



CONVERSION APPLICATION

Check the Plan for which you are eligible: **Plan 1** - \$1,000 Deductible with Maternity Benefits
 Plan 2 - \$1,000 Deductible without Maternity Benefits

Please follow instructions carefully. Inaccurate, incomplete or illegible applications will be returned.

1. MUST BE COMPLETED BY THE APPLICANT
2. PRINT IN BLUE OR BLACK INK
3. COMPLETE ALL APPLICABLE AREAS
4. ATTACH CHECK FOR QUARTERLY OR SUREPAY PREMIUM
(If SUREPAY, also attach Authorization Form and a copy of your "voided" check.)

PREVIOUS COVERAGE INFORMATION – In the spaces below, please provide information about the policy and coverage from which you are converting.

Name of BlueCross and/or BlueShield Company:		
Policy Number of Previous Coverage:	State:	BC/BS Telephone No: () _____-_____
Original Effective Date of Previous Coverage:	Prior Coverage Termination Date:	
Class of Coverage: <input type="checkbox"/> Group <input type="checkbox"/> Individual	If group, employer/company name:	
Were you continuously covered for at least six months prior to your termination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Status at time of transfer: <input type="checkbox"/> Single Only <input type="checkbox"/> Two Party <input type="checkbox"/> Family	

Applicant's Name: Last First Initial

Were children under age 26 covered under your previous plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage: <input type="checkbox"/> Comp/Major/Medical <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other: _____
Was Maternity a covered benefit under your previous plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Mailing Address

City State ZIP Code

Applicant's Phone Number:
() _____-_____

First Names of Dependents covered under previous plan:

Current Family Status: Single Married
 Divorced Widowed

INDIVIDUAL AND FAMILY INFORMATION - REQUIRED FOR ALL PERSONS TO BE COVERED

Family Members Applying for Coverage (Note Child's Last Name if Different)	Check Relationship	Birth Date Month Day Year	Social Security Number
Applicant	Self Male <input type="checkbox"/> Female <input type="checkbox"/>		
Lawful Spouse	Husband <input type="checkbox"/> Wife <input type="checkbox"/>		
Children (under 26, eldest first)	Daughter <input type="checkbox"/> Son <input type="checkbox"/>		
	Daughter <input type="checkbox"/> Son <input type="checkbox"/>		
	Daughter <input type="checkbox"/> Son <input type="checkbox"/>		

1 Are all family members previously covered included on this application? Yes No
 If "No" state name of dependent(s) not included and the reason: _____

2 Do you or any listed family members have any other health coverage? Yes No
 If "Yes" note below their names, insurance company, and employer if covered through a group: _____

Signature of Applicant: _____ Date: _____