAME	FIRST	MIDDLE	DATE OF BIRTH (MM / DD / YYYY)	HEIGHT ' "	WEIGHT	SEX M ☐ F ☐	SOCIAL SECURITY NUMBER
IS THIS DEPENDENT A NATURAL CHILD, STEP-CHILD, OR ADOPTED CHILD? ☐ YES ☐ NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEP-CHILD OR ADOPTED CHILD ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO						RELATIONSHIP TO APPLICANT

PLEASE COMPLETE THIS SECTION FOR ALL DEPENDENTS APPLYING FOR COVERAGE THAT ARE OVER AGE 19 AND UNDER AGE 23 AND ARE FULL-TIME STUDENTS AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY

FIRST NAME OF STUDENT	NAME OF SCHOOL	CURRENT SEMESTER ENROLLED ☐ SPRING ☐ FALL ☐ SUMMER	☐ UNDER GRADUATE ☐ GRADUATE PROGRAM	# HOURS ENROLLED
FIRST NAME OF STUDENT	NAME OF SCHOOL	CURRENT SEMESTER ENROLLED ☐ SPRING ☐ FALL ☐ SUMMER	☐ UNDER GRADUATE ☐ GRADUATE PROGRAM	# HOURS ENROLLED
FIRST NAME OF STUDENT	NAME OF SCHOOL	CURRENT SEMESTER ENROLLED ☐ SPRING ☐ FALL ☐ SUMMER	☐ UNDER GRADUATE ☐ GRADUATE PROGRAM	# HOURS ENROLLED
FIRST NAME OF STUDENT	NAME OF SCHOOL	CURRENT SEMESTER ENROLLED ☐ SPRING ☐ FALL ☐ SUMMER	☐ UNDER GRADUATE ☐ GRADUATE PROGRAM	# HOURS ENROLLED

CHOOSE ONE PLAN AND ONE DEDUCTIBLE

☐ HEALTH CHECK SELECT CARE *OR* CHILDREN'S MAJOR MEDICAL

CHOOSE ONE DEDUCTIBLE:

☐ $200 ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000

☐ HEALTH CHECK BASIC

CHOOSE ONE DEDUCTIBLE:

☐ $500 ☐ $1,000 ☐ $2,500

MATERNITY BENEFITS (FOR FEMALE APPLICANT OR SPOUSE, AGE 19 AND OVER – CHECK ONE) ☐ WITH MATERNITY COVERAGE ☐ NO MATERNITY COVERAGE	APPLICANT: ☐ I HAVE ☐ I HAVE NOT SPOUSE: ☐ I HAVE ☐ I HAVE NOT SMOKED OR USED TOBACCO IN THE LAST 12 MONTHS	
DO YOU NOW HAVE BLUE CROSS AND BLUE SHIELD INSURANCE? ☐ YES ☐ NO	IF YES, YOUR CURRENT BLUE CROSS AND BLUE SHIELD SUBSCRIBER NUMBER ______	CURRENT BLUE CROSS AND BLUE SHIELD GROUP NUMBER ______
IS THIS AN APPLICATION FOR TRANSFER FROM EXISTING BLUE CROSS AND BLUE SHIELD COVERAGE? ☐ YES ☐ NO	LOCATION OF CURRENT BLUE CROSS AND BLUE SHIELD PLAN (CITY/STATE) ______	DOES ANYONE APPLYING FOR THIS COVERAGE HAVE OTHER GROUP HEALTH INSURANCE OR MEDICARE? ☐ YES ☐ NO

IF YES, LIST OTHER GROUP INSURER	WILL COVERAGE BE CONTINUED? ☐ YES ☐ NO IF NO, EXPECTED CANCEL DATE: ______	NAME OF POLICY HOLDER	POLICY NUMBER	TYPE OF COVERAGE: ☐ INDIVIDUAL ☐ FAMILY

VENDOR NO.	PRINT INSURANCE AGENT'S NAME	INSURANCE AGENT'S SIGNATURE	PHONE NO.	E-MAIL ADDRESS	FAX NO.
FOR OFFICE USE ONLY	TM	GROUP #	LIFE		

Continued on next page →

APPLICANT NAME: _____

EVIDENCE OF INSURABILITY

All health history/medical questions must be completed for all individuals (including dependents) applying for coverage. Each person applying for coverage may be accepted, denied, or offered coverage with a limitation of coverage (Exclusion of Coverage Rider). An Exclusion of Coverage Rider does not have an expiration date.

