



**Personal/Blue PPO<sup>SM</sup>**

Offered by  
CAPITAL BLUE CROSS AND CAPITAL ADVANTAGE INSURANCE COMPANY®  
Independent Licensees of the Blue Cross and Blue Shield Association

**Individual Direct Pay Comprehensive Major Medical  
Preferred Provider Organization Personal/Blue PPO<sup>SM</sup> Enrollment Application And Instructions For Medically Underwritten**

*Issued By: Capital BlueCross and Capital Advantage Insurance Company  
2500 Elmerton Avenue  
Harrisburg, PA 17177*

Dear Applicant,

Thank you for your interest in our *Personal/Blue* PPO coverage. We appreciate the opportunity to become your health insurer of choice. *Personal/Blue* PPO is available for persons under the age of 65, who are not Medicare-eligible.

This enrollment application is for the medically underwritten program, meaning that we examine your personal health history as part of the application process. This allows us to determine your suitability for the product and to help maintain affordable premiums for you and other *Personal/Blue* PPO customers. We may need to obtain additional health-related information from you as part of the underwriting process. A guaranteed issue program with no medical questions is available to you. Please contact us if you prefer the *Personal/Blue* PPO Guarantee Issue Application.

For your added convenience and faster turnaround time, the *Personal/Blue* PPO enrollment application is also available to you at **WWW.CENTRALPENNBENEFITS.COM**

**Please carefully review the enclosed materials before completing your enrollment application and remember the following when applying:**

- Complete all sections. If information is missing from the enrollment application, it will be returned to you for completion. This will delay the processing of your enrollment application.
- **Send no money with this enrollment application.** After a review of your enrollment application, we will notify you whether or not we accept or decline to cover you, your spouse, and/or dependents. If at least one individual is accepted, you will receive a proposal acceptance form, which will indicate a premium rate based on the health status of all individuals accepted for coverage. You must indicate your acceptance of coverage on the proposal acceptance form and return it to us by the date specified.
- If you are approved, you will receive information regarding your rates, effective date, payment options, and other related material.

If your enrollment application for *Personal/Blue* PPO is not approved, you may still be eligible for other individual insurance products, including *PPO*, *Traditional*, and *Comprehensive* coverage available from Capital Advantage Insurance Company and Capital BlueCross. If you have any questions about the *Personal/Blue* PPO program, contact our representative at the number listed below or visit our Web site.

Capital Advantage Insurance Company and Capital BlueCross, together referred to as “Capital,” strictly maintain the privacy of applicants and Members. Any personal information you provide to us will be carefully protected according to federal and state regulations.

Again, thank you for considering Capital for your health insurance needs.

Contact a *Personal/Blue* PPO Representative at

**CENTRAL PENN BENEFITS**  
**717-718-5687**  
**WWW.CENTRALPENNBENEFITS.COM**

Health care benefit programs issued or administered by Capital BlueCross and its subsidiary Capital Advantage Insurance Company®. Independent licensees of the Blue Cross and Blue Shield Association.  
Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.

## INSTRUCTIONS

### PLEASE READ:

Unless every question is answered, we may either call you for the missing information or return the form to you for completion. Do not leave a section blank, as this will delay the processing of your enrollment application. Please indicate “not applicable” if appropriate. When you have completed the application form, tear off this page. Send us only the completed enrollment application. Print clearly in blue or black ink to avoid any delay.

Mail To: **CENTRAL PENN BENEFITS**  
**280 WEST MARKET STREET**  
**YORK, PA 17401**

### ELIGIBILITY

To be eligible for coverage, the applicant must be at least 18 years old and no more than 64 years old, live in our 21-county service area for at least six months per year, and have his/her primary residence in Capital’s 21-county service area. Counties served are: Adams, Berks, Centre, Columbia, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Lehigh, Mifflin, Montour, Northampton, Northumberland, Perry, Schuylkill, Snyder, Union, and York. Individuals living within our 21-county service area for at least six months per year, and who are between the ages of 18 and 64, can submit an application for *Persona/Blue* PPO.

**Any applicant or dependent eligible for or enrolled in Medicare is not eligible for this coverage.**

### DIRECTIONS FOR COMPLETING THE ENROLLMENT APPLICATION

A material misrepresentation of facts may lead to higher rates, cancellation, or voidance of coverage.

