



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

Empty box for 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.

Form with fields for Primary Applicant (Name, Sex, Birth Date, Age, Social Security Number, Address, City, State, ZIP Code, Home Phone, Work Phone, Cell Phone, Fax #, E-mail) and Spouse/Dependents (Name, Sex, Birth Date, Age, Social Security Number, Full Time Student).

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
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... [ ] 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)... [ ] Yes [ ] No
5. Has any person applying for coverage been declined for insurance due to health reasons within the past 18 months? [ ] 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 all 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 or 6 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<br>(1, 2, 3, 4, 5, 6 months)                               | _____ months |
|  | =            |
| Total Premium Due  | \$ _____     |
| <b>Make your check payable to: Blue Cross and Blue Shield of Illinois.</b> |              |
| 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: \_\_\_\_\_ Agent Code: \_\_\_\_\_

Agent Phone Number: ( ) \_\_\_\_\_ Agent Fax Number: ( ) \_\_\_\_\_

Agent Email Address: \_\_\_\_\_ Mail Policy(ies) to:  Agent  Applicant



**Take these simple steps for hassle-free monthly premium payments:**

- Verify with your financial institution that it can accept automated electronic withdrawals.
- Complete, sign and return this authorization form.
- If submitting by fax, please fax this form to **1-800-625-5916**.
- If submitting this form by mail, please use this address:

**Blue Cross and Blue Shield of Illinois  
P.O. Box 3236  
Naperville, IL 60566-9708**

If you have any questions about this program, please call our Member Service Department toll-free at **1-800-538-8833**.

**AGREEMENT**

I request and authorize Blue Cross and Blue Shield (BCBS) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This authorization will remain in effect until I notify BCBS or the Financial Institution in writing to terminate and BCBS or the Financial Institution has a reasonable time to act on the termination.

**Please complete the following – Print or Type information**

- Yes**    **No**   Deduct the initial premium payment only from my checking or savings account.
- Yes**    **No**   Deduct ongoing monthly premium payments only from my checking or savings account.
- Yes**    **No**   Deduct both the initial premium payment and ongoing monthly payments from my checking or savings account.
- Yes**    **No**   **SelecTEMP<sup>SM</sup> PPO only** – Upon receipt and approval of my SelecTEMP PPO application, please deduct the premiums due for the length of coverage designated.

An initial premium payment will draft upon receipt of the application. Ongoing premium drafts will be drawn on the preferred draft date (if specified below). If a preferred draft date is not selected, drafts will be drawn on the date the premium is due. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day.

(Please note that coverage cannot be issued until the first month of premium has been received in our office, unless you have authorized BCBSIL to deduct the initial payment upon receipt of your application.)

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Preferred Draft Date. It must be on or prior to the premium due date. If the selected preferred draft date falls after the premium due date, the monthly premium will be drawn on the date premium is due.  
MM   DD   YYYY  
(Cannot be the 29th, 30th or 31st.)

BCBS Member ID/Applicant's Social Security Number: \_\_\_\_\_

Name of Member/Applicant: \_\_\_\_\_

Name of Depositor(s) if other than the member/applicant: \_\_\_\_\_

Phone number of Member/Applicant/Depositor: \_\_\_\_\_

Name of Bank, City and State where account is authorized: \_\_\_\_\_  
\_\_\_\_\_

Please check one:    Checking Account    Savings Account

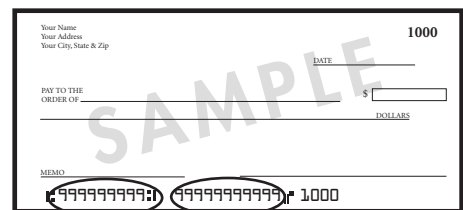
Bank Transit Number: \_\_\_\_\_

Depositor's Account Number: \_\_\_\_\_

**I have read and accept the above agreement.**

**Please continue to pay your premiums by check or money order until you receive a confirmation letter from us stating the date automatic payments will begin.**

Bank check – bottom left corner



Bank Transit Number   Depositor's Account

Depositor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# CONDITIONAL RECEIPT FOR



**BlueCross BlueShield of Illinois**

*Experience. Wellness. Everywhere.®*

Proposed Insured: \_\_\_\_\_

Date of Application: \_\_\_\_\_ Amount Received: \_\_\_\_\_ Date of Receipt: \_\_\_\_\_

**NO INSURANCE WILL BECOME EFFECTIVE UNLESS EACH AND EVERY CONDITION CONTAINED IN THIS RECEIPT IS MET. NO PRODUCER IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS.**

Subject to the limitations shown below, insurance will become effective under the receipt if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Health Care Service Corporation, a Mutual Legal Reserve Company (Blue Cross and Blue Shield of Illinois), hereafter "HCSC," at its Home Office (or the office of the designated administrator).
2. The first full premium, according to the mode of premium payment chosen, has been paid and the check is honored on first presentation for payment.  
"An effective date in compliance with HCSC guidelines" means the latter of:
  - a. The requested coverage date, if any, shown on the application; or
  - b. The date upon which the application is approved by HCSC at its Home Office (or office of the designated administrator).
3. The policy is issued by HCSC exactly as applied for within 60 days from date of application, delivered, and accepted by the proposed insured.

Limitation:

This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided herein. In the event HCSC declines to issue a policy as applied for, the amount received by HCSC will be refunded.

Signature of Secretary

Signature of Producer

Producer's Code: \_\_\_\_\_

Blue Cross and Blue Shield of Illinois  
PO Box 3236  
Naperville, Illinois 60566-7236

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF ILLINOIS. DO NOT PAY CASH OR MAKE CHECKS PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.**

If you do not hear from HCSC regarding the proposed insurance within 30 days, please call 1-800-538-8833.

**THIS FORM LIMITS OUR LIABILITY. BE SURE TO READ AND SIGN THE APPLICATION AND, IF DESIRED, THE AUTOMATIC PAYMENT REQUEST FORM. KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.**