If any health changes occur prior to the effective date (if coverage approved), or while this application is being reviewed, all health changes for each person (self, and/or spouse and/or dependent children), must be reported to Blue Cross and Blue Shield of Oklahoma, Individual Enrollment Department within 5 days of the change in health. Medical conditions that occur after the signature date of this application, and before the effective date of the application (if approved), are considered in the decision to issue coverage.

HEALTH HISTORY / MEDICAL QUESTIONS

If you answer "Yes" to ANY questions on this page, please give complete details on the next page. Please note the timeframe reference for each question.

1. Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last 10 years for the following: Please mark ☐ Yes ☐ No

If any boxes are marked "Yes" (☒ Yes), also circle the condition, e.g. migraines, and give details on the next page.

A. Migraines; headaches; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? . . . . . ☐ Yes ☐ No

B. Memory Loss, Dementia, Narcolepsy, Alzheimer's Disease. . . . . ☐ Yes ☐ No

C. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? . . . . . ☐ Yes ☐ No

D. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? . . . . . ☐ Yes ☐ No
If "Yes" to HBP, provide reading by a health care professional within the last 30 days
BP Reading _____ Date

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

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

G. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach; diverticular disease or any other digestive disorder or condition? . . . . . ☐ Yes ☐ No

H. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? . . . . . ☐ Yes ☐ No
(if yes, indicate type of hepatitis: _____)

I. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? . . . . . ☐ Yes ☐ No
(if yes, indicate diagnosis and location) _____

J. Acne; keratosis; psoriasis; basal cell carcinoma; skin lesions, eczema or any other skin disorder? . . . . . ☐ Yes ☐ No

Questions continue at right

K. Kidney stones; 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. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; TMJ; any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; bunions; carpal tunnel syndrome; joint replacement; manipulation therapy or spinal fusion? . . . . . ☐ Yes ☐ No

N. Thyroid disorder; goiter; Graves' disease; diabetes; lupus; pituitary or adrenal disorder? . . . . . ☐ Yes ☐ No

O. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? . . . . . ☐ Yes ☐ No
How many ear infections in the last 2 years?
Date of last ear infection _____ Tubes? . . . ☐ Yes ☐ No
If yes, date tubes removed _____

P. Acquired Immune Deficiency Syndrome (AIDS); AIDS-Related Complex (ARC); HIV positive or other immune disorders? . . . . . ☐ Yes ☐ No

Q. <u>Question for **MALES** applying for coverage</u>
Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? . . . . . ☐ Yes ☐ No

R. <u>Question for **FEMALES** applying for coverage</u>
Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? . . . . . ☐ Yes ☐ No
Is any female applying for coverage now pregnant? . . . . . ☐ Yes ☐ No

Questions continue on next page

APPLICANT NAME: _____

EVIDENCE OF INSURABILITY *(continued)*

2. Has any person applying for coverage been advised to seek treatment for alcohol use or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism within the last 10 years? . . . . . ☐ Yes ☐ No
3. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use or dependency within the last 10 years? . . . . . ☐ Yes ☐ No
4. During the last 5 years, has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist? . . . . . ☐ Yes ☐ No
5. Has any person applying for coverage been prescribed or taken any medication due to sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss in the last 12 months? . . . . . ☐ Yes ☐ No
6. Does any person applying for coverage have or ever had an implant (e.g. breast, chin, or penile implant), internal fixation (e.g. pins, plates or screws), prosthesis, pacemaker, valve replacement, shunt, stent or monitoring device? . . . . . ☐ Yes ☐ No
7. 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
8. Has any person applying for coverage ever been hospitalized or been treated in the emergency room or had any physical impairment, deformity, congenital anomaly, sickness, operation, injury or hospitalization other than admitted to on this page? . . . . . ☐ Yes ☐ No

DETAILS OF HEALTH HISTORY

If you answered "Yes" to ANY question in the health history/medical questions section, please provide further information on the spaces below. Be sure to use the "correct" example as your guide. (if more space is needed, attach a separate signed and dated page)

	QUESTION #	PERSON AFFECTED	CONDITION, INJURY, SYMPTOM, OR DIAGNOSIS			WAS RECOVERY COMPLETE?	TYPES OF TREATMENT ADVICE GIVEN, AND MEDICATIONS PRESCRIBED	NAME, ADDRESS AND PHONE NUMBER OF DOCTORS AND HOSPITALS
			DESCRIPTION (SPECIFY "LEFT" OR "RIGHT" IF APPLICABLE)	DATE THAT IT STARTED	DATE OF RECOVERY			
INCORRECT	~~C~~	~~MR. SMITH~~	~~BLOOD PRESSURE~~	~~1999~~	~~N/A~~	~~N/A~~	~~PRESCRIPTION~~	~~DR. JONES GENERAL HOSPITAL~~
CORRECT	1C	JOE SMITH	HIGH BLOOD PRESSURE	*06/99*	NONE	NO, ONGOING	*40MG ATENOLOL / ONE PER DAY 140/80 — 07/08/04 138/78 — 10/12/04 139/77 — 02/09/05*	DR. JONES GENERAL HOSPITAL ANYTOWN, OK (345) 555-1212

Continued on next page ⟶

APPLICANT NAME: _____

APPLICATION AGREEMENT AND SIGNATURES *Please read and sign at bottom.*

I and any persons whose names appear on this application hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma and Member Service Life Insurance Company as indicated in this application.

