Traditional Blue℠

Classic Comprehensive
Major Medical Protection with
Complete Freedom of Choice
Traditional Blue

For solid security and maximum freedom of choice...it just fits

If you are looking for a “classic” health plan that can stand the test of time, we think you’ll really like the traditional major medical coverage, valuable features and exceptional freedom of choice offered by Traditional Blue. It includes a $5,000,000 lifetime maximum benefit for a variety of expenses, including hospitalization, doctor office visits, emergency care, output prescription drugs, well-child care, optional maternity care and more. Traditional Blue also gives you maximum choice when it comes to your choice of health care providers. With freedom to use any doctor you want — with no referrals — it’s easy to select the health care professionals that fit you best!
Traditional Blue, The Smart Choice for Reliable Protection and Freedom of Choice

Traditional Blue includes Benefits for Inpatient and Outpatient Care, Well-Child Care, Optional Maternity Coverage and More!

Traditional Blue provides affordable health insurance coverage that many individuals and families consider essential. This includes benefits for covered hospitalizations, surgery, doctor office visits, inpatient and outpatient care, emergency care, and more. Traditional Blue also features benefits for covered well-child care and optional maternity coverage.

A Choice of Deductibles

Traditional Blue gives you the flexibility of choosing either a $250, $500, $1,000, $2,500, or $5,000 deductible. Generally, the higher the deductible, the lower your monthly premium. Given this wide range of choice, you are certain to find an option that fits your budget.

Select Your Coverage Level to Control Your Costs: 100% or 80%

The coverage level (percentage) that Traditional Blue pays for covered services after you meet your deductible is called coinsurance. With 100% coinsurance, you pay nothing for most covered services once your deductible has been met when you use PPO hospitals. When you choose Traditional Blue’s 80% coinsurance option, the plan pays 80% of your covered services once your deductible has been met and when you use PPO hospitals.

Outpatient Prescription Drug Coverage

Outpatient prescription drugs are covered at 80% after you’ve met the deductible. Your claim will be automatically processed when you purchase your prescription drugs at any one of the participating pharmacies in Illinois — and 98% of all Illinois pharmacies participate.

Freedom of Choice

When you choose Traditional Blue you are completely free to choose any doctors you want — and you don’t need a referral to see a specialist.

What’s more, Traditional Blue is supported by one of the largest hospital networks in Illinois. In fact, with more than 200 Illinois hospitals included, it’s likely that hospitals near you participate.
With Traditional Blue, You’ll Enjoy this Unique Combination of Features

$5,000,000 in Lifetime Protection
With Traditional Blue, you have the option of applying for individual or family coverage to protect yourself, your spouse, and your eligible unmarried dependent children. Each person will be eligible for up to $5,000,000 in lifetime benefits. That’s substantial protection for today and the years ahead.

Travel with Confidence — You’re Covered Away from Home
As a member of Blue Cross and Blue Shield of Illinois, you’ll have access to a program called BlueCard PPO. This is a nationwide network of providers that allows you to receive benefits for covered services when you travel. Simply present your Blue Cross and Blue Shield of Illinois ID card to a participating BlueCard PPO provider wherever you are. To find a participating provider while you’re away, just call the toll-free number on the back of your card. It’s that easy!

Financial Stability You Can Count On
Blue Cross and Blue Shield of Illinois has been serving the health insurance needs of Illinois residents for more than 65 years. We’re one of the largest and most financially secure insurance companies in the state. A.M. Best, one of the leading rating agencies of the insurance industry, has awarded us an “A+” (Superior) rating.* This stability is one reason why over 6.5 million members count on us to be there when they need us.

No Paperwork — Your Claims Are Handled For You
In most cases, all you have to do is show your Blue Cross and Blue Shield ID card at a doctor’s office or hospital, and your claim will be filed for you. We want you to concentrate on regaining your health — not worrying about hospital and doctor bills.

