Blue Cross Blue Shield of Rhode Island

Direct Pay Medical Underwriting Addendum

Please complete the following if you want to apply for a preferred rate or if you do not qualify for guaranteed availability pursuant to state law.

Applicant name	Home phone
Mailing address (street, city/town, ZIP code)	Date of birth

1. Applicant height ___'_____" weight _____ lbs.

   Spouse name _____ height ____'_____" weight _____ lbs.

   Dependent name _____ height ____'_____" weight _____ lbs.

   Dependent name _____ height ____'_____" weight _____ lbs.

   Dependent name _____ height ____'_____" weight _____ lbs.

2. Do you, your spouse or your dependents to be covered smoke now or have you or they ever smoked?

   ☐ Yes ☐ No

   If yes, at what age did you, your spouse or your dependents start smoking? _____

   Are you, your spouse or your dependents still smoking? ☐ Yes ☐ No

   If no, when did you, your spouse or your dependents quit? _____

3. Have you or any other person listed on this application had medical or surgical advice, treatment, or consultation for any accident, injury, illness, or disease in the past for any of the following? (Include routine physical examinations.)

Yes	No		
☐	☐	A.	Diabetes? Age at onset _____, insulin dosage _____ .
☐	☐	B.	Nephritis, kidney stones, or any disease or disorder of the kidneys, prostate, urinary tract, or albumin or sugar in the urine?
☐	☐	C.	Any disease or disorder of the stomach, intestines, rectum, appendix, liver, or gallbladder, including ulcers, chronic indigestion, or diarrhea?
☐	☐	D.	Chest pain or pressure, shortness of breath, heart murmur, aneurysm, high blood pressure, irregular heartbeats, or any other disease or disorder of the heart or circulatory system?
☐	☐	E.	Epilepsy (seizures), stroke, paralysis, chronic or severe headaches, cerebrovascular disease, or any other disorder of the brain or nervous system?
☐	☐	F.	Any disease or disorder of the blood vessels, including varicose veins or phlebitis?
☐	☐	G.	Any disease or disorder of the eyes, ears, nose, throat, mouth, or sinuses?
☐	☐	H.	Any type of cancer or other tumor?
☐	☐	I.	Asthma, emphysema, chronic cough, spitting of blood, tuberculosis, allergies, or any other disease or disorder of the lungs or respiratory system?

continued ➤

Yes	No		
☐	☐	J.	Any disease or disorder of the blood or lymph system, including anemia, leukemia hemophilia, goiter, or other disease or disorder of the glands or thyroid?
☐	☐	K.	Any type of hernia? Type _____
☐	☐	L.	Alcoholism, drug or substance abuse, or addiction?
☐	☐	M.	Are you or any of your dependents to be covered currently pregnant? If "yes," give due date _____
☐	☐	N.	Have you or any of your dependents to be covered experienced sudden weight loss, night sweats, persistent fever, malaise, mouth infections, or lymph node enlargement?
☐	☐	O.	Have you or any of your dependents to be covered ever been told that you had, or have you ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), or AIDS-related conditions?
☐	☐	P.	Positive blood test for HIV?
☐	☐	Q.	Are you or any of your dependents currently taking any medications? If yes, please list medications below.
☐	☐	R.	Any disease or disorder of the back, neck, spine, bones, joints, or muscles, including Lyme Disease, gout, rheumatism, or arthritis? Type _____
☐	☐	S.	Treatment or counseling for mental, nervous, or emotional disorders?
☐	☐	T.	Any disease or disorder of the skin?
☐	☐	U.	Any disease or disorder of the reproductive organs, including breast, infertility, impotence, and venereal disease?
☐	☐	V.	Any present conditions or symptoms for which a physician has been consulted?
☐	☐	W.	Any other illness, injury, condition, symptom, or disorder not mentioned above?
☐	☐	X.	Advised by a healthcare provider that future hospitalization, surgery, or treatment is necessary?
☐	☐	Y.	Exam or treatment for any illness, injury, accident, birth defect, congenital defect, disease, or disorder not mentioned above?
☐	☐	Z.	Have you or any of your dependents to be covered ever been rejected, ridered, or rated for health insurance?

If you answered "yes" to any of the conditions outlined in the Medical Questionnaire for you or any dependent to be covered, please complete the following. Attach an additional sheet of paper if more space is needed.

ADDITIONAL SHEETS ATTACHED? ☐ Yes ☐ No

<table>
<tr><td>Question letter</td><td colspan="2">Name</td><td>Illness or nature of complaint/treatment or medication.</td></tr>
<tr><td colspan="2">Duration dates</td><td rowspan="2">Please indicate if you are still receiving care.
☐ Yes ☐ No</td><td rowspan="2">Name and address of physician or other healthcare provider.</td></tr>
<tr><td>From: Mo./Yr.</td><td>To: Mo./Yr.</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
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Question letter	Name		Illness or nature of complaint/treatment or medication.
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From: Mo./Yr.	To: Mo./Yr.	☐ Yes ☐ No	

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From: Mo./Yr.	To: Mo./Yr.	☐ Yes ☐ No	

Other Remarks: ____

____

NOTE: To ensure the most accurate medical information, you may be requested to update any changes to your medical condition if your application is not processed within 90 days of the date of application.

continued ➤

READ CAREFULLY BEFORE SIGNING

By signing this form, I authorize BCBSRI to:

1.) Request any provider to give BCBSRI all health information about me or my eligible minor dependents for whom coverage is requested, which may include:
   - Treatment plans,
   - Dates of services,
   - Nature of accident or sickness,
   - Record of surgery, and,
   - Lab test results, including HIV.

2.) Use health information to verify the information relevant to this application.

3.) Use the information in this form to invite me or any of my eligible dependents to take part in medical management, case management, and/or disease management programs.

This authorization is valid for 24 months from the date below. By signing this form, I further understand this authorization can be withdrawn at any future time by notifying BCBSRI in writing; the withdrawal:

- Will not affect the rights of anyone acting on it prior to notice.
- May affect my eligibility for the preferred rate program.
- Notice must be sent to:

Blue Cross & Blue Shield of Rhode Island
500 Exchange Street, Providence, Rhode Island 02903-2699
Attn: Small Group and Dental Underwriting Department

I hereby certify that I have read the above statements, or that they have been read to me, and that they are true and complete. If anyone knowingly lied or hid the truth BCBSRI will have the right to deny claims or void the contract. Also, any benefits previously paid will be subject to collection by BCBSRI.

SIGN HERE

Signature of Applicant or signature of parent or guardian *if applicant is under 18 years of age* _____ Date _____

Signature of spouse _____ Date _____

Signature of dependent aged 18 and over _____ Date _____

INTERNAL USE ONLY

Sales rec'd _____ Sales eff. date _____ ID# _____ Eligibility A T Q N O Other _____

MU rec'd _____ Send out _____ Send back in _____ Results _____ Determination _____

Complete date _____ Initial _____ AB Lev 1 Lev 2 Memb. rec'd _____

Blue Cross Blue Shield of Rhode Island

www.BCBSRI.com

500 Exchange Street • Providence, RI 02903-2699