



# Application for Individual Medical Insurance, Individual Dental Insurance, and Annual Renewable Term Life Insurance



Home Office Use Only

CWA:	
------	--

**SUBMIT BY FAX:**  
1-800-625-5916

**APPLY & SUBMIT ONLINE (Internet):**  
www.bcbsnm.com or some brokers' websites

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

**For quicker processing, 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. Print all answers 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) and question numbers. Then sign and date each sheet.
5. Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line. For signing child-only policies, see the top of Section A, below.
6. If applicable, be sure Broker section at end is completed (unless sending this form to broker).
7. Make a copy of your completed application for your records.
8. Please submit all application materials using one of the methods listed at the left. Include the Automatic Premium Payment Authorization Agreement if you want premiums deducted from your account at a bank or other financial institution. If required, submit legal guardianship papers, court orders, or administrative orders.

**SELECT ALL THAT APPLY:**  New Policy  Add Spouse and/or Dependent(s)  Upgrade (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 be a New Mexico resident at least for 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.
- If applying for a child-only policy (no adult on policy), you must be the child's parent, trustee, or legal guardian. List the child's information in the Primary Applicant section below. If the child is 15 - 17 years of age, both the child and the parent/guardian must sign the application. If applying for more than one child-only policy, submit a separate application for each child.
- Infants are eligible after the first postnatal visit if there are no medical issues.

### PRIMARY APPLICANT

FIRST NAME, MIDDLE INITIAL, LAST NAME		SOCIAL SECURITY NO.		SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE	DATE OF BIRTH (MM / DD / YY)	HEIGHT ' "	WEIGHT LBS
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)							OCCUPATION (Optional)	
MAILING ADDRESS (P.O. BOX or STREET, CITY, STATE, ZIP+4) if different than above							Okay to use listed mailing address at left for non-billing mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	
FAX (if acceptable contact method) ( )	HOME PHONE ( )	BEST PLACE TO CALL (if necessary): <input type="checkbox"/> Home <input type="checkbox"/> Work		PRIMARY APPLICANT Work Phone: ( )		SPOUSE (if applying) Work Phone: ( )		
EMAIL (if available and acceptable contact method)		BEST TIME TO CALL (if necessary): <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		Cell Phone: ( )		Cell Phone: ( )		

### SPOUSE and/or UNMARRIED DEPENDENT CHILDREN\* TO BE COVERED (dependent children must be under age 25)

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SEX	HEIGHT	WEIGHT LBS	DATE OF BIRTH (MM / DD / YY)	SOCIAL SECURITY NO.
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	' "			
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	' "			
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	' "			
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F	' "			
	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> 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) Indicate 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 you answered "Yes" in 2a, please attach copies of legal guardianship papers, court orders, or administrative orders.

**SECTION B: SELECT BILLING AND INSURANCE OPTIONS**

Section B-1: Select Effective Date & Billing for Health and Dental Insurance

Billing for health (medical) and dental insurance is combined – one payment covers both products (if applicable). Fort Dearborn Life bills separately for the optional Life Insurance. Enrollment in Dental and Life policies depends on acceptance and enrollment in Health Insurance.

To setup a Monthly Bank Draft (the health/dental premium is deducted from your bank account), submit an Automatic Premium Payment Authorization Agreement (required for online applications). This premium mode can also be added later.

Complete the following:

**REQUESTED EFFECTIVE DATE** (cannot be 29<sup>th</sup>, 30<sup>th</sup>, or 31<sup>st</sup>): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YY

**ONGOING PREMIUM MODE:**  Monthly Bank Draft (Complete Automatic Premium Payment Authorization Agreement and submit with this form)  
 One-Month Direct Bill  
 Two-Month Direct Bill

**SUBMITTED PREMIUM DEPOSIT** (Optional, except for online applications): \$ \_\_\_\_\_ (bank draft; check; credit card [online only])

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.

