

Blue Shield of California Life & Health Insurance Company

Non-Renewable Short-Term Health Insurance Application



Blue Shield
of California
Life & Health
Insurance Company
An Independent Licensee
of the Blue Shield Association

Option Twelve Monthly Payment Plan

Complete this form in full. Mail the application along with your check (payable to Blue Shield Life) or your Credit Card Authorization to Blue Shield Life:

Blue Shield Life
P.O. Box 750309
Petaluma, CA 94975-0309

Fax: 707-778-0425
(Use fax # only when paying by credit card)
Phone: 800-443-8284

For producers: Producer # or Tax ID

APPLICANT INFORMATION: (Please print or type)

APPLICANT'S LAST NAME	FIRST	MI	SOCIAL SECURITY NO.
HOME TELEPHONE	EMAIL		DATE OF BIRTH
HOME ADDRESS			CITY
COUNTY	STATE CA	ZIP CODE	
BILLING ADDRESS			CITY
COUNTY	STATE	ZIP CODE	
ARE YOU EMPLOYED? YES <input type="checkbox"/> NO <input type="checkbox"/>	IF YES, COMPLETE NAME AND ADDRESS OF EMPLOYER		
ARE YOU APPLYING FOR A BLUE SHIELD OF CALIFORNIA HMO OR INDIVIDUAL OR FAMILY PLAN TO BEGIN WHEN OPTION TWELVE COVERAGE ENDS? YES <input type="checkbox"/> NO <input type="checkbox"/>			

Please Note: • If parents/guardians are not applying for coverage, a separate application must be completed for each child.
• This policy will not cover anyone who is under 15 days of age, or over 64 years and six months of age on the policy effective date.

LIST APPLICANT AND ALL ELIGIBLE FAMILY MEMBERS APPLYING FOR COVERAGE:

LAST NAME	FIRST	MI	SOCIAL SECURITY NO.	SEX M F	BIRTH DATE MO/DAY/YR	PREMIUM
1. APPLICANT						\$
2. SPOUSE/DOMESTIC PARTNER						\$
3. CHILD						\$
4. CHILD						
5. CHILD						

MONTHLY PREMIUM DUE \$ _____

PLAN SELECTIONS:

A. DEDUCTIBLE

\$500 \$1,000 \$1,500 \$2,000 \$3,000

B. POLICY EFFECTIVE DATE

If you are approved, coverage will begin at 12:01 a.m. on the date following the U.S. Postal Service postmark date stamped on the envelope to Blue Shield Life or, if the application is faxed, the day after the fax is received by Blue Shield Life. Coverage can also begin on a future effective date that you specify (within 45 days):

Effective Date: _____

(Postmark date must precede requested effective date. Exceptions are not permitted.)

PAYMENT METHOD:

Check VISA Mastercard American Express

IMPORTANT – Total premium due by check or credit card authorization must accompany application and will be held while this application is evaluated by Blue Shield Life.

IF PAYING BY CREDITCARD – I authorize Blue Shield Life to bill my account for the first month's premium.*

ACCOUNT NO. _____
PLEASE PRINT CREDIT CARD NUMBER CLEARLY

EXP. DATE ____/____/____ CARDHOLDER NAME: _____

SIGNATURE _____

*Your credit card will be charged for the first month only. You will receive a premium notice for future payments and may pay by check or money order only.

ELIGIBILITY: (Answer the following questions completely and accurately)