I understand, certify, and agree to the items listed below:

- This is an application only, and I should not cancel any existing coverage unless I am notified in writing by Blue Cross and Blue Shield of Oklahoma of acceptance.
- I appoint the Board of Directors of Blue Cross and Blue Shield of Oklahoma my true and lawful attorney to represent me at any and all meetings of the members of Blue Cross and Blue Shield of Oklahoma and to vote in my name upon any matters arising at said meetings. However, I retain the right to attend and vote at any and all meetings of the members.
- 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, money or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.
- If someone, other than myself, has completed any portion of this application on my behalf, I have reviewed the information and agree it is accurately reflected.
- I am a resident of, and have principal residence located within, the State of Oklahoma and understand that proof of residency may be required at any time.
- This coverage is not an employer-group health plan and is not intended in any way to be an employer sponsored health insurance plan. Further, I certify that my employer will not contribute any part of the premium, nor will I be reimbursed for any part of the premium by my employer now, or in the future.
- Maternity coverage must be in effect for 365 days prior to delivery before maternity benefits will be available.
- If my application is being handled through an independent insurance agent, I understand that the insurance agent is my agent for this application process.
- This application when processed may result in acceptance, denial, exclusion, or limitation of coverage.
- If my application is accepted, no benefits will be provided for any preexisting condition or complication of a preexisting condition for a period of twelve (12) months after my coverage becomes effective. A condition or complication thereof is considered "preexisting" if any of the following events occurred within 12 months before the Subscriber's Effective Date: medical expenses were incurred; medical advice or diagnosis was given; medication was taken or prescribed; treatment was recommended by or received from a Physician or other Provider; or the Subscriber had an awareness of symptoms.
- 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 covered 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 any medical condition(s) or other information required to be reported was not correctly represented.
- This is an age-rated health plan. Rates are subject to change based upon age and other factors.

APPLICANT'S SIGNATURE (IF AGE 15 OR OVER) X _____ DATE SIGNED: _____

SPOUSE'S SIGNATURE (IF APPLYING FOR COVERAGE) X _____ DATE SIGNED: _____

PARENT OR LEGAL GUARDIAN (IF APPLICANT IS UNDER 18) X _____ DATE SIGNED _____

DEPENDENT'S SIGNATURE (AGE 18 OR OVER, IF APPLYING) X _____ DATE SIGNED: _____

DEPENDENT'S SIGNATURE (AGE 18 OR OVER, IF APPLYING) X _____ DATE SIGNED: _____

THANK YOU FOR APPLYING. PLEASE BE SURE TO COMPLETE THE HIPAA AUTHORIZATIONS ON THE FOLLOWING PAGES. PLEASE INCLUDE ALL NECESSARY MATERIALS BEFORE MAILING. IF LEGAL GUARDIAN, PLEASE ENCLOSE COURT DECREE.

APPLICANT NAME: _____

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION. *Please read and sign at bottom.*

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION
HEALTH CHECK Select Care, HEALTH CHECK Basic, HEALTH CHECK HSA, Children's Major Medical

I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, or other medical or medically related facility, governmental agency or other person or firm, to disclose to Blue Cross and Blue Shield of Oklahoma or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize Blue Cross and Blue Shield of Oklahoma to review and research its own records for information.

As mandated by state law, it is understood that this release must contain wording to the effect that information authorized for release may include information which may be considered a communicable or venereal disease which may include, but not be limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), or other conditions for which I may have had symptoms or have been treated as a patient.