* As of November 2007
Traditional Blue offers reliable coverage at a price that fits your budget

Choose from two coverage levels to meet your needs and budget! Traditional Blue 100 pays 100% for most covered services once your deductible has been met. Traditional Blue 80 pays 80% for most covered services once your deductible has been met. Generally, the lower your coverage level, the lower your monthly premium.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>Traditional Blue 100</th>
<th>Traditional Blue 80</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Network</td>
<td>Use any doctor; more than 200 hospitals</td>
<td></td>
</tr>
<tr>
<td>Lifetime Benefit</td>
<td>$5,000,000</td>
<td></td>
</tr>
<tr>
<td>Individual Deductible</td>
<td>$250, $500, $1,000, $2,500 or $5,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Individual Out-of-Pocket Expense Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits and Outpatient Physician Medical Services</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Includes surgery and pre-admission testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Includes semi-private room and board pre-admission testing, prescription drugs and more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient Diagnostic Testing</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Includes X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies and more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-Child Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To age 16. Includes immunizations, physical exams and routine diagnostic tests. ($500 per calendar year maximum)</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Outpatient Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes covered services received in a hospital or physician’s office</td>
<td>100% (deductible does not apply)</td>
<td></td>
</tr>
<tr>
<td>Physical, Occupational or Speech Therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>($3,000 per therapy, per calendar year maximum)</td>
<td>80%²</td>
<td></td>
</tr>
</tbody>
</table>

Continued
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>Traditional Blue 100</th>
<th>Traditional Blue 80</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participating Provider Option (PPO) Coverage¹</td>
<td>Participating Provider Option (PPO) Coverage¹</td>
</tr>
<tr>
<td>Outpatient Prescription Drugs</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Illness Treatment and Substance Abuse Rehabilitation Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(30 Inpatient Hospital days per calendar year)</td>
<td>80%²</td>
<td></td>
</tr>
<tr>
<td>• Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospital — First 14 days</td>
<td>60%²</td>
<td></td>
</tr>
<tr>
<td>Therefore</td>
<td>50%²</td>
<td></td>
</tr>
<tr>
<td>Outpatient Care</td>
<td>50%²</td>
<td></td>
</tr>
<tr>
<td>(30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physician and Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Optional Maternity Coverage</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Inpatient/Outpatient Hospital Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Medical/Surgical Services</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Benefits are reduced when non-plan facilities are used.
² Does not apply to out-of-pocket expense limit.

**Maximizing Your Benefits Can Be Just a Phone Call Away!**

Blue Cross and Blue Shield of Illinois can assist you in trying to maximize your benefit coverage. That’s why our Traditional Blue health insurance plan includes the services of two units of health professionals. They’re called the Mental Health Unit and the Medical Services Advisory (MSA®).

Call one of these units whenever you need mental health and substance abuse services, or if you find yourself receiving treatment at an out-of-network hospital. They can assist you in maximizing your available benefits.
This Sales Kit provides health insurance plan highlights only.

When we receive your application, we will evaluate your medical history, and if approved, you will receive your ID card and policy.

Your coverage documents include a full description of benefits, limitations, exclusions, and other features of coverage. You have 30 days to examine your coverage with no risk or obligation. We want you to be 100% satisfied. If you should change your mind about your Blue Cross and Blue Shield policy, even after you’ve made your first premium payment, simply return your policy and membership card to your insurance representative within 30 days of the activation of the policy. If no claims were filed, you will get a refund of your premium. You’ll be under no further obligation.

PRODUCER’S NEW BUSINESS CHECKLIST

For quick processing of all applications...

Use this simple checklist before submitting your applications to assure prompt processing.

Have you:
- Reviewed each application to verify that it is complete and legible?
- Assured that all the necessary signatures are provided?
- Assured that a separate application has been completed for each child applying for individual coverage?
- Assured that any changes to an application are initialed by the applicant?
- Attached detailed descriptions for any health questions which have been answered “YES”?
- Included your Agent Code and phone number on the application?
- Completed the “Conditional Receipt” form?
- Given the applicant a copy of the Outline of Coverage?

