BlueCross BlueShield of Illinois

P.O. Box 3236, Naperville, IL 60566-7236
Apply via fax: 1-630-328-4505

SelecTEMP®′ PPO

Short -Term Limited Duration Coverage

HOME OFFICE USE ONLY

APPLICATION FOR MAJOR MEDICAL INSURANCE

Please print all information in **blue or black ink.** Pencil will not be accepted.

Requested Effective Date ___/___/___ Mo. / Day / Yr.

PERSON(S) APPLYING FOR COVERAGE (please print)

IMPORTANT: Are all persons to be insured U.S. citizens or permanent residents living in the United States for at least 2 years? ☐ **Yes** ☐ **No**
If the answer is "No" the coverage cannot be issued to any person not meeting this requirement.

Primary Applicant First Name, M.I., Last Name	Sex ☐ M ☐ F	Birth Date (Mo./Day/Yr.) / /	Age	Social Security Number – –
Residential Street Address	City		State	ZIP Code

Home Phone #	Work Phone #	Cell Phone #	Fax # *(if available)*	E-mail *(if available)*
( )	( )	( )	( )	

Spouse and Dependents to be Covered (First Name, M.I., Last Name)	Sex	Birth Date (Mo./Day/Yr.)	Age	Social Security Number	Full Time Student
	☐ M ☐ F	/ /		– –	☐ Yes ☐ No
	☐ M ☐ F	/ /		– –	☐ Yes ☐ No
	☐ M ☐ F	/ /		– –	☐ Yes ☐ No
	☐ M ☐ F	/ /		– –	☐ Yes ☐ No

Information for additional dependent children must be provided on a separate page and be signed and dated. Children must be unmarried, at least 60 days of age, under age 26, or under age 30 if in the military. For child only coverage the child must be at least one year of age.

DEDUCTIBLE SELECTION AND BENEFIT PERIOD (please choose one benefit period and one deductible amount)

I (we) hereby apply for:

Benefit Period: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months ☐ 7 months ☐ 8 months ☐ 9 months ☐ 10 months ☐ 11 months

Deductible Amount: ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 ☐ $5,000

HEALTH INFORMATION – Every question must be answered.

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

1. Do you or any person to be covered have hospital, major medical, group health, government or medical insurance coverage that will not terminate prior to the effective date of this coverage? ☐ **Yes** ☐ **No**
2. Is any female to be covered now pregnant or is any male to be covered an expectant parent? ☐ **Yes** ☐ **No**
3. In the past five years, has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized, taken medication for, or been recommended for treatment for any of the following: heart or circulatory disorder (including heart attack, stroke, or uncontrolled blood pressure, but excluding elevated cholesterol or lipids); 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**
4. Has any person applying for coverage ever been diagnosed or treated by a physician for, acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC); or has any person applying for coverage in the past five years tested positive for HIV virus (ELISA or Western Blot), or other immune disorders? ☐ **Yes** ☐ **No**

Representations, Acknowledgments and Authorizations: I have read all statements on this application and represent that they are true and complete. I understand that failure to disclose information on this application may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of Blue Cross and Blue Shield of Illinois. 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 Illinois will provide no coverage until my application is accepted and the correct premium is received by Blue Cross and Blue Shield of Illinois; 2) this contract will pay no benefits for any illness, accident or physical impairments which existed or occurred within 12 months 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 Illinois; (c) the date an online application is submitted.**

Medical Authorization: I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, or other medical or medically related facility, governmental agency or other person or firm, to disclose to BCBSIL or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs or alcohol. I also authorize release of information relating to mental illness. In addition, I authorize BCBSIL to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

APPLICANT'S SIGNATURE(S)

IMPORTANT: Your application must be signed and dated by <u>all</u> applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant Signature: X _____ **Date Signed:** ____ /____ /____ Mo./Day/Yr.

Spouse Signature
(ONLY if to be insured): X _____ **Date Signed:** ____ /____ /____ Mo./Day/Yr.

Parent/Guardian Signature
(If Primary Applicant is UNDER the age of 18): X _____ **Date Signed:** ____ /____ /____ Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____ /____ /____ Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____ /____ /____ Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____ /____ /____ Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): X _____ **Date Signed:** ____ /____ /____ Mo./Day/Yr.

If any question(s), you may **(1)** call our Customer Service Department toll-free at **1-800-654-7385**, or **(2)** call your insurance agent at their number below, or **(3)** visit **www.bcbsil.com**.

PREMIUM PAYMENT

The entire premium must be submitted with the application. If faxing the application, be sure to include a completed Automatic Payment Authorization form.

HOW TO CALCULATE RATES

Step 1 Determine your area based on the ZIP code from the ZIP code area listing in the book.

Step 2 Select the rate chart that corresponds to your sex. Find the rate corresponding to the chosen deductible ($500, $1,000, $1,500, $2,000, $2,500 or $5,000), your area and age.

Step 3 Select the rate chart that corresponds to your spouse's sex. Find the rate corresponding to the chosen deductible ($500, $1,000, $1,500, $2,000, $2,500 or $5,000), your spouse's area and age.

Step 4 Find the appropriate child(ren) rate by checking the deductible, area and selecting: 1 child or 2+ children.

Note: If only children are applying, use one application per child. Do not use the dependent rates.

Select the rate chart that corresponds to the child's sex. Find the rate corresponding to the chosen deductible ($500, $1,000, $1,500, $2,000, $2,500 or $5,000), the child's area and age.

Step 5 Add the rates for you, your spouse, if applicable, and your child(ren), if applicable, using the rate calculator at right.

Step 6 Multiply the total from Step 5 by the number of months of coverage you need (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 months).

Step 7 This is the total premium for the coverage period selected.

RATE CALCULATOR

Applicant Rate	$_____
	+
Spouse's Rate	$_____
	+
Child(ren) Rate	$_____
	=
Total Monthly Rate	$_____
	X
Coverage Period (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 months)	_____ months
	=
Total Premium Due	$_____

Make your check payable to: Blue Cross and Blue Shield of Illinois.

Premium Amount Enclosed $_____

Note: Deductibles are per person, per benefit period. There is no deductible credit or carry over from one Contract to another.

AGENT INFORMATION (if applicable)

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

Agent Signature: X _____ **Date Signed:** _____ /_____ /_____ Mo./Day/Yr.

Print Agent Name: Randal Sable **Agent Code:** 045739000

Agent Phone Number: (847) 905-1915 **Agent Fax Number:** (847) 905-1915

Agent Email Address: rsable@totalbenefitservices.com **Mail Policy(ies) to:** ☑ **Agent** ☑ **Applicant**