I understand my authorization is voluntary and that such information will be used by Blue Cross and Blue Shield of Oklahoma for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for Blue Cross and Blue Shield of Oklahoma to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by Blue Cross and Blue Shield of Oklahoma as permitted or required by law and no longer protected by federal privacy laws. I understand that I or any authorized representative will be sent a copy of this authorization upon written request. This authorization is valid from the date signed and, provided Blue Cross and Blue Shield of Oklahoma approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time by sending a written request to Blue Cross and Blue Shield of Oklahoma, Privacy Department, P.O. Box 3283, Tulsa, OK 74102-3283. Any revocation will not affect the activities of Blue Cross and Blue Shield of Oklahoma prior to receipt of the revocation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

INDIVIDUAL(S) AUTHORIZING USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I have had a full opportunity to read and consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

APPLICANT'S SIGNATURE X _____ DATE SIGNED: _____

PARENT OR LEGAL GUARDIAN (IF APPLICANT IS UNDER 18) X _____ DATE SIGNED _____

SPOUSE'S SIGNATURE (IF APPLYING) X _____ DATE SIGNED: _____

DEPENDENT'S SIGNATURE (AGE 18 OR OVER IF APPLYING) X _____ DATE SIGNED: _____

DEPENDENT'S SIGNATURE (AGE 18 OR OVER IF APPLYING) X _____ DATE SIGNED: _____

If this authorization is signed by a personal representative, on behalf of an individual, complete the following:

PERSONAL REPRESENTATIVE'S NAME X _____ RELATIONSHIP _____

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
YOU ARE ENTITLED TO A COPY OF THIS SIGNED AUTHORIZATION.

Continued on next page →

APPLICANT NAME: _____

MEMBER SERVICE LIFE INSURANCE COMPANY *Beneficiary Information*

APPLICANT: I, on behalf of myself only, hereby apply for $5,000 of guaranteed renewable life insurance and $5,000 of guaranteed renewable accidental death and dismemberment benefits with Member Service Life Insurance Company.			
BENEFICIARY LAST NAME	FIRST	MIDDLE	RELATIONSHIP TO APPLICANT
IS THIS LIFE INSURANCE TO REPLACE ANY OTHER POLICY? ☐ YES ☐ NO	IF YES, COMPANY NAME AND POLICY NUMBER		
SPOUSE: I, on behalf of myself only, hereby apply for $5,000 of guaranteed renewable life insurance and $5,000 of guaranteed renewable accidental death and dismemberment benefits with Member Service Life Insurance Company.			
BENEFICIARY LAST NAME	FIRST	MIDDLE	RELATIONSHIP TO APPLICANT
IS THIS LIFE INSURANCE TO REPLACE ANY OTHER POLICY? ☐ YES ☐ NO	IF YES, COMPANY NAME AND POLICY NUMBER		

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION. *Please read and sign at bottom.*

MEMBER SERVICE LIFE INSURANCE COMPANY

Member Service Life Insurance Company is a Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma

HEALTH CHECK SELECT CARE, HEALTH CHECK BASIC, HEALTH CHECK HSA, CHILDREN'S MAJOR MEDICAL

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, or other medical or medically related facility, governmental agency or other person or firm, to disclose to Blue Cross and Blue Shield of Oklahoma, Member Service Life Insurance Company (MSL) or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize Blue Cross and Blue Shield of Oklahoma and MSL to review and research its own records for information.

As mandated by state law, it is understood that this release must contain wording to the effect that information authorized for release may include information which may be considered a communicable or venereal disease which may include, but not be limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), or other conditions for which I may have had symptoms or have been treated as a patient.

I understand my authorization is voluntary and that such information will be used by Blue Cross and Blue Shield of Oklahoma and MSL for the purpose of evaluating my application. Further, I understand that my authorization is required for Blue Cross and Blue Shield of Oklahoma and MSL to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by Blue Cross and Blue Shield of Oklahoma and MSL as permitted or required by law and no longer protected by federal privacy laws. I understand that I or any authorized representative will be sent a copy of this authorization upon written request. This authorization is valid from the date signed and, provided Blue Cross and Blue Shield of Oklahoma and MSL approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time by sending a written request to Blue Cross and Blue Shield of Oklahoma, Privacy Department, P.O. Box 3283, Tulsa, OK 74102-3283. Any revocation will not affect the activities of Blue Cross and Blue Shield of Oklahoma or MSL prior to receipt of the revocation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524.

INDIVIDUAL(S) AUTHORIZING USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have had a full opportunity to read and consider the contents of this authorization. I understand that by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

APPLICANT'S SIGNATURE X _____ DATE SIGNED: _____

SPOUSE'S SIGNATURE (IF APPLYING) X _____ DATE SIGNED: _____

PARENT OR LEGAL GUARDIAN (IF APPLICANT IS UNDER 18) X _____ DATE SIGNED _____

If this authorization is signed by a personal representative, on behalf of an individual, complete the following:

PERSONAL REPRESENTATIVE'S NAME X _____ RELATIONSHIP _____

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.
YOU ARE ENTITLED TO A COPY OF THIS SIGNED AUTHORIZATION.