#### I. Application Category.

- If you are not currently covered or enrolled in our medically underwritten *Persona/Blue* PPO product, check “New Application.”
- If you are a *Persona/Blue* PPO Member with a medically underwritten contract and wish to submit an enrollment application for a new contract, check Request New Contract. Please enter your subscriber ID (the number on your identification card).

**II. Applicant Information.** Fill in all information requested. If applying as a married couple or for family coverage, the applicant does not need to be the older spouse, but rates are based on the age of the older spouse.

#### III. Coverage Selection.

- Benefit Options Desired—*Persona/Blue* PPO: Check the box for the coverage and benefits that best fit your needs.
- Benefit Options Desired—Additional Coverage: If you want prescription drug coverage, check “Yes.” Drug benefits can be added at a later date only by reapplying for coverage (and going through medical underwriting again).

**IV. Applicant/Family Information.** Fill in all information requested. Remember that should you be accepted for coverage, you may later add dependents or a spouse to your coverage without going through medical underwriting. The addition of a spouse will require medical underwriting for the new individual(s); however, the existing contract can continue in effect for the original contract Members. Birth of a child/placement or adoption of a child due to life status changes will not require medical underwriting as long as we are notified of the event within 31 days.

**V. Health Status.** For you and each family member for whom you are seeking coverage, answer each question. In section VI, you will be asked to supply additional detail and to identify the applicable family member to whom that condition applies. It is very important to answer these questions as completely and accurately as possible. Also note that the questions refer not just to current medical conditions, but to medical conditions as far back as five years.

**VI. Professional Services.** Provide the requested details for you and each family member applying for coverage.

**VII. Prescription Medications.** If you and/or any of your family members applying for coverage are taking prescription medication(s), or have taken prescription medications, or been prescribed medications in the last 12 months, provide the name of each medication and dosage. If neither you nor any family member applying for coverage are taking any medication nor have taken any prescription medication in the last 12 months, check the “None” box.

**VIII. Conditions of Enrollment.** Read this section carefully. You must supply requested signatures and/or authorizations for both the Disclosure Authorization and the Enrollment Application Authorization. We will not accept your enrollment application if this section is not completed. Keep a copy of the signed agreement for your records.

### NEXT STEPS

We will review your enrollment application and make the determination to approve or decline it. All details of our review will be kept confidential. Please note that any enrollment applications requesting coverage for two adults, with or without dependents, may receive a proposal acceptance form with more than one option and associated rates. Read the proposal carefully before making your decision.

### QUESTIONS

If you have any questions and/or need help filling out this enrollment application, please contact your *Persona/Blue* PPO representative at **717-718-5687**.



**III. COVERAGE SELECTION (check the benefit option(s) desired)**

Personal/Blue PPO: (Information will be provided for all selections checked)

\$0 Deductible    \$250 Deductible    \$500 Deductible    \$1,100 Deductible    \$1,500 Deductible    \$2,500 Deductible

**Additional Coverage**

Prescription Drug  Yes  No

**IV. APPLICANT/FAMILY INFORMATION—LIST ALL INDIVIDUALS IN YOUR FAMILY FOR WHOM YOU ARE REQUESTING COVERAGE:**

Rates are based on the age of the older of the applicant or applicant's spouse, if the spouse is also applying for coverage.

Last Name, First Name, Middle Initial	Social Security Number	Date of Birth	Exact Height	Exact Weight	Handicapped	Date of Last Physician Visit
Applicant			(ft./in.)	(lbs.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___
Co-applicant/Spouse						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Occupation _____		___/___/___	(ft./in.)	(lbs.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___
Dependent						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		___/___/___	(ft./in.)	(lbs.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___
Dependent						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		___/___/___	(ft./in.)	(lbs.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___
Dependent						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		___/___/___	(ft./in.)	(lbs.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___
Dependent						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		___/___/___	(ft./in.)	(lbs.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___
Dependent						
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		___/___/___	(ft./in.)	(lbs.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___

For any dependent you marked as handicapped, you will receive a *Handicapped Dependent Application and Certification Form* to complete and return for approval. It must be returned before medical underwriting can be completed.

**Is the insurance being applied for intended to replace any other accident and health insurance currently in force?**  Yes  No

If "Yes," please complete and submit the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance.

