

# Wait!

**Please call before  
attempting to complete your application!**

Avoid headaches and delays by allowing our office to assist you. We can help you complete your application and answer any questions you may have. You'll be surprised at how simple completing an application can be.

**1 800 721-2618**

(6:30 a.m. to 6:30 p.m. PST. Monday through Friday)

Please mail your application to:

Health One Insurance Agency  
1344 Disc Dr. #210  
Sparks, NV 89436  
Attn: APDT

Or you may fax your application to:

800 905-6750





## 6. Health History

## 6A. Health History Questionnaire—ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.

Give COMPLETE details for any "Yes" answers below in Section 6B on the following page.

1. Has any applicant had a physical exam or any diagnostic test or screening test such as blood tests, X-rays, CAT scans, MRIs, mammograms, etc. within the past <b>60 days</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Has any applicant discussed or been advised to have testing, treatment, therapy or surgery that has not yet been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Has any applicant been prescribed or taken any prescribed medication within the past <b>12 months</b> except for birth control pills or short-term (10 days or less) antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Has it been more than <b>40 days</b> since any female applicant's last menstrual period? Name(s): _____ <input type="checkbox"/> Applicant/spouse _____ <input type="checkbox"/> Dependent If yes, explain _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any applicant been diagnosed, treated, evaluated for or experienced any male/female genital/gynecological or reproductive problem(s), including infertility, prostatitis, endometriosis or abnormal Pap smear/test within the past <b>five years</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Has any applicant been evaluated or treated for or experienced breast cysts or lumps within the past <b>two years</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Is any applicant an expectant parent, and/or has initiated or is considering the process of adoption or surrogate pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Has any applicant had or been treated for herpes, HPV or any other sexually transmitted disease (STD) within the past <b>five years</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Has any applicant been treated for any mental, emotional or behavioral disorder, including anorexia, attention deficit disorder or depression, within the past <b>10 years</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Has any applicant been hospitalized within the past <b>10 years</b> for any mental, emotional or behavioral disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Has any applicant been diagnosed with or treated or evaluated for symptoms related to alcoholism and/or use or abuse of alcohol within the past <b>10 years</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Has any applicant used illegal drugs, IV drugs or been treated for drug abuse within the past <b>10 years</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Has any applicant been diagnosed with or treated or evaluated for or experienced any of the following within the past <b>six months</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
A. Allergy injections <input type="checkbox"/> Yes <input type="checkbox"/> No	
B. Increased and/or irregular heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Heartburn (recurrent) and/or reflux <input type="checkbox"/> Yes <input type="checkbox"/> No	
D. Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No	
E. Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	
F. Recurrent diarrhea and/or excessive vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No	
G. Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No	
H. Loss of consciousness and/or fainting <input type="checkbox"/> Yes <input type="checkbox"/> No	
I. Blood and/or sugar in urine <input type="checkbox"/> Yes <input type="checkbox"/> No	
J. Persistent and/or intense pain <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Does any applicant have any implants or prostheses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Has any applicant been diagnosed with or incurred charges, received treatment, had treatment recommended, consulted a health care professional, or taken prescription drugs for any of the following within the past <b>10 years</b> : <input type="checkbox"/> Yes <input type="checkbox"/> No	
A. AIDS/ARC; evaluated for or recommended ANTIVIRAL treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	
B. Heart/circulatory/bleeding disorders, including chest pain, hypertension, high cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	
C. Diabetes or other endocrine (glandular) disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	
D. Kidney/gall bladder/stomach/intestinal disorders, including colitis, diverticulitis, GERD or ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	
E. Hepatitis and/or liver disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	
F. Hernia/hemorrhoid/rectal disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	
G. Muscle/bone/tendon/joint/back/injuries or disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	
H. Multiple sclerosis, migraine headaches, convulsions, Parkinson's disease or other brain/nervous disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	
I. Congenital heart or other birth defects/ congenital disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	
J. Emphysema, asthma, bronchitis or other respiratory disorders <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Has any applicant had or been treated for cancer or a malignant tumor within the past <b>10 years</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. In the past <b>10 years</b> has any applicant been diagnosed with or incurred charges, received treatment, had treatment recommended, consulted a health care professional or taken prescription drugs for any condition(s) not listed elsewhere on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Has any applicant been hospitalized or treated in the emergency room within the past <b>12 months</b> (except for pregnancy)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. In the past <b>12 months</b> , has/is any applicant considered/ considering any hospitalization or medical or surgical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Has any applicant smoked cigarettes, cigars or pipes or used chewing tobacco within the past <b>12 months</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family member's name(s): _____	
_____	
_____	
<p><b>I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I have personally reviewed and answered all health questions correctly. I understand that if I provided incomplete or false material information, Anthem Blue Cross and Blue Shield may cancel my membership as if it never existed, and I will be personally responsible for all medical and pharmacy claims. Initial _____</b></p>	



