



SelecTEMP® PPO

Temporary Individual Coverage

Application for Comprehensive Major Medical Insurance
Please Print all information in blue or black ink.

Home office use only

Requested Effective Date

MM/DD/YY

P.O. Box 2034, Aurora, IL 60507-2034
(888) 697-0683

Your Information

Applicant's First Name, M.I., Last Name	Sex	Birth Date	Age	Social Security Number
Street Address	City	State	ZIP Code	
Home Telephone Number	Work Telephone Number			
Dependents to be Covered (First Name, M.I., Last Name)	Sex	Birth Date	Age	Social Security Number

Children you wish to cover must be unmarried, at least 60 days of age, and less than 25 years of age.

Plan Selection and Benefit Period – Which plan would you like to select and for how long?

I (we) hereby apply for: Benefit Period: 1 month 2 months 3 months 4 months 5 months 6 months

Deductible Amount: \$500 \$1,000 \$1,500 \$2,000 \$2,500

Total Premium Due \$ _____ Make your check payable to **Blue Cross and Blue Shield of Texas**. Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.

Method of Payment – Which method of payment do you prefer?

- Single Payment Plan Available for 1-6 month benefit periods. The entire premium must be submitted with the application.
- Monthly Bank Draft Available for 2-6 month benefit periods. The first month of premium must be submitted with the application along with a completed Bank Draft Authorization Request Form and a blank check marked "VOID."

➔ **Are you or any person to be insured a U.S. citizen or a permanent resident living in the United States for at least 2 years?** Yes No
If the answer is "No" the coverage cannot be issued.

Health Information – Tell us about yourself.

If the answer is "Yes" to any of the following questions, this coverage cannot be issued.

- Is any female to be covered now pregnant **or** is any male to be covered an expectant parent? Yes No
- In the past five years, has any person applying for coverage been advised, consulted, tested, diagnosed, treated, hospitalized, taken medication for, or been recommended for treatment for any of the following: heart or circulatory system disorder, including heart attack or stroke; diabetes; cancer or tumors; disorder of the blood; kidney or liver disorder; mental or nervous conditions or disorders; alcoholism or alcohol abuse; drug abuse, addiction or dependency; organ transplant? Yes No
- Has any person applying for coverage been diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS-related complex; or has any person applying for coverage in the past five years tested positive for HIV virus (ELISA or Western Blot)? Yes No
- Do you or any person named on this application plan on participating in motor vehicle or boat racing; mountain climbing; bungee jumping; hang gliding or sky diving during this coverage? Yes No
- Do you or anyone else who will be insured by this contract plan to reside outside of Texas during this coverage? Yes No

Acknowledgment: I have read this application and to the best of my knowledge, the statements and answers are true and complete. I understand that fraud or any intentional misrepresentation of a material fact may result in the loss of coverage under this contract. I also understand that: 1) Blue Cross and Blue Shield of Texas will provide no coverage until my application is accepted and the correct premium is received by Blue Cross and Blue Shield of Texas; 2) this contract will pay no benefits for any illness, accident or physical impairments which existed or occurred within two years prior to the effective date; 3) if the contract is issued, it will not be a continuation of any previous medical plan, including any prior short term coverage; **4) if my completed application is approved, the coverage will take effect on the later of: (a) the requested effective date; or (b) the day after the postmark date affixed by the U.S. Postal Office. If the envelope containing the application is not postmarked, or the postmark is not legible, the effective date will be the later of: (a) the requested effective date; or (b) the date the completed application is received by Blue Cross and Blue Shield of Texas.**

Health Authorization: I authorize any hospital, physician, provider, clinic or medical related facility, governmental agency, insurance carrier, group health plan or other entity to give Blue Cross and Blue Shield of Texas (BCBSTX) the Company or its authorized representative, upon request, any information concerning the health condition of any person listed on this application whenever such information is considered necessary by the Company for the proper disposition of this application.

I understand that this authorization is voluntary and that my signature is required for the Company to consider this application and to make a determination on whether to accept and issue the coverage applied for herein and that without my signed authorization no action will be taken on this 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 by the Company 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.

The undersigned Applicant further acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an Individual Policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if **he/she desires** additional information regarding any commissions or other compensation paid the agent by the Company in connection with the issuance of the Individual Policy, they should contact the agent.

Applicant's Signature (If Applicant is under the age of 18, parent or guardian's signature) _____ Date _____

Spouse's Signature _____ Date _____

Dependent's Signature (age 18 and over) _____ Date _____

Agency Name _____ Agent Address _____ City _____ State _____ ZIP Code _____ (Area Code) FAX Number _____

Agent Name _____ Agent Number _____ Signature _____ (Area Code) Telephone Number _____ Date _____