**APPLICANT INFORMATION (please provide again to assist in case pages become separated.)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

**Va. HEALTH STATUS: ALL QUESTIONS MUST BE ANSWERED BEFORE THE ENROLLMENT APPLICATION CAN BE PROCESSED.  
Please check the appropriate box.**

1. Have you or anyone applying for coverage ever been denied for either a medical or life insurance policy?  Yes  No  
If so, please indicate the name(s) of the person(s) denied, reason(s) for denial and the date(s) of denial: \_\_\_\_\_  
\_\_\_\_\_
  
2. Do you or any family members applying for coverage, currently use any medical equipment such as, but not limited to, a walker, wheelchair, cane, or hospital bed?  Yes  No If "Yes", provide the following details:  
  
Name of Person \_\_\_\_\_ Condition/Reason \_\_\_\_\_  
  
Name of Person \_\_\_\_\_ Condition/Reason \_\_\_\_\_
  
3. Are you, or any family member whether or not applying for coverage, pregnant or have been medically diagnosed or treated for pregnancy within the past nine months?  Yes  No  
  
Name of Family Member \_\_\_\_\_ Date pregnancy determined or, if treated, date \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
  
Name of Family Member \_\_\_\_\_ Date pregnancy determined or, if treated, date \_\_\_\_/\_\_\_\_/\_\_\_\_\_
  
4. Have you, or any family member applying for coverage, gained or lost more than 20 pounds or 10% of your body weight over the past three months?  Yes  No If "Yes", provide the following details:  
  
Name of Person \_\_\_\_\_ Weight Gained/Lost \_\_\_\_\_  
  
Name of Person \_\_\_\_\_ Weight Gained/Lost \_\_\_\_\_
  
5. Have you or any family member applying for coverage, taken prescription medication, within the last year?  Yes  No If "Yes", list all such medications in Section VII.
  
6. Within the last 12 months, have you, or any family member applying for coverage been medically diagnosed and/or advised by a member of the medical profession to have surgery, treatment, tests, or studies that have not yet been performed?  Yes  No If "Yes", provide additional detail in Section VI.
  
7. Have you or any person applying for coverage ever had or been advised by a physician or health care provider to have a transplant of any type?  Yes  No

**Vb. HEALTH STATUS: History—ALL QUESTIONS MUST BE ANSWERED BEFORE THE ENROLLMENT APPLICATION CAN BE PROCESSED.** Indicate if you or any family member applying for coverage has been treated by a physician or health care provider for any conditions listed below including emergency room visits within the past five years. Check the appropriate box. If “Yes” box is checked, explain completely and in detail in the spaces provided in Section VI.

8. Leukemia, hemophilia, varicose veins, phlebitis, anemia, aneurysm, coronary artery disease, blood clots, or any other vein, artery, or blood disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Any type of cancer, tumors, cysts, polyps, or other growth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Ear infections, hearing impairment, deviated nasal septum, or any other disorder of the ear, nose, or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Severe burn, severe scars, or any other skin disorder, such as acne, psoriasis, eczema, or skin tumors?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you or any person applying for coverage smoked or used tobacco products? Answer “Yes” or “No”, even though you may not have been treated for this condition.	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. AIDS, AIDS Related Complex (ARC), or tested positive for HIV or other diseases related to the immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Any connective tissue disease, such as arthritis, gout, or lupus. Any osteoporosis or TMJ? Any disease or injury to joint(s) including knee, back, neck, and spine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Any loss of limb? Any fixation device or artificial joint (e.g. for knee, hip replacements)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Nephritis, kidney stones, bladder infections, kidney infections, blood in urine, or any other disease or disorder of the bladder, kidneys, or urinary system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Any disease or disorder of the esophagus, stomach, intestines, bowels, rectum, gallbladder, pancreas, or spleen; Crohn’s disease or liver disorder including cirrhosis or Hepatitis A, B, C, D, E, or G?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Have you or any person applying for coverage been treated or counseled due to use of the following: alcohol, sedatives, hallucinogens, illegal substances, narcotics, or any other drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Diabetes, thyroid disease, or any other disorder of the glands? If answer is “Yes” to diabetes, answer the following: Date of diagnosis ____/____/_____. Controlled by <input type="checkbox"/> Diet <input type="checkbox"/> Oral Medication <input type="checkbox"/> Insulin _____ (units per day). Provide the most current hemoglobin A1C reading completed within the past 6 months. Reading _____ Date ____/____/_____. <i>For more than one family member, attach a separate sheet if necessary.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Disorder of the male or female reproductive organs including enlarged prostate, prostatitis, menstrual irregularities or disorder, abnormal pap smear, ovarian cyst, polycystic ovaries, sexually transmitted disease, infertility, impotency, breast disorders, fibrocystic disease, breast implant (saline or silicone)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Nervous, mental, or emotional conditions, attempted suicide, depression, or any other psychiatric or behavioral health problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Chest pain, shortness of breath, heart murmur, irregular heartbeat, heart attack, congestive heart failure, blood clots, high cholesterol, or high blood pressure or any other heart disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Allergies (including allergy shots), asthma, chronic obstructive pulmonary disease, emphysema, pleurisy, tuberculosis, or any other disease or disorder of the lungs or respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Any disorder of the brain or nervous system, such as chronic fatigue syndrome, epilepsy, Lyme disease, meningitis, multiple sclerosis, muscular dystrophy, cerebral palsy, sleep disorders, paralysis, stroke, migraine, or recurrent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Any eye injury or disorder, such as glaucoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Have you or any person applying for coverage consulted a physician, psychiatrist, psychologist, social worker, chiropractor, nurse practitioner, physical, occupational or speech therapist, or any other health care professional for any reason not specified below?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**APPLICANT INFORMATION (please provide again to assist in case pages become separated.)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

