

# Split Application Authorization Form



If you wish to remove one or more dependents from the previously submitted application in order to make them eligible for a separate individual policy, please complete this form. A separate Split Application Authorization Form must be completed for each separate policy being accepted.

1. List all family members who will be covered on each policy.
2. For each separate policy, choose only one plan in section C.
3. Submit the original Acceptance Letter and first month's premium for all policies being accepted.

Original Applicant's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

## Section A

If the original applicant is accepting coverage, please complete this section. If the original applicant is not accepting coverage, continue to section B.

I, \_\_\_\_\_ (original applicant), choose to accept individual coverage for myself and each of the dependents listed below. I have completed the original acceptance letter in full, including choosing a plan and effective date.

I understand that the policy effective date will be \_\_\_\_\_ at a rate level of \_\_\_\_\_.

Dependent(s)		
Name	Date of Birth	Relationship to Applicant

## Section B

I, \_\_\_\_\_ (original applicant), request that the dependent(s) listed below be removed from my previously submitted application and set up on a separate individual policy.

I understand that the policy effective date will be \_\_\_\_\_ at a rate level of \_\_\_\_\_.

Dependent(s)		
Name	Date of Birth	Relationship to Applicant

## Section C: Plan Options (Please choose the desired policy below)

<input type="checkbox"/> BlueCare® PPO 1000 <input type="checkbox"/> BlueCare® PPO 2000 <input type="checkbox"/> BlueCare® PPO 5000 <input type="checkbox"/> Supplemental Accident for BlueCare® PPO  <input type="checkbox"/> Essential Blue Basic <sup>sm</sup> PPO 1000* <input type="checkbox"/> Essential Blue Basic <sup>sm</sup> PPO 2000* <input type="checkbox"/> Essential Blue Basic <sup>sm</sup> PPO 3000* <input type="checkbox"/> Essential Blue Basic <sup>sm</sup> PPO 5000*  <input type="checkbox"/> Essential Blue Plus <sup>sm</sup> PPO 1000* <input type="checkbox"/> Essential Blue Plus <sup>sm</sup> PPO 2000* <input type="checkbox"/> Essential Blue Plus <sup>sm</sup> PPO 3000* <input type="checkbox"/> Essential Blue Plus <sup>sm</sup> PPO 5000*  <input type="checkbox"/> Latitude <sup>sm</sup>	<input type="checkbox"/> Simply Blue <sup>sm</sup> (\$2,500 / 70%) <input type="checkbox"/> Simply Blue <sup>sm</sup> (\$5,000 / 70%) <input type="checkbox"/> Simply Blue <sup>sm</sup> (\$7,500 / 70%) <input type="checkbox"/> Simply Blue <sup>sm</sup> (\$10,000 / 100%) <input type="checkbox"/> Simply Blue <sup>sm</sup> (\$2,500 / 70% with Buy-up) <input type="checkbox"/> Simply Blue <sup>sm</sup> (\$5,000 / 70% with Buy-up) <input type="checkbox"/> Simply Blue <sup>sm</sup> (\$7,500 / 70% with Buy-up) <input type="checkbox"/> Simply Blue <sup>sm</sup> (\$10,000 / 100% with Buy-up)	<p><i>Federally qualified health insurance program:</i></p> <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$2,000 deductible / 80% coinsurance) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$3,000 deductible / 80% coinsurance) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$2,000 deductible / 90% coinsurance) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$3,000 deductible / 90% coinsurance) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Single (\$5,000 deductible / 100% coinsurance)  <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$4,000 deductible / 80% coinsurance) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$6,000 deductible / 80% coinsurance) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$4,000 deductible / 90% coinsurance) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$6,000 deductible / 90% coinsurance) <input type="checkbox"/> HSA Blue <sup>sm</sup> PPO Family (\$10,000 deductible / 100% coinsurance)
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3000 E. Pine Ave. • Meridian, Idaho 83642 • (208) 345-4550  
 Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

**Statement of Understanding**

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No Independent Producer, agent or employee of Blue Cross of Idaho may alter any part of this application or waive the requirement that I answer all questions completely and accurately, nor may any such person change the terms of the policy, except by endorsement issued expressly for that purpose over the signature or facsimile signature of the President of Blue Cross of Idaho.
- Blue Cross of Idaho may, at its discretion, request supplemental information from me, any family member listed on this application, or any health care providers before deciding whether to approve or reject the application.
- Blue Cross of Idaho may deny benefits or terminate or rescind my policy retroactive to its effective date for any misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any persons listed on this application that was or would have been material to Blue Cross of Idaho's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.
- If this application is not approved for the program(s) applied for upon initial review, any payment submitted with this application will be refunded. Upon the refund of the payment, Blue Cross of Idaho will have no further obligations to me or any family member listed on this application.
- If this application is approved, coverage for me and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.
- If this application is approved, I understand a copy of the application will be attached to my policy. I approve the inclusion of any needed alterations to the application as long as I have been consulted by a duly authorized employee of Blue Cross of Idaho or a licensed and duly appointed Independent Producer representing me, the alterations are duly noted in the "Processing Notations" section of the application, and I have had an opportunity to review the application that will be attached to my policy.

- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at [www.bcidaho.com](http://www.bcidaho.com).
- I have been advised that if I am declined coverage under the plan I am applying for, I may be eligible for my choice of the High Risk Basic, Standard, Catastrophic A, Catastrophic B or Idaho HSA plans. I have also been advised that I may be eligible for one of the High Risk Basic, Standard, Catastrophic A, Catastrophic B or Idaho HSA plans if Blue Cross of Idaho refuses to issue a health benefit plan providing coverage substantially similar to coverage offered under an equivalent High Risk Pool plan except at a rate exceeding the rate of the High Risk Pool plan.
- If you have had group or individual health coverage or a government health care program for at least 12 months, you are entitled to receive a Certificate of Creditable Coverage from your previous employer or insurance company. This document will state the effective date of prior coverage and the termination date of coverage for you and any covered dependents. Your previous employer or insurance company will furnish you this certificate upon request. If you need assistance in obtaining a certificate, Blue Cross of Idaho can assist you.
- **I affirm that I have reviewed all the information provided on this application and, if an Independent Producer or other person has filled out the answers for me and on my behalf, I verify the answers accurately reflect all the information I have provided. I certify that the answers given on the "Health Statement" section are complete and accurate. I understand that this application will become part of any agreement or policy that Blue Cross of Idaho issues.**

**If selecting the Essential Blue Policy:  
The Essential Blue<sup>SM</sup> policy provides limited benefits.  
Review your policy carefully.**

The above listed dependents are to be removed from my original application and receive their own individual policies. This authorization is part of the original application and of the dependent's individual policy application.

X \_\_\_\_\_  
Signature of dependent  
(Parent or Guardian's signature if applicant is under age 18)

\_\_\_\_\_ Date

X \_\_\_\_\_  
Signature of original applicant

\_\_\_\_\_ Date