In addition...
- There are NO C.O.D.s.
- The check for the exact amount should be made payable to Blue Cross and Blue Shield of Illinois.
  - If applicant is paying by bank draft authorization, make sure the authorization form is completed, a voided check or deposit slip is attached, and a check for the first month’s premium is submitted.
  - If applicant is selecting the two-month payment mode, a check for the first two months’ premium should be submitted.
- If applicant is replacing his/her current coverage, make sure a signed replacement form is also attached.
OUTLINE OF COVERAGE

1. READ YOUR POLICY CAREFULLY—This outline of coverage provides a brief description of the important features of your Policy. This is not the insurance contract, and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2. Traditional Blue Coverage — Traditional Blue coverage is designed to provide you with economic incentives for using designated hospitals. It provides, to persons insured, coverage for major Hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, In-Hospital medical services, and Out-of-Hospital care, subject to any Deductibles, Copayment provisions, or other limitations which may be set forth in the Policy. Although you can go to the Hospitals of your choice, your benefits under the Traditional Blue plan will be greater when you use the services of participating Hospitals.

<table>
<thead>
<tr>
<th>BASIC PROVISIONS</th>
<th>TRADITIONAL BLUE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Benefit</strong></td>
<td>$5,000,000</td>
</tr>
<tr>
<td><strong>Deductible</strong> Per individual, per calendar year. (If two or more family members receive covered services as a result of injuries received in the same accident, only one Deductible will apply.)</td>
<td>$250*</td>
</tr>
<tr>
<td><strong>Carryover Deductible</strong> If an insured incurs covered expenses for the Deductible in the last three months of the calendar year, we will carry over that amount as credit toward the Deductible for the following calendar year.</td>
<td>$500*</td>
</tr>
<tr>
<td><strong>Family Aggregate Deductible</strong> Per family, per calendar year.</td>
<td>Equal to three times the individual Deductible</td>
</tr>
<tr>
<td><strong>Hospital Admission Deductible</strong> Per admission, per individual.</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Coinsurance</strong> The level of coverage provided by the plan after the calendar year Deductible has been satisfied. You must select a level of participating provider coverage:</td>
<td>100% participating provider coverage, or 80% participating provider coverage</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Expense Limit</strong> The amount of money an individual pays toward covered hospital and medical expenses during any one calendar year. Deductibles, reduction in benefits applicable to the Medical Services Advisory and/or the Mental Health Unit, charges that exceed the Usual and Customary Fee or the Eligible Charges, and items asterisked (*) do not apply to the out-of-pocket expense limit.</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>Family Aggregate Out-of-Pocket Expense Limit</strong> Equal to three times the individual out-of-pocket limit, per family, per calendar year.</td>
<td>$3,000</td>
</tr>
<tr>
<td>BASIC PROVISIONS</td>
<td>TRADITIONAL BLUE</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient/Outpatient Physician Medical/Surgical Services</strong></td>
<td>80%</td>
</tr>
<tr>
<td><strong>Well-Child Care</strong> To age 16. Includes immunizations, physical exams, and routine diagnostic tests. ($500 per calendar year maximum, per dependent.)</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Inpatient /Outpatient Hospital Services</strong> Includes surgery pre-admission testing and services received in a Skilled Nursing Facility, Coordinated Home Care Program and Hospice. (For mental health coverage levels, please refer to mental health benefits on the next page.)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Inpatient/Outpatient Hospital Diagnostic Testing</strong> Includes but not limited to X-rays, lab tests, EKGs, ECGs, pathology services, pulmonary function studies, radioisotope tests, and electromyograms.</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Optional Maternity Coverage</strong> When elected, maternity benefits will begin 365 days after the effective date of the maternity coverage.</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Outpatient Emergency Care (Accident or Illness)</strong> For both Hospital and Physician.</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Additional Surgical Opinion Program</strong> Following a recommendation for elective surgery, provides additional consultations and related diagnostic service by a Physician, as needed.</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Other Covered Services</strong> Of a registered physical, occupational, or speech therapist ($3,000 per therapy, per calendar year maximum*); naprapathic services rendered by a Naprapath ($1,000 per calendar year maximum*); ambulance service; durable medical equipment; artificial limbs and other prosthetic devices; oxygen and its administration; blood plasma; private duty nursing services ($1,000 per month maximum*); Temporomandibular Joint Dysfunction (TMJ) and related disorders ($1,000 lifetime maximum*); leg, arm, back, and neck braces; surgical; dressing; casts and splints; and outpatient prescription drugs.</td>
<td>80%</td>
</tr>
</tbody>
</table>
BASIC PROVISIONS

