



SelectTEMP[®] 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 Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.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?
If the answer is "No" the coverage cannot be issued. Yes No

Health Information - Tell us about yourself.

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

1. Is any female to be covered now pregnant or is any male to be covered an expectant parent? Yes No

2. 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

3. Has any person applying for coverage been diagnosed 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

4. 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

5. 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 _____

Clark Insurance Associates 7548 Preston, #141-101 Frisco, TX 75034 (972).977.2057	Agent Address	City	State	ZIP Code	(Area Code) FAX Number 469-467-9055
Agent Number 000011150	Signature	(Area Code) Telephone Number	Date		

How to Calculate Rates

- Step 1** Determine your area based on the first three digits of your ZIP code from the ZIP code area listing below.
- 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 or \$2,500), 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 or \$2,500), your spouse's area and age.
- Step 4** Find the appropriate child(ren) rate by checking the deductible, area and selecting: 1 child, 2 children or 3 or more children.*
- Step 5** Add the rates for you, your spouse, if applicable, and your child(ren), if applicable.
- Step 6** Multiply the total from Step 5 by the number of months of coverage you need (1, 2, 3, 4, 5 or 6 months).
- Step 7** This is the total premium for the coverage period selected.

IMPORTANT

- Step 8** The total premium must be submitted with the application unless you have chosen the Monthly Bank Draft option. The Monthly Bank Draft option is available to the applicant who selects a 2- to 6-month coverage period. A check for the first month of premium must accompany the application. A blank check marked "VOID" and Bank Draft Authorization Request Form **MUST** also be included with the application. **A deposit slip is not acceptable.**

*Children applying without a parent or guardian must submit one application per child.

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

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

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

ZIP CODE AREA LISTING

Area 1
788, 798, 799, 885

Area 2
759, 764-767, 780-782, 785, 790

Area 3
733, 757, 758, 760, 761, 763, 768-772, 774, 775, 778, 783, 784, 786, 787, 789, 791, 792, 795-797

Area 4
751, 755, 756, 773, 776, 777, 793, 794

Area 5
750, 752-754, 762, 779

Monthly Premium Rates for Area 1

Zip Codes 788, 798, 799, 885

		MALE					
		Deductible	\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1		165	115	93	84	77
	1-4		66	46	37	34	31
	5-12		52	36	29	26	24
	13-19		57	40	32	29	27
	20-24		68	48	38	35	32
	25-29		73	50	41	37	34
	30-34		81	56	46	41	38
	35-39		94	65	53	48	44
	40-44		113	78	63	57	52
	45-49		136	94	76	69	63
	50-54		164	114	92	84	76
55-59		216	150	122	110	101	
60-64		288	200	162	147	134	

		FEMALE					
		Deductible	\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1		179	124	101	91	83
	1-4		52	36	29	26	24
	5-12		41	29	23	21	19
	13-19		65	45	36	33	30
	20-24		88	61	50	45	41
	25-29		96	67	54	49	45
	30-34		109	76	62	56	51
	35-39		126	88	71	64	59
	40-44		145	101	81	74	67
	45-49		164	114	92	84	76
	50-54		185	129	104	94	86
55-59		210	146	118	107	98	
60-64		246	171	138	125	114	

CHILD ADD-ON

Deductible	\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child	59	41	33	30	27
2 Children	106	74	59	54	49
3 or More	130	90	73	66	59