**BILLING NAME and ADDRESS** if other than applicant's mailing address on page 1: \_\_\_\_\_

**Note: DO NOT CANCEL any current coverage you may have. Wait for BCBSNM's final decision on your application.**

Section B-2: Select Health Insurance Plan Select box for one plan and another box for the deductible level:

- BlueDirect<sup>®</sup> Plan A** Choose a deductible below:  
 \$100  \$250  \$500  \$1,000
- BlueDirect Plan B** Choose a deductible below:  
 \$250  \$500  \$1,000  \$2,000  \$5,000
- BlueDirect Plan C** Choose a deductible below:  
 \$500  \$1,000  \$2,000  \$5,000

- BlueEdge<sup>SM</sup> Individual Plan** (An HSA-eligible plan)  
Choose a deductible below:  
 Basic  Enhanced  Premier
- BlueEdge<sup>SM</sup> 100 Plan** (An HSA-eligible plan)  
Choose a deductible below:  
 \$3,500  \$5,000

Section B-3: Optional BlueCare Dental PPO Select box below to apply:

**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.**

Section B-4: Optional Individual Annual Renewable Term Life Insurance

This life insurance is underwritten by Fort Dearborn Life Insurance Company. This is the only opportunity to buy this insurance. This product offering is only available if you (or your spouse if applying for life insurance) are both an adult (age 18–65) and approved for BCBSNM health insurance. Fort Dearborn Life bills members directly (it is separate from billing for health and dental policies). Once a life policy is active, it does not depend on continued health plan membership.

**PRIMARY APPLICANT:** Face Amount:  \$15,000  \$25,000  \$50,000

**SPOUSE:** Face Amount:  \$15,000  \$25,000  \$50,000

**PREMIUM MODE:**  Annual billing  Quarterly billing

**LIFE INSURANCE BENEFICIARY OF PRIMARY APPLICANT** (Primary Applicant is beneficiary of Spouse Insurance unless otherwise specified.) *If additional space is needed for beneficiary information, please attach a separate sheet to application. Sign and date the sheet and include this heading: "Section B-4: Optional Individual Annual Renewable Term Life Insurance."*

Primary Beneficiary: \_\_\_\_\_  
NAME RELATIONSHIP DATE OF BIRTH SOCIAL SECURITY NO.

Address: \_\_\_\_\_  
STREET CITY/STATE ZIP CODE

Contingent Beneficiary: \_\_\_\_\_  
NAME RELATIONSHIP DATE OF BIRTH SOCIAL SECURITY NO.

Address: \_\_\_\_\_  
STREET CITY/STATE ZIP CODE

**OWNER'S INFORMATION** if other than applicant (SIGNATURE required on page 7):

Name & Billing Address: \_\_\_\_\_

*Fort Dearborn Life Insurance Company is a separate life insurance company that does not provide Blue Cross and Blue Shield of New Mexico products or services. Fort Dearborn Life Insurance Company is solely responsible for the life insurance coverage provided.*

**SECTION C: HEALTH HISTORY / MEDICAL QUESTIONS**

- All health history / medical questions must be completed for all individuals (including adults and children) applying for coverage.
- If you answer "Yes" to ANY questions in Section C, please give complete details in Section D. Please note the time frame 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.**

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.*

1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_

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 Chol.: \_\_\_\_\_  
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 & location: \_\_\_\_\_*

J. Acne; keratosis; psoriasis; basal cell carcinoma; malignant melanoma; lesions of the skin or mouth; hemangioma(s); or any other skin disorder? .....  Yes  No

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. **For all Male applicants (adults and children)**  
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. **For all Female applicants (adults and children)**  
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 applicant had a C section? .....  Yes  No

c) Has any female applicant 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

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 applicant (adults and children), complete the following information regarding their last physical exam, including checkup:
- |                         |                                       |   |
|-------------------------|---------------------------------------|---|
| Applicant's Name: _____ | Exam Date (Month/Year): _____ / _____ | Exam Results:..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal* |
| Applicant's Name: _____ | Exam Date (Month/Year): _____ / _____ | Exam Results:..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal* |
| Applicant's Name: _____ | Exam Date (Month/Year): _____ / _____ | Exam Results:..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal* |
| Applicant's Name: _____ | Exam Date (Month/Year): _____ / _____ | Exam Results:..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal* |
| Applicant's Name: _____ | Exam Date (Month/Year): _____ / _____ | Exam Results:..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal* |
| Applicant's Name: _____ | Exam Date (Month/Year): _____ / _____ | Exam Results:..... <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal* |

