

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION FOR UNDERWRITING

This authorization is only needed if you are applying for a Personal BluePlanSM Policy.

Please complete this form and send it to the following address if you have been seen by a licensed medical provider within the last 10 years:

Group & Individual Privacy Official (AX-E05)
BlueCross[®] BlueShield[®] of South Carolina
I-20 at Alpine Road
Columbia, SC 29219
Fax: (803) 264-0174

Section 1: Authorization – I authorize my past or present treating physicians/hospitals/clinics, licensed medical providers, pharmacies, and/or pharmacy-related service organizations to disclose to BlueCross BlueShield of South Carolina (“BlueCross”), or its designated agent, my protected personal health information concerning symptoms or conditions for which I may have been treated or given advice for, but does not include psychotherapy notes, in the 10 years prior to my signing this authorization. I further authorize BlueChoice[®] HealthPlan of South Carolina (formerly Companion HealthCare) to disclose to BlueCross, my electronic claims history for the same time period, if any. I understand this authorization is voluntary. However, BlueCross reserves the right to deny enrollment or eligibility for benefits if I refuse to sign this form.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

Section 2: Purpose – The purpose of this authorization is for BlueCross to obtain copies of documents related to my medical history in order to determine eligibility before enrollment, and the requested use or disclosure does not include psychotherapy notes.

Section 3: Options for Disclosures – Disclosure may occur by sending copies of documents concerning my medical history in the 10 years prior to my signing this form by U.S. mail, by fax, hand delivery or by an electronic transmission.

Section 4: Expiration and Revocation – Expiration: This authorization will expire: 1) upon the effective date of my enrollment with BlueCross; or 2) upon BlueCross’ denial of coverage; or 3) upon my written revocation, whichever occurs first. **Revocation:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to the address listed above.

BlueCross will condition my eligibility for insurance based on whether or not I sign this form. I understand that revocation of this authorization will not affect any action BlueCross took in reliance on this authorization before BlueCross received my notice of revocation.

Section 5: Signature – I, the undersigned, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction.

Print Applicant’s Name: _____

Applicant’s Social Security No.: -- Spouse’s Social Security No.: --

List Dependents to be included in this Authorization to Disclose Protected Health Information for Underwriting:

Name: _____ D.O.B. ____/____/____ Name: _____ D.O.B. ____/____/____

Name: _____ D.O.B. ____/____/____ Name: _____ D.O.B. ____/____/____

Signature: _____ Print Name: _____ Date: ____/____/____

Spouse’s Signature: _____ Print Name: _____ Date: ____/____/____

(If Applying for Coverage)

Please Note: If this authorization is for a Dependent age 16 or over, that dependent must sign below.

Dependent’s Signature: _____ Print Name: _____ Date: ____/____/____

(If Applying for Coverage and Age 16 or Over)

You are entitled to a copy of this Authorization Form

Underwriting (Rev. 9/07)

Order # 12216M

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