**6B. Other Health Questions**

Applicant Social Security or ID Number									

**Professional Services**

Give **COMPLETE** details in all sections below for any "Yes" answers to the questions in Section 6A.

Question #	Name of Family Member (as identified on physician record)	Name of Hospital, Clinic and/or Person Providing Care	Phone number
Date Treatment Started (month/year)	Date Ended	<input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness			
Results of Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			

Question #	Name of Family Member (as identified on physician record)	Name of Hospital, Clinic and/or Person Providing Care	Phone number
Date Treatment Started (month/year)	Date Ended	<input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness			
Results of Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			

Question #	Name of Family Member (as identified on physician record)	Name of Hospital, Clinic and/or Person Providing Care	Phone number
Date Treatment Started (month/year)	Date Ended	<input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness			
Results of Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			

Question #	Name of Family Member (as identified on physician record)	Name of Hospital, Clinic and/or Person Providing Care	Phone number
Date Treatment Started (month/year)	Date Ended	<input type="checkbox"/> Still Under Treatment	
Name of Condition/Illness			
Results of Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			

To provide further information, please use additional sheets if necessary. List the page number, section name and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

	Number of sheets attached
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**6C. Prescription Medications**

List all medications taken within the last 12 months by any family member listed on this application.

Applicant Social Security or ID Number									

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (mm/dd/yy)	Date Discontinued (mm/dd/yy)	Name, Phone Number of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____

**TO BE COMPLETED BY YOUR ANTHEM BLUE CROSS AND BLUE SHIELD-APPOINTED AGENT**

- Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that might have a bearing on the risk? .....  Yes  No  
If yes, please attach explanation.
- Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? .....  Yes  No  
If no, please explain: \_\_\_\_\_

To the extent not already identified in Section 3 of this application, I have listed in an attachment to this application any other accident or sickness policies I have sold to the applicants in the past five years. With respect to those policies listed on the attachment, I will also identify those that are currently in force.

Signature of Agent (required)	Date (required)
X	

- Breakdown of Funds Collected:**

Total Medical Funds	\$	_____
Total Dental Funds	\$	_____
<b>Total Funds Collected</b>	<b>\$</b>	<b>_____</b>
- Was the term life insurance option selected? (If yes, first term life insurance payment will be billed.) .....  Yes  No

Gary E. Jackson		1344 Disc Dr. #210	
Agent ID Number FGGPMHNMLY	Sub-agent ID Number	City/State/ZIP Code Sparks, NV 89436	Location Number
Phone Number (800 ) 721-2618	Fax Number (800 ) 905-6750	E-mail Address service@justhealthplans.com	

**Mailing Address: Agent:** Please mail this application to the following address: **Anthem Blue Cross and Blue Shield • P.O. Box 173334 • Denver, CO 80217-9411**

**Effective Date**  
**REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING WILL BE COMPLETED BEFORE THE DATE REQUESTED.**

If Anthem Blue Cross and Blue Shield approves my application, please assign an effective date of \_\_\_\_\_.  
 The effective date must be after the signature date but not greater than 75 days from the signature date on this application.

