

TO: BLUE CROSS/BLUE SHIELD OF TEXAS, INC.
P. O. BOX 833940
RICHARDSON, TEXAS 75083-3940
ATTN. (GROUP) MEDICAL UNDERWRITING

PHONE # 1-800-554-6303 # 2

INDIVIDUAL UNDERWRITING TRANSMITTAL FORM

GROUP NAME: _____
ADDRESS: _____

GROUP # _____ PHONE # _____

WE ARE REQUESTING REVIEW AND RECOMMENDATION ON THE ENCLOSED APPLICATIONS FOR GROUP HEALTH INSURANCE BY YOUR UNDERWRITING STAFF.

DATE	SIGNATURE OF GROUP REPRESENTATIVE	
NAME OF APPLICANT or MEMBER	EMPLOYEE SS #	RECOMMENDATIONS BY MEDICAL UNDERWRITING
1) _____	_____	_____
DEP. TO BE ADDED	_____	_____
	_____	_____
	_____	_____
2) _____	_____	_____
DEP. TO BE ADDED	_____	_____
	_____	_____
	_____	_____
3) _____	_____	_____
DEP. TO BE ADDED	_____	_____
	_____	_____
	_____	_____

YOU MAY ATTACH 3 SEPARATE APPLICATIONS TO THIS FORM AND PROVIDE INFORMATION REQUIRED.

Date _____

Dependent Child's Statement of Disability

Group No. _____ Certificate No. _____

Employee Name _____

Employee's Address _____
Street Address City State ZIP Code

Dependent Child's Name _____ Marital Status _____ Date of Birth _____

Social Security No. _____ Relationship _____

Dependent Child's Place of Residence/Address _____
Street Address
City Texas ZIP Code

I authorize any hospital, physician, provider, clinic or medical related facility, governmental agency, insurance carrier, group health plan, or other entity that has record or knowledge of my health or that of any member of my family to furnish to Blue Cross and Blue Shield of Texas (BCBSTX) and HMO Blue® Texas or its authorized representative any information considered necessary for the proper underwriting of an application.

I understand that this authorization is voluntary and that my signature is required for BCBSTX and HMO Blue® Texas to consider the disability request and to make a determination on whether to grant the disability request for eligibility for the above dependent child and that without my signed authorization no action will be taken on the application. I also understand that I may revoke this authorization at any time in writing and that such revocation will have no effect on any actions taken prior to receipt of the revocation. I further understand the potential that any information disclosed pursuant to this authorization may be redisclosed and is no longer protected by the Federal privacy laws. A photographic copy of this authorization shall be as valid as the original. Yes No Initial _____

Signature: _____ Date: _____

TO BE COMPLETED BY ATTENDING PHYSICIAN

Note: Any fee for the completion of this form is the responsibility of the patient.

1. Patient's Name _____

2. Diagnosis (Be as detailed as possible) _____

3. If dependent child has ever been under observation, care or treatment in any hospital, sanitarium, asylum or similar institution, please complete the following:

Name of hospital or institution _____

Number of days _____ Date of last treatment or care _____

4. Treatment (a) Date of first visit _____ (b) Frequency of visits Weekly () Monthly () Other ()

5. Extent of Disability

(a) Is patient now incapable of self-support because of disability? Yes () No ()

(b) Disability has existed continuously since _____

(c) When do you think patient will be able to return to gainful employment?
Approximate Date _____ Indefinite _____ Never _____

Name of Physician _____ Phone _____

Address of Physician _____
Street Address City State Zip Code

Physician's Signature _____ Date _____