



SelecTEMP[®] PPO

Temporary Individual Coverage

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

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

Requested Effective Date

Home office use only

MM/DD/YY

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 Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.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 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	

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	_____ months
(1, 2, 3, 4, 5, 6 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				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	174	119	96	90	84
	1-4	65	45	36	33	31
	5-12	56	39	31	29	27
	13-19	60	41	33	31	29
	20-24	76	52	42	39	36
	25-29	79	54	44	41	38
	30-34	87	60	48	45	42
	35-39	99	68	55	51	48
	40-44	119	81	66	61	57
	45-49	143	98	79	74	69
	50-54	173	119	96	89	83
	55-59	227	156	126	117	109
60-64	288	198	160	149	139	
65-69	421	288	233	217	202	

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	188	129	105	97	91
	1-4	51	35	28	26	25
	5-12	42	29	23	21	20
	13-19	68	47	38	35	33
	20-24	98	67	54	51	47
	25-29	104	71	58	54	50
	30-34	118	81	65	61	57
	35-39	134	92	74	69	65
	40-44	152	104	85	79	73
	45-49	173	118	96	89	83
	50-54	195	134	108	100	94
	55-59	217	149	120	112	104
60-64	246	169	137	127	119	
65-69	337	231	187	174	162	

		CHILD ADD-ON				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child		60	41	34	31	29
2 Children		108	74	61	56	52
3 or More		132	90	75	68	64

Monthly Premium Rates for Area 2

Zip Codes 759, 764-767, 780-782, 785, 790

		MALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	182	125	101	94	88
	1-4	68	47	38	35	33
	5-12	59	41	33	31	29
	13-19	63	43	35	32	30
	20-24	80	55	44	41	38
	25-29	83	57	46	43	40
	30-34	91	63	51	47	44
	35-39	104	72	58	54	50
	40-44	125	86	69	64	60
	45-49	150	103	83	77	72
	50-54	182	125	101	94	87
	55-59	239	164	133	123	115
	60-64	303	208	168	156	146
	65-69	442	303	245	228	213

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	198	136	110	102	95
	1-4	54	37	30	28	26
	5-12	44	30	24	23	21
	13-19	72	49	40	37	34
	20-24	103	71	57	53	50
	25-29	109	75	61	56	53
	30-34	123	85	68	64	59
	35-39	141	97	78	73	68
	40-44	160	110	89	83	77
	45-49	181	124	101	94	87
	50-54	205	140	114	106	98
	55-59	228	156	126	117	110
	60-64	259	177	144	133	125
	65-69	354	243	197	183	171

		CHILD ADD-ON				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child		63	44	35	33	31
2 Children		113	79	63	59	56
3 or More		139	97	77	73	68

Monthly Premium Rates for Area 3

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

		MALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	190	131	106	98	92
	1-4	71	49	40	37	34
	5-12	62	42	34	32	30
	13-19	65	45	36	34	32
	20-24	83	57	46	43	40
	25-29	86	59	48	45	42
	30-34	95	65	53	49	46
	35-39	109	75	60	56	52
	40-44	130	89	72	67	63
	45-49	157	108	87	81	75
	50-54	190	130	105	98	91
	55-59	249	171	138	129	120
	60-64	316	217	175	163	152
	65-69	461	316	256	238	222

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	207	142	115	107	99
	1-4	56	38	31	29	27
	5-12	46	31	25	24	22
	13-19	75	51	41	39	36
	20-24	107	74	60	55	52
	25-29	114	78	63	59	55
	30-34	129	88	72	66	62
	35-39	147	101	82	76	71
	40-44	167	115	93	86	80
	45-49	189	130	105	98	91
	50-54	214	147	119	110	103
	55-59	238	163	132	123	114
	60-64	270	185	150	139	130
	65-69	370	254	205	191	178

		CHILD ADD-ON				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child		66	45	37	34	32
2 Children		119	81	67	61	58
3 or More		145	99	81	75	70

Monthly Premium Rates for Area 4

Zip Codes 751, 755-756, 773, 776-777, 793-794

		MALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	199	136	110	102	96
	1-4	74	51	41	38	36
	5-12	65	44	36	33	31
	13-19	68	47	38	35	33
	20-24	87	59	48	45	42
	25-29	90	62	50	46	43
	30-34	99	68	55	51	48
	35-39	114	78	63	59	55
	40-44	136	93	75	70	65
	45-49	164	112	91	84	79
	50-54	198	136	110	102	95
	55-59	260	179	144	134	125
	60-64	330	226	183	170	159
65-69	481	330	267	248	232	

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	216	148	120	111	104
	1-4	58	40	32	30	28
	5-12	48	33	26	25	23
	13-19	78	53	43	40	38
	20-24	112	77	62	58	54
	25-29	119	82	66	62	57
	30-34	134	92	75	69	65
	35-39	154	105	85	79	74
	40-44	174	120	97	90	84
	45-49	198	136	110	102	95
	50-54	223	153	124	115	107
	55-59	248	170	138	128	119
	60-64	282	193	156	145	136
65-69	386	265	214	199	186	

		CHILD ADD-ON				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child		69	47	38	36	33
2 Children		124	85	68	65	59
3 or More		152	103	84	79	73

Monthly Premium Rates for Area 5

Zip Codes 750, 752-754, 762, 779

		MALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	197	135	109	102	95
	1-4	74	51	41	38	35
	5-12	64	44	35	33	31
	13-19	68	46	38	35	33
	20-24	86	59	48	44	41
	25-29	89	61	50	46	43
	30-34	99	68	55	51	47
	35-39	113	77	63	58	54
	40-44	135	92	75	69	65
	45-49	162	111	90	84	78
	50-54	196	135	109	101	94
	55-59	258	177	143	133	124
	60-64	327	224	181	169	157
65-69	477	327	265	246	230	

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	214	147	119	110	103
	1-4	58	40	32	30	28
	5-12	47	32	26	24	23
	13-19	77	53	43	40	37
	20-24	111	76	62	57	53
	25-29	118	81	66	61	57
	30-34	133	91	74	69	64
	35-39	152	104	84	78	73
	40-44	173	118	96	89	83
	45-49	196	134	109	101	94
	50-54	221	152	123	114	106
	55-59	246	169	136	127	118
	60-64	279	192	155	144	134
65-69	382	262	212	197	184	

		CHILD ADD-ON				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child		69	47	38	35	33
2 Children		124	85	68	63	59
3 or More		152	103	84	77	73