If Anthem Blue Cross and Blue Shield approves my application, please assign an effective date of the first day after Anthem Blue Cross and Blue Shield approval.

Please note: If you are changing existing Anthem coverage, your effective date will always be the first of the month following approval.



**7. Application Understandings, Conditions and Agreement**

Applicant Social Security or ID Number									

**IMPORTANT: It is important that you carefully read and fully understand the following.**

**All applicants age 18 and over must personally read, agree to and sign the following.**

I, the undersigned, understand that under the Anthem Blue Cross and Blue Shield plan for which I am applying, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use an in-network hospital or physician.

**CURRENT HEALTH COVERAGE: If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.**

**Agreement**

**By applying for coverage, I, the undersigned, agree to the following:**

1. Anthem Blue Cross and Blue Shield may decline my application. No coverage comes into effect until Anthem approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem at its discretion.
2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, I will not be entitled to benefits or coverage from Anthem.
3. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and Blue Shield underwriting policy or the terms of any Anthem coverage.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. Court documents establishing guardianship must be submitted if the responsible adult is not the parent.
5. In no event shall Anthem Blue Cross and Blue Shield or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the money submitted with this application if this application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by Anthem.
6. I understand Anthem Blue Cross and Blue Shield may use any information prior to the effective date of coverage in considering my application, including medical conditions that occur after my signature and before the original effective date.

I agree to update Anthem in writing with any additional medical history which relates to any of the preceding questions and of which I became aware after the date of this application, but before the effective date of coverage.

**Rescission of Membership**

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if I provided incomplete or false material information, Anthem Blue Cross and Blue Shield may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if incomplete or false material information is discovered by Anthem that was not provided to Anthem prior to the effective date of the policy, the plan may revoke coverage.

I understand that if my coverage is revoked, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and

considered for enrollment. I also understand that I may be required to pay for any claims that were paid while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem.

**I have personally read and completed this application.** If I am accepted, this application will become part of the contract between Anthem Blue Cross and Blue Shield and me. I agree to abide by the terms of that contract.

**Requirement for Binding Arbitration:**

**I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND ME MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT. UNDER THIS BINDING ARBITRATION REQUIREMENT, ANTHEM AND I ARE GIVING UP THE CONSTITUTIONAL RIGHT TO HAVE THE DISPUTE DECIDED IN A COURT OF LAW BY A JURY.**

**BEFORE COMMENCING ARBITRATION, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.**

**IMPORTANT NOTICE REGARDING THE REPLACEMENT OF YOUR POLICY OF LIFE INSURANCE**

You may have been offered a policy to replace all or part of your existing policy of life insurance.

Before you replace your existing policy you should consider whether you could suffer a Financial Loss under the new policy because of your Age or the condition of your Health. You should also consider whether you will pay more for premiums because of your age or health.

You Will incur additional costs to acquire the new policy, including the payment of commissions to the agent advocating the replacement of your existing policy.

To make an informed decision about the replacement of your policy, you should discuss the provisions of your existing policy with your agent or the company which issued it to determine whether your policy can be changed to meet your present needs.

Your new policy provides 10 days for you to decide whether you wish to keep it.

The agent who is offering to replace your existing policy is required to obtain your signature on this notice. Also, he will be notifying your existing insurance company that you are considering the replacement of your policy.

I have read this notice and received a copy of it for my records.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE VOLUNTARILY AGREEING TO HAVE ANY DISPUTE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL**

**Signature (Required) – IMPORTANT: All applicants over age 18 must sign and date. A parent or legal guardian must sign and date if applicant is under 18.**

Applicant/Parent or Legal Guardian	Today's Date	Applicant's Spouse	Today's Date
Applicant's Dependent, Age 18 or Older	Today's Date	Applicant's Dependent, Age 18 or Older	Today's Date



**8. Payment Method (Premium payment required. Please choose from A or B.)**

**A. Please choose from the following options for future payments. If you choose one of these options, you are not required to send in a check for initial payment**

- Monthly Checking Account Automatic Premium Payment (complete Section 8C)       Monthly Credit/Debit Card (complete Section 8D)