<table>
<thead>
<tr>
<th>Mental Illness Treatment and Substance Abuse Rehabilitation Treatment**</th>
<th>TRADITIONAL BLUE Participating Provider Option (PPO) Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Care</strong> (30 Inpatient Hospital days per calendar year.)</td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>80%*</td>
</tr>
<tr>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>First 14 days</td>
<td>60%*</td>
</tr>
<tr>
<td>Thereafter</td>
<td>50%*</td>
</tr>
<tr>
<td><strong>Outpatient Care</strong> (30 visits per calendar year combined annual maximum and 100 visits per lifetime maximum.)</td>
<td></td>
</tr>
<tr>
<td>Physician and Hospital</td>
<td>50%*</td>
</tr>
</tbody>
</table>

**Mental Health Unit**  
In order to maximize your benefits, the Policyholder is responsible for notifying the Mental Health Unit for ALL care related to mental health and substance abuse. In the event of an admission, for either mental illness or substance abuse, notification is required three days prior for non-emergencies and within 24 hours for emergencies. Failure to contact the Mental Health Unit may result in a reduction of benefits of up to $1,000.*

**Medical Services Advisory (MSA®)**  
The MSA helps you maximize your benefits. The Participating Provider is responsible for notifying MSA when services are rendered at a Participating Hospital. The Policyholder is responsible for notifying MSA for Hospital admissions at Non-PPO and Non-Plan Hospitals. MSA notification is required within three business days for non-emergencies and within one business day for emergencies and maternity admissions. If Policyholder does not notify MSA, Hospital benefits are reduced by $1,000.*

Benefits for covered services are provided at either the Eligible Charge or the Usual and Customary Fee.

**IF USING A NON-PPO HOSPITAL OR NON-PLAN HOSPITAL...**

A $300 per admission Deductible will apply in addition to the individual or family Deductible.*

**If You’ve Selected 100% Participating Provider Coverage...**

Hospital benefits shown on the previous pages, which are paid at 100% at Participating Hospitals, are paid at 80% at Non-PPO Hospitals, and 50% at Non-Plan Hospitals, except for Outpatient Emergency Care, and additional surgical opinions which are paid at 100%, regardless of the Hospital selected.

With the exception of alcoholism, there are no benefits for Substance Abuse Rehabilitation Treatment at Non-Plan facilities.

The out-of-pocket expense limit for Non-PPO Hospitals is $5,000 for individual coverage and $15,000 for family coverage.

**If You’ve Selected 80% Participating Provider Coverage...**

Hospital benefits shown on the previous pages, which are paid at 80% at Participating Hospitals, are paid at 60% at Non-PPO Hospitals, and 50% at Non-Plan Hospitals, except for Outpatient Emergency Care, and additional surgical opinions which are paid at 100% regardless of the Hospital selected.

With the exception of alcoholism, there are no benefits for Substance Abuse Rehabilitation Treatment at Non-Plan facilities.

The out-of-pocket expense limit for Non-PPO Hospitals is $5,000 for individual coverage and $15,000 for family coverage.

* Does not apply to out-of-pocket expense limit.
** In order to receive benefits for Substance Abuse care (other than alcoholism), the treatment program must be approved by Blue Cross and Blue Shield of Illinois. Contact the Mental Health Unit for additional details.
† Deductible does not apply.
PRE-EXISTING CONDITIONS LIMITATION Pre-existing Conditions are those health conditions which were diagnosed or treated by a Provider during the 12 months prior to the coverage effective date, or for which symptoms existed which would cause an ordinarily prudent person to seek diagnosis or treatment. Any Pre-existing Condition will be subject to a waiting period of 365 days.