**\*Abnormal exam results include any recommendation for additional testing, medication or follow-up visit(s).**

3. **During the last 5 years**, has any applicant 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 applicant been prescribed or advised to take medication (other than for the common cold or flu) **other than** 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 (if over age 17) ..... *If YES, list name(s) in Section D*.....  Yes  No
6. **A. Question for all FEMALE applicants (including dependents):**  
 Is any female applicant currently pregnant or now an expectant parent?.....  Yes  No  
*If "Yes," coverage cannot be offered.*
- B. Question for all MALE applicants (including dependents):**  
 Is any male applicant now an expectant parent? .....  Yes  No  
*If "Yes," coverage cannot be offered.*
7. Has any applicant **ever** been seen, tested, prescribed or taken medication, or treated for infertility or to assist in becoming pregnant?.....  Yes  No
8. A. Does any applicant **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:**
- B. Indicate reason(s) for breast implants: .....  Cosmetic reasons  Disease/Illness/Injury/Congenital Anomaly
- C. Have there been any complications or has either of the breast implant(s) been replaced?.....  Yes  No
9. A. Does any applicant drink beer or alcohol? .....  Yes  No  
*If "Yes," please complete the following: (NOTE: 1 drink is equivalent to one 12 oz. beer, or one 5 oz. glass of wine, or 1.5 oz. of hard liquor)*
- |                         |  |
|-------------------------|--|
| Applicant's Name: _____ | Average Number of Drinks per Week: _____ |
| Applicant's Name: _____ | Average Number of Drinks per Week: _____ |
| Applicant's Name: _____ | Average Number of Drinks per Week: _____ |
- B. Has any applicant **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 applicant **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 applicant discussed or been advised to have treatment, testing, counseling, therapy, or surgery **which has not yet been performed?** .....  Yes  No
12. Has any applicant **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 you answered "YES" to any questions in Section C, please give complete details in Section D.***



**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)

2. Does any person applying for coverage have 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 (check ID card): \_\_\_\_\_ Anticipated Termination Date: \_\_\_\_\_

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

If "Yes," provide names: \_\_\_\_\_ Explanations: \_\_\_\_\_

**Do NOT cancel any current coverage you may have. Wait for BCBSNM's final decision on your application.**

**SECTION F: REPRESENTATIONS, ACKNOWLEDGEMENTS, and AUTHORIZATIONS**

**Conditions of Health Statement:** I understand that the purpose of the Health Statement is to provide BCBSNM and Fort Dearborn Life Insurance Company (FDL) with information for determining the qualifications of myself (individual) and/or my dependents for BCBSNM health benefits coverage and FDL for life insurance coverage, and I agree that this Health Statement shall become part of the contracts between BCBSNM and myself, and between FDL 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 and that I may provide proof of prior creditable coverage to reduce or eliminate this pre-existing period.

**Authorization:** I understand that BCBSNM and FDL must 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 or FDL 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 and FDL 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 or FDL as permitted or required by law, and by FDL to its reinsurers, 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 or FDL's activities prior to receipt of the revocation. I should retain one duplicate of this authorization as my copy.

In no event shall BCBSNM or FDL incur any liability before a policy is effective or with respect to an application that has been declined.

**I acknowledge that I have read and verified the above. I understand the foregoing answers and certify and warrant that they are true and shall be the basis for the issuance of the coverage applied for, and that the omission or misstatement of any material information in answer to the foregoing questions shall void my coverage and may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of BCBSNM.**

Applicant Name \_\_\_\_\_

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.

## SECTION G: 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 Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Child-Only Policy: Need signature of child if age 15-17. All child-only cases need signature of Parent, Trustee or Legal Guardian below.* MM DD YY

**Spouse's Signature** (If applying): \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

**Parent, Trustee or Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

**Dependent's Signature** (ONLY if 18 or over and to be insured): \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

**Dependent's Signature** (ONLY if 18 or over and to be insured): \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

**Dependent's Signature** (ONLY if 18 or over and to be insured): \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

**LIFE INSURANCE ONLY** – Signature of Owner (if other than applicant): \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

## 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 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 Signature (OPTIONAL):** \_\_\_\_\_

**Print Your Name as You Signed It:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YY

- If you are using an insurance broker, be sure the *Broker Information* section 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.

## SECTION I: BROKER INFORMATION (if applicable)

NAME IN BCBSNM CONTRACT (AGENCY OR INDIVIDUAL)	BROKER NUMBER	Mail New Member Packet to: <input type="checkbox"/> Broker <input type="checkbox"/> Member
BROKER'S NAME	BROKER'S PHONE	BROKER'S FAX (OPTIONAL)

**Thank you for applying. Please include all materials when submitting this application.**

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