

Application For BlueEssentialsSM

Complete and sign the application.



South Carolina

*BlueCross BlueShield of South Carolina
is an independent licensee of the
Blue Cross and Blue Shield Association*

P.O. Box 100228, Columbia, SC 29260

Benefits are available in-Network only. Benefits are provided at the in-Network Coinsurance amount for an Out-of-Network Emergency Room visit for an Emergency Medical Condition.

SECTION A - APPLICANT INFORMATION

☐ Male ☒ Female Social Security Number: 5 9 9 - 1 4 - 6 2 2 0 Date of Birth: 12/31/1972

Last Name: Serrano Cruz First Name: Liz M.I.: J

Telephone Numbers:

Home: **(843) 712-4313**

Cell:

Work:

Street Address: 1321 Apache Drive A 303

City: Myrtle Beach State: SC ZIP: 29577 E-mail Address: serranocruzliz@gmail.com

Billing Address for Premium Notices. (Complete only if different from above).

Street Address: _____

City: _____ State: _____ ZIP: _____

Coverage is available for Dependent children through age 25. List Dependents to be insured:

Last Name	First Name	M.I.	Social Security Number	Sex	Birthdate
-----------	------------	------	------------------------	-----	-----------

Spouse:

Child:

Child:

Child:

How would you like for us to communicate with you? ☐ E-mail ☐ US Mail ☐ Phone

If e-mail, an e-mail address is required: serranocruzliz@gmail.com

Your coverage Effective Date will be automatically assigned. Coverage will always be effective on the first of the month, except for birth or adoption. Coverage cannot be issued until the first month's premium has been received.

Are you and every person listed on the application a United States citizen or national? ☐ Yes ☐ No

If no, please provide: Document Type: _____ ID Number: _____

Check which enrollment option applies:

☒ Open Enrollment ☐ Special Enrollment

If Special Enrollment, what is the qualifying event? _____ Date of Event: _____

SECTION B – BENEFIT INFORMATION**Choose One Plan:****On and Off-Exchange Plans**

<input type="checkbox"/> Gold 1	<input type="checkbox"/> Gold 2	<input type="checkbox"/> HD Gold 3	<input type="checkbox"/> Gold 4	<input type="checkbox"/> Silver 1	<input type="checkbox"/> Silver 2
<input type="checkbox"/> Silver 3	<input type="checkbox"/> Silver 4	<input type="checkbox"/> HD Silver 5	<input type="checkbox"/> HD Silver 6	<input type="checkbox"/> Silver 8	<input type="checkbox"/> Silver 9
<input type="checkbox"/> Silver 10	<input type="checkbox"/> Silver 11	<input type="checkbox"/> Silver 12	<input type="checkbox"/> HD Silver 13	<input type="checkbox"/> Bronze 1	<input type="checkbox"/> HD Bronze 2
<input type="checkbox"/> HD Bronze 3	<input type="checkbox"/> Bronze 4	<input type="checkbox"/> HD Bronze 5	<input type="checkbox"/> Catastrophic 1		

The Catastrophic plan is only available for people under age 30, or people who have a certification in effect that he or she is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 regarding individuals without affordable coverage or with hardships.

These plans are available in all South Carolina Counties EXCEPT for: Berkeley, Charleston, Colleton and Dorchester

<input checked="" type="checkbox"/> Silver 7	<input type="checkbox"/> Silver 14
---	---------------------------------------

These plans are only available in the following South Carolina Counties: Berkeley, Charleston, Colleton and Dorchester

<input type="checkbox"/> Silver 29	<input type="checkbox"/> Silver 30	<input type="checkbox"/> Silver 33	<input type="checkbox"/> Silver 34
---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

Off-Exchange ONLY Plans

<input type="checkbox"/> Silver 15	<input type="checkbox"/> Silver 16	<input type="checkbox"/> Silver 17	<input type="checkbox"/> Silver 18	<input type="checkbox"/> HD Silver 19	<input type="checkbox"/> HD Silver 20	<input type="checkbox"/> Silver 22
<input type="checkbox"/> Silver 23	<input type="checkbox"/> Silver 24	<input type="checkbox"/> Silver 25	<input type="checkbox"/> Silver 26	<input type="checkbox"/> HD Silver 27		

These plans are available in all South Carolina Counties EXCEPT for: Berkeley, Charleston, Colleton and Dorchester

<input type="checkbox"/> Silver 21	<input type="checkbox"/> Silver 28
---------------------------------------	---------------------------------------

These plans are only available in the following South Carolina Counties: Berkeley, Charleston, Colleton and Dorchester

