

**Individual / Family Application for JACL
Health Benefits Administrators Health Plans**

Underwritten by

JACL HEALTH BENEFITS ADMINISTRATORS



Blue Shield of California
An Independent Member of the Blue Shield Association

220 Sansome Street, Suite 1360
San Francisco, CA 94104

JACL Chapter Name:

JACL Membership is required to be eligible for this health plan coverage.

Application must be completed in pen or ink.

PART 1 – Please provide the following:

CHOOSE PLAN (check one box only):

PPO PLAN ACCESS+ HMO PLAN BASIC PLAN \$1,500 Deductible ACTIVE CHOICE

INDICATE THE PURPOSE OF THIS APPLICATION (Check One): New Membership Plan Transfer Add family member to existing coverage

APPLICANT'S SOCIAL SECURITY NUMBER		APPLICANT'S FIRST NAME		MI	LAST NAME	
MARRIED YES NO	SPOUSE'S SOCIAL SECURITY NUMBER		APPLICANT'S BUSINESS PHONE NUMBER ()		APPLICANT'S HOME PHONE NUMBER ()	
HOME (MAILING) ADDRESS					APPLICANT'S DATE OF BIRTH	
CITY					STATE	ZIP CODE
BILLING ADDRESS (IF DIFFERENT FROM ABOVE)				CITY	STATE	ZIP CODE
COUNTY OF RESIDENCE			IF YOU HAVE BEEN A BLUE SHIELD OF CALIFORNIA MEMBER INDICATE:		PRIOR BLUE SHIELD NUMBER	
					DATE CANCELLED MO. DAY YR.	
To help us serve you better in the future Please indicate your language Preference: <input type="checkbox"/> ENGLISH <input type="checkbox"/> JAPANESE <input type="checkbox"/> SPANISH <input type="checkbox"/> CHINESE <input type="checkbox"/> OTHER: _____					LIST BILL NUMBER (FOR BLUE SHIELD USE ONLY)	

PART 2 – List yourself and all family members you wish covered. (Dependent children must be under age 25.)

(For those applicants selecting Access+ HMO Plan: You must select an HMO Personal Physician for yourself and each family member from **The Blue Shield HMO Physician and Hospital Directory** for your service area. You may choose the same or a different Personal Physician for each family member. Be sure to include each Personal Physician's provider number listed in the directory. (If you do not select a Personal Physician, Blue Shield will select one for you. If you have questions regarding your Personal Physician selection, call 1-800-424-6521.)

1	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: Personal Physician First Name			MI	LAST	PROVIDER#	MED GROUP/IPA#
2	<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: Personal Physician First Name			MI	LAST	PROVIDER#	MED GROUP/IPA#
3	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: Personal Physician First Name			MI	LAST	PROVIDER#	MED GROUP/IPA#
4	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: Personal Physician First Name			MI	LAST	PROVIDER#	MED GROUP/IPA#
5	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: Personal Physician First Name			MI	LAST	PROVIDER#	MED GROUP/IPA#
APPLICANT'S OCCUPATION			EMPLOYER AND EMPLOYER'S ADDRESS (ACCESS+ HMO ONLY)			CITY	ZIP
SPOUSE'S OCCUPATION			EMPLOYER AND EMPLOYER'S ADDRESS (ACCESS+ HMO ONLY)			CITY	ZIP

PART 3 – Please answer ALL questions.

Have you or any applying family member ever received any professional advice or treatment for or had any symptoms pertaining to any of the following? All questions must be checked (✓) “Yes” or “No”. If “Yes”, circle the condition(s) applicable and provide the information requested in Part 5.

