



**MAJOR RISK  
MEDICAL INSURANCE PROGRAM  
REQUEST**

**Please return this form to the following address:**

Blue Cross of California  
P.O. Box 9041  
Oxnard, CA 93031-9041

**Or send fax to: (805) 713-8829**

- One applicant per form
- Applicant must be 64 years, 9 months old or younger

**PLEASE PRINT**

NAME OF APPLICANT		<input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	SOCIAL SECURITY NO.	
ADDRESS		CITY		STATE	ZIP CODE
PHONE NO.	HEIGHT		WEIGHT		SMOKER <input type="checkbox"/> Yes <input type="checkbox"/> No

DIAGNOSIS
CURRENT TREATMENT
PENDING TREATMENT
CURRENT MEDICATION(S) BEING TAKEN

I understand that due to my medical history listed above, I am not eligible for Blue Cross of California's Individual PPO or HMO plans.  
Please send the Major Risk Medical Insurance Program letter and application to the above address.

APPLICANT'S SIGNATURE <b>X</b>	DATE
AGENT'S NAME (please print)	AGENT'S I.D. NO.
AGENT'S PHONE NO.	AGENT'S FAX NO.

FOR HOME OFFICE USE ONLY			
UNDERWRITER REVIEWED BY:	<input type="checkbox"/> Accept <input type="checkbox"/> Decline	LETTER SENT <input type="checkbox"/> Y <input type="checkbox"/> N	DATE