**VI. PROFESSIONAL SERVICES—Give COMPLETE details in all sections below for any “Yes” answers to questions 6-26 in Section V. If two members answer “Yes” to the same question, provide details for both. Attach a separate sheet if necessary.**

Question Number	Name of Family Member (as identified on physician’s record)	Question Number	Name of Family Member (as identified on physician’s record)
Diagnosis or Condition		Diagnosis or Condition	
Date of Onset/Treatment ____/____/____	Date Treatment Ended ____/____/____ <input type="checkbox"/> Still Under Treatment	Date of Onset/Treatment ____/____/____	Date Treatment Ended ____/____/____ <input type="checkbox"/> Still Under Treatment
Physician/Hospital	Phone Number ( )	Physician/Hospital	Phone Number ( )
Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.)/Results		Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.)/Results	
Question Number	Name of Family Member (as identified on physician’s record)	Question Number	Name of Family Member (as identified on physician’s record)
Diagnosis or Condition		Diagnosis or Condition	
Date of Onset/Treatment ____/____/____	Date Treatment Ended ____/____/____ <input type="checkbox"/> Still Under Treatment	Date of Onset/Treatment ____/____/____	Date Treatment Ended ____/____/____ <input type="checkbox"/> Still Under Treatment
Physician/Hospital	Phone Number ( )	Physician/Hospital	Phone Number ( )
Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.)/Results		Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.)/Results	
Question Number	Name of Family Member (as identified on physician’s record)	Question Number	Name of Family Member (as identified on physician’s record)
Diagnosis or Condition		Diagnosis or Condition	
Date of Onset/Treatment ____/____/____	Date Treatment Ended ____/____/____ <input type="checkbox"/> Still Under Treatment	Date of Onset/Treatment ____/____/____	Date Treatment Ended ____/____/____ <input type="checkbox"/> Still Under Treatment
Physician/Hospital	Phone Number ( )	Physician/Hospital	Phone Number ( )
Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.)/Results		Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.)/Results	

**VI. PROFESSIONAL SERVICES (continued)**

Question Number	Name of Family Member (as identified on physician's record)	Question Number	Name of family member (as identified on physician's record)
Diagnosis or Condition		Diagnosis or Condition	
Date of Onset/Treatment ____/____/____	Date Treatment Ended ____/____/____	<input type="checkbox"/> Still Under Treatment	
Date of Onset/Treatment ____/____/____	Date Treatment Ended ____/____/____	<input type="checkbox"/> Still Under Treatment	
Physician/Hospital	Phone Number ( )	Physician/Hospital	Phone Number ( )
Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.)/Results		Treatment Rendered (i.e., x-ray, lab, surgical procedure, etc.)/Results	

**VII. PRESCRIPTION MEDICATIONS—List ALL prescription medications taken or prescribed within the last 12 months by any family member applying for coverage. Add additional names and information on separate piece of paper. If the answer is “None” for both you and all members of your family applying for coverage, check here:  None**