	Yes	No		Yes	No
1. Brain or nervous system - such as: dizziness, headaches, seizure disorder, loss of consciousness, epilepsy, paralysis, muscular dystrophy, multiple sclerosis, stroke, cerebral palsy, polio, mental retardation, etc.?			13. Diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing – such as: any infections, crossed eyes, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, problems with tonsils or adenoids, sleep apnea, etc.?		
2. Cardiovascular system - such as: heart or valve problems, coronary artery disease, heart attack, heart murmur, pericarditis, mitral valve prolapse, mitral regurgitation, rheumatic fever, palpitations, high blood pressure, shortness of breath, chest pains, etc.?			14. Cancer, tumor, cysts, leukemia, Hodgkins, etc.? Type: _____		
3. Circulatory system - such as: varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder, anemia, or enlarged lymph nodes, etc.?			15. Alcoholism, drug dependency or substance abuse? Type: _____		
4. Respiratory tract - such as: asthma, reactive airway disease, bronchitis, hayfever, allergies, sinusitis, lung/chest problems of any kind, emphysema, tuberculosis, spitting or coughing up blood, shortness of breath, pneumonia, cystic fibrosis, pulmonary fibrosis, chronic obstructive pulmonary disease, etc.?			16. Presently a member of a support group? How long: _____ Type: _____		
5. Digestive system - such as: mouth, tongue, esophagus or stomach problems, ulcer, gall bladder disorder, liver disease, cirrhosis, jaundice, ascites, pancreatitis, colon, intestinal or rectal problems, colitis, chronic diarrhea, hemorrhoids, hernia, weight or eating problems, hepatitis, etc.? Hepatitis type: _____			17. Congenital abnormalities, birth defects - such as: Down’s Syndrome, Cerebral Palsy, cleft lip or palate, clubfoot, developmental delay, mental retardation, or other neurological or physical abnormalities?		
6. Urinary tract - such as: renal colic, gravel or stone, urethra, bladder or kidney problems, infections, stricture, pyelonephritis, etc.?			18. Have you or any applying family member ever received any counseling or treatment for symptoms of depression, manic depression, anxiety, panic attacks, nervousness, mental or emotional disorders, schizophrenia, behavior problems, hyperactivity, attention deficit disorder, eating disorders, bulimia, anorexia, alcohol or substance abuse, or for any other reason?		
7. Male reproductive system - such as: prostate problems, infertility, impotency, male breast problems, gynecomastia, infections, herpes, syphilis, gonorrhea, or other venereal disease, etc.?			19. Have you or any applying family member ever been an inpatient or outpatient in a hospital, surgicenter, sanitarium, or other medical facility, including an emergency room, or had any surgery, including angioplasty, cosmetic/reconstructive, bypass, or transplant surgery?		
8. A. Female reproductive system - such as: breast problems, breast implants, adhesion, abnormal bleeding, amenorrhea, endometriosis, fibroid tumors, abnormal Pap test, problems of the ovaries, uterus and associated female organs, infertility, in-vitro fertilization, history of caesarean delivery, infections, genital warts, herpes, syphilis, or other venereal disease, etc. Type of implants: _____ B. Does any female applicant menstruate? If yes, has it been more than 40 days since her/their last menstrual period? If yes, explain which family member(s): _____			20. Have you or any applying family member ever had abnormal laboratory results, blood work, x-rays, EKG, nerve condition, blood flow studies, MRI scan, CT scan, or PET scan?		
9. A. Is either the applicant or spouse, whether or not listed on the application, currently pregnant? B. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on the application? C. Is any female dependent listed on this application currently pregnant? D. If any of the above questions are answered yes, please complete: Expected delivery date: _____ Method of Conception: <input type="checkbox"/> Normal <input type="checkbox"/> In-vitro <input type="checkbox"/> G.I.F.T. <input type="checkbox"/> Other Prior caesarean delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No			21. Do you or any applying family member have a prosthesis, implant, or retained hardware? Type: _____		
10. Musculo-Skeletal system - such as: neck, spine/back sprain, pain, injury, sciatica, hemlated or bulging disc(s), or problems; curvature of the spine, scoliosis, any pain, injuries, or problems of the joints, bones, or muscles; arthritis; rheumatoid arthritis, temporo-mandibular joint syndrome (TMJ), Lyme disease, fractures/residual hardware, dislocations, bunions, hammertoe, carpal tunnel syndrome, physically handicapped, polio, amputation, etc.?			22. Have you or any applying family member been advised to undergo further testing, treatment or surgery which has not yet been performed by a physician, dentist, or other provider?		
11. Skin conditions - such as: skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns, etc.?			23. Do you or any applying family member have any symptoms and/or health problems that have not yet been evaluated by a physician, or have any diagnoses, symptoms or problems not mentioned elsewhere on this application, or have any complications or residuals remaining following any treatment?		
12. Metabolic system - such as: diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders, such as: lupus, Raynauds, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID or Pentamidine therapy, etc.? (CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING COVERAGE.)			24. Have you or any applying family member ever smoked cigarettes? Family member: _____ Packs per day: _____ How many years: _____ When did you/they stop?: _____		
			25. Do you or any applying family member drink alcoholic beverages? Family member: _____ Drinks per week: _____ Type: _____		
			26. Have you or any applying family member ever had any application for health or life insurance revoked, declined, postponed or restricted in any way? Family member: _____ Date: _____ Please explain: _____		
			27. Have you or any applying family member ever requested or received a pension, benefits or payment because of any injury, sickness or disability? Family member: _____ Date: _____ Please explain: _____		
			28. In the past two years, have you or any applying family member seen a physician or health care provider for an examination that was prompted by symptoms: that the physician wanted to observe; or that resulted in a diagnostic condition, a recommendation for further tests, or treatment; or that resulted in abnormal findings (excluding provider visits for diagnosed flu or cold of less than 14 days duration, and prior completed pregnancies with no complications)?		
			29. Have you or any applying family member seen a physician or health care provider for any reason within the last 60 days?		
			30. In the last 12 months, have you or any applying family member taken or been ordered to take prescription medication(s) other than: antibiotics solely for seasonal flu or cold infection OR birth control pills solely for the prevention of conception OR female hormones solely for replacement therapy?		