PREMIUMS We may change premium rates only if we do so on a class basis for all DB-44 HCSC policies. Premiums can be changed based on age, sex, and rating area.

GUARANTEED RENEWABILITY Coverage under this Policy will be terminated for nonpayment of premiums. In addition, Blue Cross and Blue Shield may terminate or refuse to renew this Policy only for the following reasons:
1. If every Policy that bears this Policy form number, DB-44 HCSC, is not renewed. If this should occur:
   a. Blue Cross and Blue Shield will give you at least 90 days prior to written notice.
   b. You may convert to any other individual policy Blue Cross and Blue Shield offers to the individual market.

2. In the event of fraud or an intentional misrepresentation of material fact under the terms of this Policy. In this case, Blue Cross and Blue Shield will give you at least thirty (30) days prior written notice.

3. If you no longer reside, live or work in an area for which Blue Cross and Blue Shield is authorized to do business. Blue Cross and Blue Shield will never terminate or refuse to renew this Policy because of the condition of your health. Blue Cross and Blue Shield may uniformly modify coverage provided by every Policy which bears this Policy form number only on the coverage Renewal Date.

Exclusions and Limitations:
Hospitalization, Services, and supplies which are not Medically Necessary; Services or supplies that are not specifically mentioned in this Policy; Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers’ Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits; Services or supplies that are furnished to you by the local, state, or federal government; Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war; Services or supplies that do not meet accepted standards of medical or dental practice; Investigational Services and Supplies, including all related services and supplies; Custodial Care Service; Routine physical examinations, unless specifically stated in this Policy; Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness; Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases; Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage; Charges for failure to keep a scheduled visit or charges for completion of a Claim form; Personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones; Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery controlled implants, except as specifically mentioned in this Policy; Eyeglasses, contact lenses, or cataract lenses and the examinations for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this Policy; Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot or routine foot care; Immunizations, unless otherwise stated in this Policy; Maintenance Occupational Therapy, Maintenance Physical Therapy, and Maintenance Speech Therapy; Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap, or mental retardation; Hearing aids or examinations for the prescription or fitting of hearing aids; Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, casefinding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this Policy; Procurement or use of prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, or unrelated to the treatment of a disease or injury; Services and supplies rendered or provided for the diagnosis and/or treatment of infertility including, but not limited to, Hospital services, Medical Care, therapeutic injection, fertility and other drugs, Surgery, artificial insemination, and all forms of in–vitro fertilization; Maternity Service, including related services and supplies, unless selected as an option (Complications of Pregnancy are covered as any other illness).
APPLICATION FOR INDIVIDUAL COVERAGE

To help us process your application promptly, please remember to:

- Print all answers in black ink. Pencil will not be accepted.
- Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.
- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid.

PART ONE

Check one:  □ New Policy  □ Add Dependent  □ Upgrade (increase of benefits)

SECTION A — PERSON(S) APPLYING FOR COVERAGE (please print)

In addition to having a permanent residence in Illinois, all persons applying for coverage who are not U.S. citizens must have resided in the U.S. for at least six months AND have had a complete physical by a physician in the U.S. within the past two years.

PRIMARY APPLICANT

<table>
<thead>
<tr>
<th>First Name, Middle Initial, Last Name</th>
<th>Social Security #</th>
<th>Sex (m/f)</th>
<th>Age</th>
<th>Date of Birth (mo./day/yr.)</th>
<th>Height (ft., in.)</th>
<th>Weight (lbs.)</th>
</tr>
</thead>
</table>

Home Phone # (                     )
Business Phone # (                   )
Fax # (if available) (                     )
Occupation/Duties (                     )
Spouse’s Business Phone # (if applying) (                     )

Residence Street Address (                     )
City / State / ZIP (                     )
County (                     )