Family Member	Medication/Dosage/Frequency (e.g., Aciphex/20mg/daily)	Diagnosis/Condition for which Medication was Prescribed	Date Prescribed (Month/Day/Year)	Date Discontinued (Month/Day/Year)	Name and Phone Number of Physician or Facility
			____/____/____	____/____/____	Name: _____ Phone: ( )
			____/____/____	____/____/____	Name: _____ Phone: ( )
			____/____/____	____/____/____	Name: _____ Phone: ( )
			____/____/____	____/____/____	Name: _____ Phone: ( )
			____/____/____	____/____/____	Name: _____ Phone: ( )
			____/____/____	____/____/____	Name: _____ Phone: ( )
			____/____/____	____/____/____	Name: _____ Phone: ( )

**APPLICANT INFORMATION (please provide again to assist in case pages become separated.)**

Last Name:

First Name:

**VIII. CONDITIONS OF ENROLLMENT. Read these notices carefully before signing this enrollment application.**

I/We, the undersigned, understand that this enrollment application is subject to medical underwriting and acceptance by Capital and that if a contract is issued, benefits will be available subject to exclusions, limitations, and other conditions as set forth in the contract. I/We further understand that acceptance is not guaranteed.

I apply for coverage for myself and all my requested eligible dependents. I represent, to the best of my knowledge and belief, that:

1. I have read and have provided all the requested information on or attached to this form with regard to me and any family members applying for coverage.
2. I have accurately disclosed all health status information for me and for all individuals/family members for whom coverage is requested. No material information has been withheld or omitted on this enrollment application, including facts about the past or present state of my health or any family member(s) applying.

**I understand and agree that:**

1. Coverage does not begin until this enrollment application is accepted by Capital, the signed acceptance form and premium is received by Capital, and an effective date of coverage is assigned.
2. Coverage is available only to residents of the geographical area of Central Pennsylvania and the Lehigh Valley served by Capital, as defined in the Eligibility Requirements section in the instructions above. Capital reserves the right to investigate and confirm your residence.
3. The actual premium(s) for the benefit options I/we selected will be provided to me/us if my/our enrollment application is accepted. I/we may accept or decline coverage at the proposed rate(s).
4. Capital may require proof of age of applicant and family members (if any) applying for coverage.
5. Capital may require me and any family member(s) applying to provide upon request, medical history or to have a medical examination, blood test or other applicable medical test prior to acceptance of the application for *Personal* Blue PPO coverage (Capital may choose to specify the provider). I understand that any physician charges or other fees incurred during completion of this enrollment application is my/our responsibility.
6. Capital may require me and my family member(s) applying to supplement this enrollment application through a telephone interview. I understand and agree that such interview may be recorded and transcribed and may be used by Capital for the purpose of underwriting and claims evaluation.
7. Capital may, if my/our enrollment application is accepted, void or cancel this contract or deny a claim or change rates retroactive to the initial effective date (as defined in the contract) during the first three (3) years from the effective date of this contract if I/we have made a misrepresentation of a material fact in the enrollment application that affected the risk assumed by Capital.
8. Capital may, if my/our enrollment application is accepted, void or cancel this contract or deny a claim (as defined in the contract) after three (3) years from the effective date only for fraudulent material misstatements made by me/us in the enrollment application for this contract.

I also understand and agree that the contract will not provide medical benefits for me or any enrolled dependents during the twelve-month period following the effective date on which I and any dependents become enrolled under the contract for any condition for which medical advice, care, or treatment has been recommended by or received from a physician (preexisting conditions) within a five-year period prior to the effective date of the contract.

I understand and agree that the terms and conditions of coverage will be controlled by the written contract with Capital and that it may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of that contract, to administer the program. I recognize that coverage will only apply to admissions that occur and services that are provided on or after the effective date of my/our coverage.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Capital may use and disclose Protected Health Information for payment, treatment and health care operations. A copy of Capital's Notice of Privacy Practices is available on the Capital BlueCross Web site, or from the Capital BlueCross Privacy Office.

