



We know you want to keep the following information confidential, and we've designed this form to help you do that.

5 HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 11-50 EMPLOYEES:

Have you, your spouse or any of your dependents:

- 1. Ever had, consulted for, had treatment rendered, been advised to have treatment, or received treatment or been hospitalized for any of the following conditions: Cardiovascular disease or heart attack; stroke; disorder of the kidney, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorders; diabetes; any disorder of the lungs or respiratory system; cancer or immune deficiency disorder, AIDS, or AIDS-related complex?
2. During the last 24 months, had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses more than \$5,000?
3a. Is any female to be covered currently pregnant?
b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?
4. Does anyone listed on this application use tobacco products?

If you answer "YES" to all or part of the above questions, complete the following: (Attach additional sheet(s) if necessary.)

Name of patient: Condition treated:
Date of first treatment: Medication(s) and dosage taken:
Date(s) of following treatment(s):
Degree of recovery: Date - From: Through:

ALL EMPLOYEES MUST COMPLETE THE FOLLOWING

6 OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS: All questions must be answered.

- A. Do any persons on this application intend to continue other Group Coverage if this application is accepted?
B. Does any person applying for coverage currently have health insurance coverage?
C. Does any persons applying for coverage currently have Dental Insurance Coverage?
D. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits?

SUBMIT PROOF OF COVERAGE - Proof of this coverage must accompany this application. Acceptable forms of proof are: certificate of coverage from prior carrier, or, copy of I.D. card and copy of payroll stub showing medical coverage deduction, or, copy of most recent medical premium bill. Failure to advise and provide proof of prior coverage may subject you or a family member to a six-month preexisting conditions clause.

7 AUTHORIZATION - The following Authorization section is to be signed by ALL EMPLOYEES applying for coverage.

I AGREE: All information on this form is correct and true. I understand that this application and any information Blue Cross of California and/or BC Life & Health Insurance Company obtains prior to the effective date of coverage is the basis on which coverage may be issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by BLUE CROSS and BC LIFE & HEALTH INSURANCE COMPANY.

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

I AM APPLYING FOR PPO PLAN COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. If a No Deductible PPO Plan is selected and a non-participating provider is used, medical payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

I AM APPLYING FOR HMO COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

I AM APPLYING FOR THE HIGH DEDUCTIBLE EPO (Medical Savings Account (MSA) compatible) PLAN: I understand that the High Deductible Plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an MSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

ARBITRATION AGREEMENT: We understand that any dispute between us and Blue Cross of California/BC Life & Health must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, not by lawsuit or resort to court process, except as California provides for judicial review of arbitration proceedings. Under this coverage, Blue Cross/BC Life & Health and we are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other.

I attest by signing below that I have reviewed the information provided on this application and confirm that it is true and accurate with no omissions or misstatements.

X Signature of Employee Date (Month / Day / Year) X Signature of Employee's Spouse (If applying for coverage) Date (Month / Day / Year)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give Blue Cross of California or Affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related Complex) of me, or any of my dependents applying for or having Blue Cross coverage. I understand that this information may be collected in connection with the review, investigation or evaluation of any application for coverage or of any claim for benefits.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance. I also authorize Blue Cross to disclose all such medical or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purposes of investigating or evaluating any claim for benefits.

This authorization is effective immediately and shall remain in effect for a period of thirty (30) months, except that it shall remain effective for use in connection with any claim for benefits for as long as any Blue Cross coverage may be in effect. A photo copy of this authorization is as valid as the original, and I, and my Blue Cross agent or broker, am entitled to receive a copy of this form.

X Signature of Employee Date (Month / Day / Year) X Signature of Employee's Spouse (If applying for coverage) Date (Month / Day / Year)

After completion, remove tape, fold closed to seal, and submit application to your employer.