Email (if available) (                     )
Best place and time to call (if necessary)  □ Home  □ Business  □ Morning  □ Afternoon

SPOUSE and DEPENDENT CHILDREN YOU WISH TO COVER (dependent children must be under age 19, or under age 25 if unmarried, full-time student)

NAME:  First                  M.I.                     Last RELATION SEX HEIGHT WEIGHT DATE OF BIRTH SOCIAL SECURITY NUMBER FULL-TIME STUDENT

SECTION B — COVERAGE APPLIED FOR (please choose only one plan)

- SelectBlue®
  Deductible:  □ $0 □ $250 □ $500 □ $1,000 □ $2,500 □ $5,000 □ $10,000
  Level of Coverage:  100%  80%
  Do You Want Maternity Coverage?  □ Yes  □ No

- SelectBlue Advantage®
  Deductible:  □ $250 □ $500 □ $1,000 □ $1,500 □ $2,500 □ $5,000
  Level of Coverage:  80%
  Do You Want Maternity Coverage?  □ Yes

- BlueChoice® Select
  Deductible:  □ $250 □ $500 □ $1,000 □ $1,750 □ $2,500 □ $5,000
  Level of Coverage:  80%
  Do You Want Maternity Coverage?  □ Yes

- Traditional Blue®
  Deductible:  □ $250 □ $500 □ $1,000 □ $2,500 □ $5,000
  Level of Coverage:  100%  80%
  Do You Want Maternity Coverage?  □ Yes

- BlueValue®
  Deductible:  □ $250 □ $500 □ $1,000 □ $2,500 □ $5,000
  Level of Coverage:  80%
  Do You Want Maternity Coverage?  □ Yes

- BlueValue Advantage®
  Deductible:  □ $250 □ $500 □ $1,000 □ $1,750 □ $2,500 □ $5,000
  Level of Coverage:  80%
  Do You Want Maternity Coverage?  □ Yes

- BlueChoice® Value
  Deductible:  □ $250 □ $500 □ $1,000 □ $1,750 □ $2,500 □ $5,000
  Level of Coverage:  80%
  Do You Want Maternity Coverage?  □ Yes

- BasicBlue®
  Deductible:  □ $500 □ $1,000 □ $2,500
  Level of Coverage:  80%
  Maternity Option Not Available

SECTION C — BILLING INFORMATION

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

REQUESTED EFFECTIVE DATE (mo./day/yr.) (                     )
PREMIUM AMOUNT ENCLOSED $ (                     )

PREMIUM MODE:  □ Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)  □ Two-Month Direct Bill

Billing Name and Address (if different than name and residence address given above)
PART TWO — EVIDENCE OF INSURABILITY

All health history/medical questions must be completed for all individuals (including dependents) applying for coverage.

SECTION A — 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 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

2. 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

3. Has any person applying for coverage been hospitalized or been treated in the emergency room or had any physical impairment, during the last 5 years? ......................................................................................................................... [ ] Yes [ ] No

4. During the last 5 years, has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consult a physician, chiropractor or therapist? ........................................................................................................................................ [ ] Yes [ ] No

5. Has any person applying for coverage been prescribed or taken any medication due to any sickness, disease, disorder, condition, or any other disease or disorder of the skin or mouth, or any other skin disorder? ................................................. [ ] Yes [ ] No

6. Any disease or disorder of the gallbladder, pancreas or stomach or duodenum, or any other digestive disorder or condition? ......................................................................................................................... [ ] Yes [ ] No

7. Any disease or disorder of the genital or reproductive system? ......................................................................................................................... [ ] Yes [ ] No

8. Question for Male: Have you or your spouse (if to be insured) smoked or used any tobacco products – such as cigarettes, during the last 5 years, and have you or your spouse had a physical examination (including check-ups), diagnostic tests, consult a physician, chiropractor or therapist? ........................................................................................................................................ [ ] Yes [ ] No

9. Question for Female: Is any female applying for coverage now pregnant? ......................................................................................................................... [ ] Yes [ ] No