**B. Please choose from the options below for your initial premium payment. If you choose one of these options, you will receive a bill every month thereafter.**

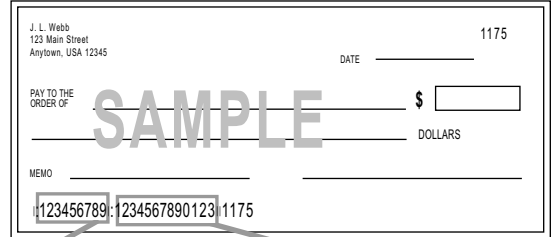
- Paper Check\*       Electronic Check (complete Section 8E)       Credit/Debit Card (complete Section 8D)

**8C. Monthly Checking Account Automatic Premium Payment**

By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not sent in an initial premium payment from choice B, your bank account will be debited one month's premium the day after approval. This will include all products selected, including dental and/or life. Subsequent premium amounts will be debited on the day you request below.

Requested debit day:   (1st to 28th of each month) If no date is requested, your premiums will be debited on the first of each month.

Provide your routing and account numbers here.



9-Digit Bank Routing Number

Bank Account Number

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from monthly checking account automatic premium payment and will be billed monthly.

**You will incur a \$15.00 service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name PRINT	Date
X		

**8D. Monthly Credit/Debit Card**

As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. We accept Visa, MasterCard, Discover and Star\*. For Star, we accept 16 digit card numbers only.

Card Number:       Expiration Date:  /       Cardholder ZIP Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card) PRINT	Date
X		

**8E. Electronic Check**

In lieu of sending a paper check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name PRINT	Bank Routing Number	Account Number	Amount \$	Check Number

\* By sending your paper check, you authorize us to convert your check to an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.



# Authorization for Use of Protected Health Information

By signing below:

I authorize Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield, to obtain any medical records (but not including psychotherapy notes) from any physicians, hospitals and/or other health care providers concerning my care and the care of any family member listed on my Individual Enrollment Application.

I also authorize any physicians, hospitals and/or other health care providers to furnish any medical records (but not including psychotherapy notes) concerning my care and the care of any family member listed on my Individual Enrollment Application to Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield. This information is needed to determine eligibility for the coverage requested for myself and/or any family members listed on my Individual Enrollment Application.

I understand that the entities indicated above may request medical records for up to the past 10 years, and this information will be used to determine whether I and my listed family members are eligible for enrollment in the coverage requested.

I understand that this form must be signed and returned with my completed Individual Enrollment Application if I am initially applying for enrollment in a medically underwritten health plan offered by Anthem Blue

Cross and Blue Shield or its affiliate, Anthem Life Insurance Company, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage. This authorization will expire when determination is completed regarding my/our eligibility for coverage.

I understand that I may revoke this authorization at any time while Anthem Blue Cross and Blue Shield is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross and Blue Shield. An Authorization Revocation Form is available by writing to: Anthem Blue Cross and Blue Shield, P.O. Box 173334, Denver, CO 80217-9411. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered by Anthem Blue Cross and Blue Shield for enrollment in one of its medically underwritten health plans. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made.

Printed Name of Applicant/Member	Signature of Applicant/Member or His/Her Personal Representative	Date

Printed Name of Spouse or Dependent Child Age 18 or Over Listed on Application	Signature of Spouse/Dependent Child* or His/Her Personal Representative	Date

Printed Name of Spouse or Dependent Child Age 18 or Over Listed on Application	Signature of Spouse/Dependent Child* or His/Her Personal Representative	Date

*\*If listed on your Individual Enrollment Form, your spouse and each dependent child age 18 or over must sign above.*

If this authorization is signed by a personal representative on behalf of the applicant/member, spouse and/or dependent child(ren), the representative must complete the following:

Printed Name of Personal Representative	Relationship to Applicant/Member, Spouse and/or Dependent Child(ren)	Date

*A photocopy of this form will be as valid as the original.  
You have the right to receive a copy of this authorization upon request.*