<input type="checkbox"/> Silver 31	<input type="checkbox"/> Silver 32	<input type="checkbox"/> Silver 35	<input type="checkbox"/> Silver 36
---------------------------------------	---------------------------------------	---------------------------------------	---------------------------------------

SECTION C – BILLING INFORMATION

<input checked="" type="checkbox"/> Pay Now	<input type="checkbox"/> Recurring	<input type="checkbox"/> Bill Me
<input checked="" type="checkbox"/> Credit Card	<input type="checkbox"/> Credit Card	<input type="checkbox"/> List Bill: (through your employer)
<input type="checkbox"/> Bank Draft	<input type="checkbox"/> Bank Draft	List Bill Account Number: _____

SECTION D - OTHER INFORMATION

1. Do you or does any member of your family to be insured have Medicare, Medicaid, Medicare Advantage or any other health insurance coverage?..... ☐Yes ☐No
 If you answered "Yes" to 1:
 A. Company Name: _____ Policy Number: _____
 B. Will this policy replace that health insurance?..... ☐Yes ☐No

C. Other Coverage Effective Date:_____ Other Coverage Termination Date:_____.

2. In the last six months, has any person to be insured, if age 18 or older, used tobacco four or more times a week?..... ☐ Yes ☒ No

SECTION E - AUTHORIZATION AND AGREEMENTS – READ CAREFULLY BEFORE SIGNING

The undersigned authorize(s) release to Blue Cross and Blue Shield of South Carolina (BlueCross) or its representatives of all past and future medical records and other information deemed necessary by BlueCross to review, process or investigate claims. This authorization for release of my past, present and future information, includes Medicare Parts A and B claims.

I fully understand and agree that no insurance coverage shall be in force until BlueCross receives the application and the first month's premium payment, and assigns the date on which coverage shall become effective. If this policy is cancelled due to nonpayment and I apply for new coverage at any time thereafter, I understand that BlueCross will require the payment of all past due premiums before new coverage will take effect.

The undersigned hereby expressly acknowledges understanding this policy constitutes a policy solely with Blue Cross and Blue Shield of South Carolina, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The "Association" permits Blue Cross and Blue Shield of South Carolina to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and Blue Cross and Blue Shield of South Carolina is not contracting as an agent of the Association. The undersigned further acknowledges and agrees to have not entered into this policy based on representations by any person other than Blue Cross and Blue Shield of South Carolina. No person, entity or organization other than Blue Cross and Blue Shield of South Carolina shall be held accountable or liable to the undersigned for any of Blue Cross and Blue Shield of South Carolina's obligations created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of South Carolina other than those obligations created under other provisions of this agreement.

SECTION F - SIGNATURE(S)

I have read and I fully understand each and every part of this application for insurance.

X Liz L Serrano Cruz 12/14/2018
Applicant's Signature Date Signed

NOTE: If Applicant Is A Minor, A Parent Or Legal Guardian Must Sign. If Legal Guardian Is Signing, Please Attach Legal Documents.

X _____
Spouse's Signature Date Signed

AMED GARCES
Agent's Name (Please Print)
X _____ B73-736
Agent's Signature Date Signed Agent's Code

For additional applications, or answers to any questions, please call toll free:

1-855-404-6752

Blue Cross and Blue Shield of South Carolina does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determination. If you are an individual living with disabilities or have limited English proficiency, we have free interpretive services available. For questions about your coverage, please contact Member Services.

IntelliScript Authorization

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize any entity covered by the HIPAA Privacy Rule as a covered entity or business associate to disclose to BlueCross BlueShield of South Carolina ("BlueCross") or its authorized representative, my protected health information, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol.

I understand this authorization is voluntary and that such information will only be used by BlueCross for the purpose of determining whether I qualify to be enrolled in a disease management, case management or wellness program.

This authorization is valid for one year from the date signed below unless earlier revoked. I understand that I may revoke this authorization at any time by sending written notice of my revocation to BlueCross. I understand that revocation of this authorization will *not* affect any action taken by BlueCross before my written notice of revocation was received.

I am making this authorization voluntarily and have had full opportunity to read and consider the contents of this authorization. I understand that BlueCross will not condition the approval of this application or my eligibility for benefits upon my signing this authorization. I further understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. Disclosure of my protected health information pursuant to this authorization may result in remuneration to the entity releasing the data.

I understand that I may receive a copy of this authorization upon my request.

This only applies to applicants 18 and older.

Signature

Date Signed (mm/dd/yyyy)

Liz Serrano Cruz

12/14/2018

