



Blue Cross Blue Shield
of Texas

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

SelecTEMP[®] 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

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 Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.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

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 _____

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
 (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				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	175	121	98	89	81
	1-4	70	49	39	36	33
	5-12	56	39	31	28	26
	13-19	61	43	34	31	29
	20-24	69	48	39	35	32
	25-29	74	52	42	38	35
	30-34	84	58	47	43	39
	35-39	97	67	55	49	45
	40-44	117	81	66	60	54
	45-49	141	98	79	72	66
	50-54	174	121	98	89	81
	55-59	233	162	131	119	109
60-64	313	218	176	160	146	
65+	415	288	233	211	193	

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	182	127	102	93	85
	1-4	58	40	32	29	27
	5-12	44	31	25	23	21
	13-19	69	48	39	35	32
	20-24	89	62	50	46	42
	25-29	98	68	55	50	46
	30-34	114	79	64	58	53
	35-39	131	91	74	67	61
	40-44	150	104	84	77	70
	45-49	170	118	96	87	79
	50-54	196	136	110	100	91
	55-59	227	158	127	116	106
60-64	268	186	151	137	125	
65+	333	231	187	170	155	

CHILD ADD-ON

Plan	I	II	III	IV	V
Deductible	\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child	61	42	34	31	28
2 Children	110	76	61	56	50
3 or More	134	92	75	68	62

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	191	133	108	97	89
	1-4	77	53	43	39	36
	5-12	61	42	34	31	28
	13-19	67	47	38	34	31
	20-24	76	53	43	39	35
	25-29	81	56	46	41	38
	30-34	92	64	52	47	43
	35-39	106	74	60	54	49
	40-44	128	89	72	65	60
	45-49	154	107	87	79	72
	50-54	190	132	107	97	89
	55-59	255	178	144	130	119
	60-64	343	239	193	175	160
	65+	454	316	255	231	211

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	199	139	112	102	93
	1-4	63	44	35	32	29
	5-12	49	34	27	25	23
	13-19	76	53	43	39	35
	20-24	98	68	55	50	46
	25-29	108	75	60	55	50
	30-34	124	86	70	63	58
	35-39	143	100	81	73	67
	40-44	164	114	92	84	77
	45-49	186	130	105	95	87
	50-54	215	149	121	109	100
	55-59	248	173	140	126	115
	60-64	293	204	165	149	136
	65+	364	253	205	186	169

		CHILD ADD-ON				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child		67	46	38	34	31
2 Children		121	83	68	61	56
3 or More		147	101	84	75	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	206	143	116	105	96
	1-4	83	58	47	42	39
	5-12	65	46	37	33	30
	13-19	72	50	41	37	34
	20-24	81	57	46	42	38
	25-29	87	61	49	45	41
	30-34	99	69	56	50	46
	35-39	114	80	64	58	53
	40-44	138	96	78	70	64
	45-49	166	115	93	85	77
	50-54	205	143	115	104	95
	55-59	275	191	155	140	128
	60-64	369	257	208	188	172
	65+	489	340	275	249	227

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	215	149	121	109	100
	1-4	68	47	38	35	32
	5-12	52	36	29	27	24
	13-19	82	57	46	42	38
	20-24	105	73	59	54	49
	25-29	116	80	65	59	54
	30-34	134	93	75	68	62
	35-39	154	107	87	79	72
	40-44	177	123	100	90	82
	45-49	201	140	113	102	93
	50-54	231	161	130	118	107
	55-59	267	186	150	136	124
	60-64	316	219	177	161	147
	65+	392	272	220	200	182

		CHILD ADD-ON				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child		72	50	40	37	33
2 Children		130	90	72	67	59
3 or More		158	110	88	81	73

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	215	149	121	109	100
	1-4	86	60	49	44	40
	5-12	68	47	38	35	32
	13-19	75	52	42	38	35
	20-24	85	59	48	43	40
	25-29	91	63	51	46	42
	30-34	103	72	58	53	48
	35-39	119	83	67	61	56
	40-44	144	100	81	73	67
	45-49	173	120	97	88	81
	50-54	214	149	120	109	100
	55-59	287	199	161	146	133
	60-64	385	268	217	196	179
	65+	510	354	287	260	237

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	224	156	126	114	104
	1-4	71	49	40	36	33
	5-12	55	38	31	28	25
	13-19	85	59	48	43	40
	20-24	110	76	62	56	51
	25-29	121	84	68	62	56
	30-34	140	97	79	71	65
	35-39	161	112	91	82	75
	40-44	185	128	104	94	86
	45-49	209	146	118	107	97
	50-54	241	167	135	123	112
	55-59	279	194	157	142	130
	60-64	329	229	187	168	153
	65+	409	284	230	208	190

		CHILD ADD-ON				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child		75	52	42	38	35
2 Children		135	94	76	68	63
3 or More		165	114	92	84	77

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	217	151	122	111	101
	1-4	87	61	49	44	41
	5-12	69	48	39	35	32
	13-19	76	53	43	39	35
	20-24	86	60	48	44	40
	25-29	92	64	52	47	43
	30-34	104	73	59	53	49
	35-39	121	84	68	61	56
	40-44	145	101	82	74	68
	45-49	175	122	99	89	82
	50-54	216	150	122	110	101
	55-59	290	202	163	148	135
	60-64	389	271	219	199	181
	65+	515	358	290	263	240

		FEMALE				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
AGE	Under 1	226	157	127	115	105
	1-4	72	50	40	36	33
	5-12	55	38	31	28	26
	13-19	86	60	48	44	40
	20-24	111	77	63	57	52
	25-29	122	85	69	62	57
	30-34	141	98	79	72	66
	35-39	163	113	92	83	76
	40-44	187	130	105	95	87
	45-49	212	147	119	108	99
	50-54	243	169	137	124	113
	55-59	282	196	158	144	131
	60-64	333	231	187	170	155
	65+	413	287	232	211	192

		CHILD ADD-ON				
Plan		I	II	III	IV	V
Deductible		\$500	\$1,000	\$1,500	\$2,000	\$2,500
1 Child		76	53	43	39	35
2 Children		137	95	77	70	63
3 or More		167	117	95	86	77