10. Question for Male: Is any male applying for coverage now an expectant parent? ......................................................................................................................... [ ] Yes [ ] No
### SECTION B — DETAILS OF HEALTH HISTORY

If you answered “Yes” to ANY questions on the previous page, please provide further information using the chart below. Be sure to use the “correct” example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Person Affected</th>
<th>Condition, Injury, Symptom, or Diagnosis</th>
<th>Date that it Started</th>
<th>Date of Recovery (if applicable)</th>
<th>Was Recovery Complete?</th>
<th>Types of Treatment, Advice Given, and Medications Prescribed</th>
<th>Name, Address and Phone Number of Doctors and Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect Example:</td>
<td>C Mr. Smith</td>
<td>blood pressure</td>
<td>1995</td>
<td>N/A</td>
<td>N/A</td>
<td>prescription</td>
<td>Dr. Jones St. Mary's Hospital</td>
</tr>
<tr>
<td>Correct Example:</td>
<td>3C Joe Smith</td>
<td>high blood pressure</td>
<td>6/95</td>
<td>none</td>
<td>no, ongoing</td>
<td>40mg Atenolol once a day 140/80 - 7/8/01 138/78 - 10/12/01 139/77 - 2/9/02</td>
<td>Dr. Jones St. Mary's Peoria, IL (309) 555-1212</td>
</tr>
</tbody>
</table>

If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)?

**SECTION C — OTHER INSURANCE INFORMATION**

1. Does any person applying for coverage currently have, or did they previously have, Blue Cross and Blue Shield of Illinois coverage, either as a primary insured or as a dependent?  □ Yes  □ No  
   *If “Yes”, please complete the following:*
   
   Member Name ____________________________  Member No. ____________________________  Group No. ____________________________

2. Does any person to be covered have any Major Medical, HMO, or PPO Medical Insurance with any other Insurer?  □ Yes  □ No

3. Will the issuance of this coverage cause you to discontinue your existing coverage?  □ Yes  □ No

   *If “Yes”, when is coverage to be discontinued (mo./day/yr.)? ______ / ______ / ______ (Note: A Notice of Replacement Form must also be submitted with your application, even if replacing Blue Cross and Blue Shield of Illinois coverage.)*

   *If “No”, please explain______________________________________________________________

4. 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?  □ Yes  □ No

   *If “Yes”, please explain______________________________________________________________

**Note:** Do not cancel any current coverage you may have until your new policy is approved and in force.
PART THREE

SECTION A — REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I apply for coverage as indicated in PART ONE, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical coverage) which is herein called the Company. I have read all the statements in PARTS ONE and TWO, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on PARTS ONE and TWO of this application may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of the Company.

I have read and understand the Outline of Coverage that has been provided to me by my agent who sells Blue Cross and Blue Shield of Illinois insurance plans. My agent has informed me of the provisions of the Blue Cross and Blue Shield of Illinois health plan and the Medical Services Advisory (MSA”) Program (along with the provisions of the Mental Health Unit if applicable).

I understand that the insurance plan applied for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws.

Medical Authorization: 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 the Company 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 the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company 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 the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

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.

| Primary Applicant’s Signature: X | Date Signed: / / yr. |
| Spouse’s Signature (ONLY if to be insured): X | Date Signed: / / yr. |
| Parent/Guardian Signature (If Primary Applicant is UNDER the age of 18): X | Date Signed: / / yr. |
| Dependent’s Signature (ONLY if 18 or over and ONLY if to be insured): X | Date Signed: / / yr. |
| Dependent’s Signature (ONLY if 18 or over and ONLY if to be insured): X | Date Signed: / / yr. |
| Dependent’s Signature (ONLY if 18 or over and ONLY if to be insured): X | Date Signed: / / yr. |

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: X

Print Your Name as You Signed It: __________________________ Date Signed: / / yr. mo. day

SECTION B — AGENT STATEMENT

I have personally, completely and accurately reaffirmed the information supplied by the applicant(s).