PART 4 – Please answer each question. If yes, please provide details in the space provided.

1. Did you or any applying family member have other health coverage (insurance) within the last 63 days?						
Family Member:	Yes	No	Type of Coverage	Effective Date	Cancel Date:	Health Plan Carrier:
PRIMARY _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> GROUP <input type="checkbox"/> COBRA <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> OTHER	_____	_____	_____
SPOUSE _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> GROUP <input type="checkbox"/> COBRA <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> OTHER	_____	_____	_____
OTHER: _____						

PART 5 – If you or any applying family member answered “YES” to questions 1-23 in PART 3, give full details, including the question number.

If additional space is necessary to provide complete information, please attach an additional sheet of paper. Be sure to identify the family member, the section and the question number, if appropriate. Check here if additional sheets of paper have been attached.

QUESTION NUMBER	FAMILY MEMBER NAME AND NAME USED ON DOCTOR'S RECORDS	DIAGNOSIS AND PRESENT STATUS	DATES OF TREATMENT, HOSPITALIZATION	FULL NAME AND ADDRESS OF EVERY PHYSICIAN, CLINIC OR HOSPITAL (INCLUDE ZIP CODE). FOR PHYSICIANS WHO BELONG TO A MEDICAL GROUP, PLEASE LIST THE MEDICAL GROUP AS WELL.		
				NAME	ADDRESS	STE#
	NAME	DIAGNOSIS AND TREATMENT	BEGAN: MO. YR. STILL UNDER TREATMENT: YES NO ENDED: MO. YR.	NAME	ADDRESS	STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: YES NO	CITY	STATE	ZIP
	NAME	DIAGNOSIS AND TREATMENT	BEGAN: MO. YR. STILL UNDER TREATMENT: YES NO ENDED: MO. YR.	NAME	ADDRESS	STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: YES NO	CITY	STATE	ZIP
	NAME	DIAGNOSIS AND TREATMENT	BEGAN: MO. YR. STILL UNDER TREATMENT: YES NO ENDED: MO. YR.	NAME	ADDRESS	STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: YES NO	CITY	STATE	ZIP
	NAME	DIAGNOSIS AND TREATMENT	BEGAN: MO. YR. STILL UNDER TREATMENT: YES NO ENDED: MO. YR.	NAME	ADDRESS	STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: YES NO	CITY	STATE	ZIP
	NAME	DIAGNOSIS AND TREATMENT	BEGAN: MO. YR. STILL UNDER TREATMENT: YES NO ENDED: MO. YR.	NAME	ADDRESS	STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: YES NO	CITY	STATE	ZIP

PART 6 – List your last physician visit.

If you or any applying family member answered yes to question 28 or 29 in part 3 please list below the details of the last visit to a physician or health care provider for any reason, including a check up or physical exam. **A complete physical examination is required for you or any family member age 55 years or older. This examination must be within the last two years.**

NAME OF FAMILY MEMBER	DATE OF VISIT	REASON FOR EXAMINATION / CHECKUP	FINDINGS AND PRESENT STATUS	FULL NAME, SPECIALTY AND MEDICAL GROUP OF PHYSICIAN	COMPLETE ADDRESS, SUITE NO. CITY AND ZIP CODE OF PHYSICIAN
				NAME	ADDRESS
				PHONE #	CITY STATE ZIP
				NAME	ADDRESS
				PHONE #	CITY STATE ZIP
				NAME	ADDRESS
				PHONE #	CITY STATE ZIP
				NAME	ADDRESS
				PHONE #	CITY STATE ZIP

PART 7 – Prescription Medication Details – Current or recent prescription medications.

If you or any applying family member answered “YES” to question 30 in PART 3, please provide the details of the current and previous medications.

NAME OF FAMILY MEMBER	NAME OF MEDICATION AND CONDITION FOR WHICH MEDICATION WAS PRESCRIBED	DATES		FULL NAME, SPECIALTY AND MEDICAL GROUP OF PHYSICIAN	COMPLETE ADDRESS, SUITE NO. CITY AND ZIP CODE OF PHYSICIAN
		FROM	TO		
	MEDICATION			NAME	ADDRESS
	CONDITION			SPECIALTY	MEDICAL GROUP CITY STATE ZIP
	MEDICATION			NAME	ADDRESS
	CONDITION			SPECIALTY	MEDICAL GROUP CITY STATE ZIP
	MEDICATION			NAME	ADDRESS
	CONDITION			SPECIALTY	MEDICAL GROUP CITY STATE ZIP
	MEDICATION			NAME	ADDRESS
	CONDITION			SPECIALTY	MEDICAL GROUP CITY STATE ZIP

