

These plans will cover you when other plans will not!

These plans will accept you without up-charging even if you fall under one or more of these conditions:

- Unemployed/Laid-off
- Have other insurance such as Crippled Children's or VA
- Have been injured by an auto accident
- Disabled
- On Worker's Comp
- Currently Uninsured
- Dependent children who are not a full-time student
- Currently an expectant parent

Pre-Existing Conditions

All covered charges requires a 6-month pre-existing exclusion period. This means if you had a medical condition for which medical advice, care or treatment was recommended or received 6 months before your enrollment date, any services you receive to treat that condition within the first 6 months after your enrollment date will not be paid. After the 6-month waiting period, the condition will be covered.

Applying for Coverage:

- Complete and review your application for accuracy
- Sign and date your application
- Send NO money with application
- Submit your application and (Automatic Payment Plan enrollment form, if desired) by using one of the methods listed below

Submitting Application

- Fax: (866) 373-0416 - or -
- Mail: P.O. Box 699, Memphis, MI 48041 - or -
- E-mail: ronb@healthspecialist.com

After Your Application is Submitted

- You will receive notification that your application is in process
- It usually takes 2-3 weeks for approval
- After your application is reviewed and approved, you will receive a bill
- Once Blue Cross had received your payment, then your policy and pocket cards will be mailed out to you • You will be billed directly from Blue Cross every other month (bi-monthly). Please note premiums are due in advance, please be prepared
- You can pay by personal check only. Sorry, no employer checks allowed
- When your policy is issued, you will receive a welcome letter that explains how to waive the pre-existing condition waiting period. Due to privacy issues, our office cannot help you determine if you qualify to waive the waiting period.

Shipping Address:
Health Insurance Specialist
P.O. Box 699
Memphis, MI 48041

Toll-free: (800) 982-8282
Local Phone: (810) 392-2012
Fax: (866) 373-0416

Email: ronb@healthspecialist.com



Individual and Direct Billed Enrollment Application

Choose your health plan:

- Value BlueSM PPO
- Value BlueSM Traditional
- Young Adult BlueSM Traditional
- Young Adult BlueSM PPO

- Individual Care BlueSM PPO
- Flexible BlueSM 1500
- Flexible BlueSM 2500
- Optional Dental
- Optional Maternity

PLEASE PRINT CLEARLY

To be eligible for this coverage, you must reside in Michigan at least six months a year and cannot be enrolled in Medicare.

Requested Coverage Start Date (N/A if you answered "Yes" to question 2.) MMDDYYYY

Your Last Name	First Name	Initial	Requested Coverage Start Date (N/A if you answered "Yes" to question 2.) MMDDYYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> - Must be Future Date

Street Address	City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Social Security Number	Telephone Number with Area Code	Date of Birth MM/DD/YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

Male Female Single Married

If you wish to apply for coverage for a spouse and/or unmarried children who are under age 19 or who will turn 19 this year, please list them below. Provide last name if different from yours. (Please use an additional sheet of paper for more than three children.) Spouses and dependent children are not eligible for Young Adult Blue. If you need family coverage, Individual Care Blue or Value Blue may be better options.

Last name (Spouse)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>

If you wish to apply for coverage for an unmarried child who is age 20-25 this year, please complete below. Provide last name if different from yours. (Please use an additional sheet of paper for more than one child.)

Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number	Preex Date MMDDYY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>	<input type="text"/>

- I live in Michigan six or more months each year: Yes No
- Are you currently active under a Blue Cross Blue Shield of Michigan (BCBSM) employer-sponsored group health plan or have you left a BCBSM employer-sponsored group health plan within the last 60 days? Yes No

If yes, please provide your:

Contract Number	Group Number	Policy End Date MM/DD/YYYY
<input type="text"/>	<input type="text"/>	<input type="text"/>

- Are any individuals listed above:
 - Enrolled in Medicare? Yes No
 - Eligible for or enrolled in a group-sponsored health plan? Yes No If yes, when will your current policy terminate?
 - Enrolled in an individual (non group) health Plan? Yes No If yes, when will your current policy terminate?

4. Does your employer pay for or reimburse you for all or part of your health care coverage or provide you with a health care plan? Yes No

I am applying for BCBSM coverage subject to the terms and conditions in the material that accompanied this application and I agree that I and my covered dependents will be bound by all provisions in the BCBSM certificates and riders. Approval of this application and coverage effective date will be determined by BCBSM and shall be subject to requirements by BCBSM for additional information and payment of bills. I certify that the requirements of eligibility are met and that the information I have given on this application is true and correct to the best of my knowledge. I authorize BCBSM to obtain from providers of service any and all records relating to me and my covered dependents and acknowledge that BCBSM has the right to use and disclose these records and other confidential member information for valid business purpose.

Area below for BCBSM Use Only			Signature of Applicant		Date
Agent Code	MA/GA Code	Assoc./Chamber Code	Agent's Signature	Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	Ronald J Bommarito	<input type="text"/>	

Group Number	Service Code	Eff.Date: MMDDYYYY	U/W:	Preex Date	DEID
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>