



**Blue Cross Blue Shield  
of Texas\***

# SelectTEMP<sup>®</sup>

TEMPORARY INDIVIDUAL COVERAGE

P.O. Box 833819, Richardson, TX 75083-3819  
(972) 766-5514 or 1-800-874-9601

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

**Requested Effective Date** \_\_\_\_\_  
MM/DD/YY

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 ( ) ( ) ( )	Have you applied for SelectTEMP coverage before? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Dependents to be Covered (First Name, M.I., Last Name)		Sex	Birth Date	Age	Social Security Number

If you wish to cover children, list all unmarried children who are at least 60 days of age and less than age 25 (court ordered dependents may be included from birth). All applicants must reside in Texas except those for whom coverage is required by court order.

Is any dependent coverage required by court order?  Yes  No To apply for court-mandated coverage for dependent children, contact Blue Cross and Blue Shield of Texas for the appropriate form.

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

**Method of Payment**

- Single Payment Plan Available for 1-6 month benefit periods. The entire premium must be submitted with the application (Required for a 1-month benefit period).
- 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."

Total Premium Due \$ \_\_\_\_\_ **Make your check payable to Blue Cross and Blue Shield of Texas.**

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 a permanent resident, please submit a copy of your Alien Registration Receipt Card or "Green Card.")

**Yes**  **No**

*If the answer is "No" the coverage cannot be issued.*

**Please Complete the Health Questions**

*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?   | <b>Yes</b>               | <b>No</b>                |
| 2. Are you or any family member (whether or not named on this application) now pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the past five years, have you or any family member to be covered ever received any medical or surgical consultation, advice or treatment including medication for any of the following: heart or circulatory system disorder including heart attack or stroke; diabetes; cancer or tumors; disorder of the blood; mental or nervous conditions or disorders; alcoholism or alcohol abuse; drug abuse, addiction or dependency? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. 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)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you or any person named on this application plan on participating in motor vehicle, boat or snowmobile racing; mountain climbing; bungee jumping; hang gliding or sky diving during this coverage?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you or anyone else who will be insured by this contract plan to reside outside of Texas during this coverage?  | <input type="checkbox"/> | <input type="checkbox"/> |

**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.  Yes  No Initial \_\_\_\_\_

Applicant's Signature (If Applicant is a minor, parent or guardian's signature) \_\_\_\_\_ Date \_\_\_\_\_

Agency Name \_\_\_\_\_ Agent Address - Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ (Area Code) FAX No. \_\_\_\_\_

Agent Name \_\_\_\_\_ Agent No. \_\_\_\_\_ Signature \_\_\_\_\_ (Area Code) Telephone No. \_\_\_\_\_ Date \_\_\_\_\_

Home Office Use Only	Grp-Sec	Pkg	Eff Date	R/D/T	SE #	Broker #
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\* A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

## 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 or \$1,500), 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, or \$1,500), your spouse's area and age.
- Note: If only child(ren) are applying, use the <25 age band for the oldest child and a child or children rate for any additional children to be covered.*
- 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.

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

FEMALE												
\$500					\$1,000				\$1,500			
Age	Area 1	Area 2	Area 3	Area 4	Area 1	Area 2	Area 3	Area 4	Area 1	Area 2	Area 3	Area 4
<25	\$90	\$110	\$71	\$66	\$64	\$79	\$51	\$48	\$57	\$70	\$45	\$42
25 - 29	97	118	76	71	69	85	55	51	61	75	48	45
30 - 34	111	136	88	82	80	97	63	59	71	86	56	52
35 - 39	128	156	101	94	91	112	72	67	81	99	64	60
40 - 44	147	180	116	108	105	129	83	78	93	114	74	69
45 - 49	165	202	131	122	118	145	93	87	105	128	83	77
50 - 54	188	229	148	138	135	164	106	99	119	146	94	88
55 - 59	221	269	174	162	158	193	124	116	140	171	110	103
60 - 64	269	329	213	198	193	236	152	142	171	209	135	126