Agent’s Signature: X Date Signed: / / yr. mo. day

Print Your Name as You Signed It: ______________________________________________________________________ Agent’s Phone Number: ______________________________________________________________________

Agent’s Code: ____________________________________________________________________________________________
NOTICE TO APPLICANT REGARDING REPLACEMENT OF HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Health Care Service Corporation. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, which may be referred to in the policy as pre-existing conditions, may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this new policy, whereas a similar claim might have been payable under your present policy.

2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY CLAIMS AND TO REFUND YOUR PREMIUM AS THOUGH YOUR POLICY HAS NEVER BEEN IN FORCE. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Note to Producer: An applicant who is replacing existing health insurance with Blue Cross and Blue Shield coverage must read, sign, and date the adjacent replacement form at right. You must then submit that replacement form along with the application. This half of the form must remain with the applicant.

The above “Notice to Applicant” was delivered to me on:

________________________________________________________

(Date)

________________________________________________________

(Applicant’s Signature)

[Social Security Number]

(Applicant’s Social Security Number)
CONDITIONAL RECEIPT FOR

Proposed Insured: ___________________________________________________________

Date of Application: ______________________ Amount Received: __________________ Date of Receipt: _____________

NO INSURANCE WILL BECOME EFFECTIVE UNLESS EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO PRODUCER IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.

Subject to the limitations shown below, insurance will become effective under the receipt if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Health Care Service Corporation, a Mutual Legal Reserve Company (Blue Cross and Blue Shield of Illinois), hereafter “HCSC,” at its Home Office (or the office of the designated administrator).

2. The first full premium, according to the mode of premium payment chosen, has been paid and the check is honored on first presentation for payment.

   “An effective date in compliance with HCSC guidelines” means the latter of:
   a. The requested coverage date, if any, shown on the application; or
   b. The date upon which the application is approved by HCSC at its Home Office (or office of the designated administrator).

3. The policy is issued by HCSC exactly as applied for within 60 days from date of application, delivered, and accepted by the proposed insured.

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____________________________________________ Check One: ☐ Checking Account ☐ Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

Applicant’s Copy (if paying by automatic bank withdrawal)

AUTOMATIC PAYMENT AUTHORIZATION

I request and authorize Blue Cross and Blue Shield of Illinois (the Company) and/or its designee to obtain payment of amounts becoming due the Company by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This Authorization will remain in effect until I notify the Company or the Financial Institution in writing to terminate and the Company or the Financial Institution has a reasonable time to act on the termination.

Preferred Draft Date: _____________________________________________ Check One: ☐ Checking Account ☐ Savings Account

NAME OF BANK WHERE ACCOUNT IS AUTHORIZED

ADDRESS OF BANK

CITY

STATE

ZIP

NAME OF INSURED, APPLICANT (PRINT)

NAME(S) OF DEPOSITOR(S) IF OTHER THAN THE INSURED

RELATIONSHIP TO INSURED

SIGNATURE OF DEPOSITOR

DATE

FOR HOME OFFICE USE ONLY: BANK TRANSIT NUMBER

DEPOSITOR’S ACCOUNT NUMBER

PLEASE ATTACH VOIDED CHECK OR DEPOSIT SLIP

Company’s Copy (if applicant is paying by automatic bank withdrawal)
Limitation:
This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided herein. In the event HCSC declines to issue a policy as applied for, the amount received by HCSC will be refunded.

Signature of Secretary

Signature of Producer

Producers Code:__________________________

Blue Cross and Blue Shield of Illinois
Administrator: Hallmark Services Corp.
PO Box 2038
Aurora, Illinois 60507-2038

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF ILLINOIS. DO NOT PAY CASH OR MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

If you do not hear from HCSC regarding the proposed insurance within 30 days, please call 1-800-538-8833.

THIS FORM LIMITS OUR LIABILITY.
BE SURE TO READ AND SIGN THE APPLICATION AND, IF DESIRED, THE AUTOMATIC PAYMENT REQUEST FORM. KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.