1. a. Have all applicants resided within the United States continuously for the past six months?
[If YES, skip to Question 2. If NO, please answer Question 1b.] YES NO
 b. If any applicant has not resided continuously in the U.S. for the past six months, is that applicant a U.S. citizen or permanent resident?
[If YES, continue to Question 2. If NO, you are not eligible for this policy.] YES NO
IF YOU ANSWER "YES" TO ANY QUESTIONS FROM 2 – 12, YOU ARE NOT ELIGIBLE FOR THIS POLICY.*
2. Is any female listed on this application currently pregnant, or in the process of adoption or surrogate pregnancy?
[Note: Please answer "no" to this question if there are no females on the application] YES NO
3. Is any male listed on this application expecting a child, or in the process of adoption or surrogate pregnancy with anyone, even if the mother is not listed on the application?
[Note: Please answer "no" to this question if there are no males on the application] YES NO
4. In the past 30 days, have you or any person applying been seen by a member of the medical profession or been hospital confined? YES NO
5. In the past twelve months, have you or any person to be insured been recommended by a health care professional to have or been scheduled for diagnostic testing, treatment or surgery including elective surgery that has not been completed? YES NO
6. Have you or any person applying received any medical or surgical consultation, advice or treatment, including medication, within the last 5 years for: heart or circulatory system disorders, including heart attack or chest pain; stroke; disorders of the blood, including hemophilia and leukemia; diabetes; cancer, skin cancer or tumor; chronic obstructive pulmonary disease; emphysema; alcoholism or alcohol abuse; drug abuse or chemical dependency; auto-immune diseases including lupus; or non-AIDS related immune system disorders? YES NO
7. Have you or any person applying received any medical or surgical consultation, advice or treatment, including medication, within the last 5 years for any organ transplant, kidney disease or liver disorder? YES NO
8. Have you or any person applying been treated for or diagnosed with acquired immune deficiency syndrome (AIDS)? YES NO
9. Have you or any person applying had one or more of the following symptoms:
 - a. within the last 3 months, an unplanned weight loss greater than 10 pounds? YES NO
 - b. within the last 6 months, a persistent fever or fatigue of unknown cause for 2 weeks or more; change in the size, shape or color of a mole; persistent pain lasting for two weeks or more, including but not limited to back, neck, joint, pelvic or abdominal pain? YES NO
 - c. within the last month, a change in bowel or bladder function such as, but not limited to chronic constipation or diarrhea, or increase or decrease in frequency of urination? YES NO
10. Have you or any person applying enrolled in training for or engaged in an occupation involving unusual hazards, and not covered by workers' compensation insurance? YES NO
11. During the policy term, will you or any person applying train for or participate in a: (1) team or individual sports activity as a professional; (2) national or international competition as an amateur; or (3) collegiate sports activity? YES NO
12. Do you or any person applying have any hospital, major medical, group health, or medical insurance coverage in force that will not terminate prior to the effective date of this coverage? YES NO

***PLEASE DO NOT INCLUDE ANYONE ON THIS APPLICATION WHO WOULD ANSWER YES TO ANY OF THE QUESTIONS FROM 2-12. THOSE PERSONS ARE NOT ELIGIBLE FOR COVERAGE.**

Prior Insurance History

Blue Shield Life credits prior coverage toward the pre-existing condition limitation period for those applicants who apply and are accepted for coverage and request an effective date within 63 days after termination of qualifying prior coverage (including previous Blue Shield Life short-term policies) as specified by law. If available, please attach I.D. cards or letters of prior creditable coverage. Please list most recent coverage first. To obtain credit toward the pre-existing period, please complete the following:

HEALTH PLAN	TELEPHONE NO.	ID NUMBER	INSURED'S NUMBER	COVERAGE FROM MO/DAY/YR	COVERAGE TO MO/DAY/YR

PLEASE PROVIDE THE NAME AND ADDRESS OF THE ATTENDING PHYSICIAN OR ANY PHYSICIAN YOU OR ANY PERSON APPLYING HAVE/HAS SEEN IN THE LAST 12 MONTHS: (If more than two names, attach a separate sheet)

APPLICANT/ENROLLING FAMILY MEMBER NAME	PHYSICIAN	ADDRESS
APPLICANT/ENROLLING FAMILY MEMBER NAME	PHYSICIAN	ADDRESS

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFICIARY INFORMATION:

BENEFICIARY	RELATIONSHIP TO APPLICANT	DATE OF BIRTH	SOCIAL SECURITY NO.
STREET ADDRESS	CITY	STATE	ZIP

TERMS & CONDITIONS:

On behalf of myself and my enrolled family members, I:

- Understand that if any person applying is hospital confined on the effective date, benefits will take effect on the first day following the hospital stay.
- Understand that no insurance is in effect unless and until my application is approved by Blue Shield Life. Blue Shield Life is not liable for any medical bills incurred before the effective date of my policy.
- Understand that no benefits are payable for any expenses incurred as a result of a pre-existing condition as defined by the policy.
- Understand that my signature on this application constitutes my agreement to the terms and conditions of the short-term health plan as described in the policy and certificate of insurance, and a copy of which will be provided to me. This form, the policy and certificate of insurance, any endorsements, appendices, and attachments thereto, collectively constitute the entire agreement between the parties. Any prior agreements, promises, negotiations, or representations (including those made by any agent) relating to the subject matter of this policy not expressly set forth herein are of no force or effect.
- Understand that I am not eligible for a continuation of any previous Option One or Option Twelve short-term health insurance policy. I further understand that the policy is not renewable.
- Understand if I/we allow my/our Option Twelve Plan to terminate due to lack of payment, it will not be reinstated or continued. Should I/we later determine that my/our need for temporary health coverage continues, I/we may apply for an Option One Plan provided that the total days of coverage for all plans combined (Option One and/or Option Twelve), does not exceed 365 days. Once the 365-day limit has been reached, there is a mandatory 6-month waiting period before I/we may re-apply.
- Understand that once a policy is issued, under no circumstances will I/we be allowed to make any changes, terminate coverage for any dependents, nor will any refunds be issued beyond the 10-day free-look period.
- Understand that acceptance of an Option Twelve policy will impact my eligibility for individual guaranteed issue health insurance as established by the Health Insurance Portability and Accountability Act of 1996 if I currently have employer-sponsored coverage. The duration of my policy term may be considered creditable coverage, which can reduce the length of a pre-existing condition exclusion of a future health insurance policy.

HIV Testing Prohibited: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

I alone am responsible for the accuracy and completeness of the information provided on this enrollment form for this short-term health plan. I understand that if any information stated in this application is incorrect, false, or incomplete, the policy may be voided.

APPLICANT'S SIGNATURE

X _____ DATE _____ CITY _____ STATE _____
Signature must be that of the applicant only and must be signed in California.

X _____
Spouse's/Domestic Partner's signature (If applying for coverage).

PARENTAL OR GUARDIAN CONSENT (to be completed if Applicant is 15 days of age or older but under 18 years old).

This serves to notify Blue Shield Life that my child (please print name of child) _____ who is 15 days of age or older but under 18 years of age, is applying for Blue Shield Life short-term health insurance, with my full knowledge and consent, and I request that Blue Shield Life consider my child for such coverage.

SIGNATURE _____ PRINT NAME _____

SOCIAL SECURITY NO. _____ RELATIONSHIP _____ DATE _____

AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this form you are authorizing the release of your and/or your dependents' healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California Life & Health Insurance Company (Blue Shield Life) for the purpose of reviewing your application for short-term health coverage.

Further, by signing this form you are authorizing Blue Shield Life to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or evaluating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield Life has the right to condition your and/or your dependents' eligibility for coverage and enrollment determinations upon receipt of this signed authorization.

You are entitled to a copy of this Authorization after you sign it.

Expiration: This authorization will remain valid: 1) for thirty (30) months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield Life. I understand that revocation of this authorization will not affect any action Blue Shield Life has taken in reliance on this authorization prior to receiving my written notice of revocation.

Applicant/Parent or Legal Guardian	Today's Date	Applicant's spouse/domestic partner	Today's Date
Applicant age 18 or over	Today's Date	Applicant age 18 or over	Today's Date

AGENT INFORMATION

Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk?

YES NO

Did you see the proposed insured (and spouse, if applying) at the time this application was executed?

YES NO

Agent's Blue Shield Life Producer Number or Tax ID Number _____ Date _____

Agent's Name (Printed) _____

Agency Name & Complete Address (Please check if new address)

Agent's Phone Number _____

Agent's Fax Number _____

Agent's Email _____

Agent's Signature _____