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

ZIP Codes - 750, 752, 753, 760, 761, 776, 777

#### Area 2

ZIP Codes - 770, 771, 772, 774, 775

#### Area 3

ZIP Codes - 751, 754, 755, 762, 764, 768, 769, 773, 778, 779, 783, 784, 786, 787, 789, 792, 793, 794, 795, 796, 797

#### Area 4

ZIP Codes - 756, 757, 758, 759, 763, 765, 766, 767, 780, 781, 782, 785, 788, 790, 791, 798, 799, 885

MALE												
\$500					\$1,000				\$1,500			
Age	Area 1	Area 2	Area 3	Area 4	Area 1	Area 2	Area 3	Area 4	Area 1	Area 2	Area 3	Area 4
<25	\$77	\$94	\$61	\$57	\$55	\$67	\$44	\$40	\$49	\$60	\$39	\$36
25 - 29	79	97	63	58	57	70	45	42	50	62	40	37
30 - 34	89	109	71	66	64	78	50	47	57	69	45	42
35 - 39	104	127	82	77	75	91	59	55	66	81	52	49
40 - 44	124	152	98	91	89	108	70	66	79	96	62	58
45 - 49	149	182	117	110	107	130	84	78	94	115	75	69
50 - 54	185	226	146	136	132	162	104	97	117	143	92	86
55 - 59	242	295	191	178	173	212	137	128	154	188	121	113
60 - 64	315	385	249	232	226	275	178	166	200	244	158	147

CHILD(REN)												
\$500					\$1,000				\$1,500			
Number of Children	Area 1	Area 2	Area 3	Area 4	Area 1	Area 2	Area 3	Area 4	Area 1	Area 2	Area 3	Area 4
1	\$59	\$72	\$47	\$43	\$42	\$52	\$33	\$31	\$37	\$46	\$30	\$27
2	118	144	94	86	84	104	66	62	74	92	60	54
3 +	177	216	141	129	126	156	99	93	111	138	90	81

# Automatic Premium Payment Program

## Authorization Agreement



BlueCross BlueShield  
of Texas

### Take these 3 simple steps to hassle-free monthly premium payments

- Complete and sign this authorization agreement.
- Verify with your financial institution that they can accept automated electronic withdrawals.
- Return this authorization and a blank check marked VOID for the account from which funds are to be withdrawn to:

**Blue Cross and Blue Shield of Texas**

P.O. Box 833819

Richardson, Texas 75083-3819

### A G R E E M E N T

I, as account holder, hereby authorize Blue Cross and Blue Shield of Texas (BCBSTX) to initiate withdrawals on a monthly basis from my account at the financial institution named in this authorization for payment of monthly insurance premium due for the named policyholder; and, I authorize the financial institution to charge such withdrawals to my account. I understand that both the financial institution and BCBSTX reserve the right to terminate this payment program and/or my participation therein. I also understand that I may discontinue this payment program, (except on individual temporary contracts) at any time with at least 10 days advance notice to BCBSTX by telephone prior to a scheduled withdrawal date. As policyholder, I am authorizing my insurance premium due be paid as described in this agreement and agree that if any withdrawal is dishonored, the premium payment for such withdrawal will be considered in default. I also authorize, as policyholder, the disclosure of my policy identification/group numbers and any other necessary personal information on the financial institution's statements to identify to the account holder named for whom withdrawals are being made.

#### Please complete the following • Print or Type information

Yes, I elect to have my insurance premium paid monthly thru the Automatic Premium Payment Program.

Policyholder: Name \_\_\_\_\_

Identification/Policy Number \_\_\_\_\_

Daytime Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Accountholder: Name(s) \_\_\_\_\_

*As shown on Account Records*

Daytime Phone Number \_\_\_\_\_

Home Address \_\_\_\_\_

Full Name of Financial Institution \_\_\_\_\_

Account Number \_\_\_\_\_

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

Policyholder Signature \_\_\_\_\_

Accountholder Signature(s) (if different from the Policyholder) \_\_\_\_\_

*As accepted by Financial Institution*



Blue Cross and Blue Shield of Texas,  
a Division of Health Care Service Corporation,  
a Mutual Legal Reserve Company, an Independent Licensee of the  
Blue Cross and Blue Shield Association