**VIII. CONDITIONS OF ENROLLMENT (continued)**

**Disclosure Authorization *Personal/Blue PPO***

So that Capital may obtain the information it needs (i) to determine whether I am eligible to enroll, (ii) to determine the premium to charge me if I am eligible, and (iii) to determine the appropriate treatment of claims once I enroll, by signing this form I authorize the following entities to use and disclose any individually identifiable health information about me that they have for the following purposes:

- A consumer reporting agency for the purposes of (i) developing a report summarizing health conditions I may or am likely to have and (ii) providing that report to Capital; and
- My current and former health care providers, insurers (or health plans), and their vendors (such as pharmacy benefit managers) for the purpose of providing the information to Capital.

I understand the nature of this release and that information affected by this authorization may include information protected by state law including, but not limited to, information about HIV status, mental health conditions, and substance abuse issues. This form does not apply to and I do not authorize disclosure of psychotherapy notes.

I understand that Capital may refuse to enroll me, unless I sign this form. I understand that I may revoke this authorization at any time by sending written notice to Capital at:

Mail To: **CENTRAL PENN BENEFITS  
280 WEST MARKET STREET  
YORK, PA 17401**

My revocation will not affect the rights of anyone who has acted in reliance on the authorization prior to receiving the notice of revocation. Unless revoked earlier, this authorization will be valid until six (6) months after termination of enrollment with Capital. I understand that the information covered by this form, once disclosed, may be further used and disclosed by Capital as permitted by Federal and State law and, if disclosed to another entity, may no longer be protected by federal rules governing privacy and confidentiality.

**Authorized Signatures (if additional space is needed, attach a separate sheet) Each proposed Member (or a personal representative on the proposed Member's behalf) must sign the application below.**

Proposed Member(s) (please print)		Signature of Proposed Member(s) (or personal representative*)	
Name (Applicant)	Date of Birth	Signature of or for Applicant	Date
Name (Co-applicant/Spouse)	Date of Birth	Signature of or for Co-applicant/Spouse	Date
Name (Dependent)	Date of Birth	Signature of or for Dependent	Date
Name (Dependent)	Date of Birth	Signature of or for Dependent	Date

\*An individual's personal representative includes the parent of a minor child, an individual's legal guardian, or a person holding a power of attorney that includes the power over the individual's health care decisions. A personal representative signing this form, other than a parent of a minor child, must include a brief description of the nature of his/her status as a personal representative (e.g. "guardian") and must include with this Application a copy of the appropriate documentation evidencing appointment as personal representative.

I request this coverage to become effective \_\_\_\_/\_\_\_\_/\_\_\_\_

Your requested effective date must be within two (2) months of your date of signature below. Capital cannot guarantee that your requested effective date can be met.

Please note: If you and your spouse are applying for this coverage, your spouse is considered a co-applicant and also must read and accept these “conditions of enrollment,” and sign and date this enrollment application below. In addition, any dependents age 18 or older for whom coverage is requested must also read and accept these “conditions of enrollment,” and sign and date this enrollment application below.

Important: If you are replacing your current health insurance coverage, by signing below, you acknowledge that you have read the “Notice to Applicant Regarding Replacement of Health Insurance Coverage” included in the enrollment application.

After the enrollment application has been completed and prior to signing, reread it carefully to be certain all information has been properly entered.

*Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

**Enrollment Application Authorization**

<b>Proposed Member</b> (please print)		<b>Signature of Proposed Member</b> (or personal representative*)	
Name (Applicant)	Date of Birth	Signature of or for Applicant	Date
Name (Co-applicant/Spouse)	Date of Birth	Signature of or for Co-applicant/Spouse	Date
Name (Dependent)	Date of Birth	Signature of or for Dependent	Date
Name (Dependent)	Date of Birth	Signature of or for Dependent	Date

\*An individual’s personal representative includes the parent of a minor child, an individual’s legal guardian, or a person holding a power of attorney that includes the power over the individual’s health care decisions. A personal representative signing this form, other than a parent of a minor child, must include a brief description of the nature of his/her status as a personal representative (e.g. “guardian”) and must include with this Application a copy of the appropriate documentation evidencing appointment as personal representative.

**DO NOT WRITE IN THIS AREA**



# ***Personal/Blue PPO***<sup>SM</sup>

*Offered by*

**CAPITAL BLUE CROSS AND CAPITAL ADVANTAGE INSURANCE COMPANY®**

Independent Licensees of the Blue Cross and Blue Shield Association