

Non-Renewable Short-Term Health Insurance Application (California)



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 Fax: 707-778-0425
P.O. Box 750309 (Use fax # only when paying by credit card)
Petaluma, CA 94975-0309 Phone: 800-443-8284

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	
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 TO BE COVERED BELOW:

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

TOTAL PREMIUM DUE \$ _____

PLAN SELECTIONS:

A. DEDUCTIBLE

\$250 \$500 \$1,000 \$1,500 \$2,000

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 or, if application is faxed, the day after fax is received. 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 in trust while this application is evaluated by Blue Shield Life.

IF PAYING BY CREDIT CARD – I authorize Blue Shield Life to bill my account for the total premium due.

ACCOUNT NO. _____
PLEASE PRINT CREDIT CARD NUMBER CLEARLY

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

SIGNATURE _____

ELIGIBILITY: (Answer the following questions completely and accurately)

1. a. Have all applicants resided within the United States continuously for the past six months? YES NO
 [If YES, skip to Question 2. If NO, please answer Question 1b.]
- 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? YES NO
 [If YES, continue to Question 2. If NO, you are not eligible for this policy.]

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? YES NO
3. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on the application? YES NO
4. In the past 30 days, have you or any person applying taken prescription medication for any medical condition, been seen by a member of the medical profession for a medical condition, or been hospital confined? [Note: This does not apply to certain medications. For a list of accepted medications, please refer to the short-term health brochure or contact your agent.] 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 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 or tumor; COPD; emphysema; alcoholism or alcohol abuse; drug abuse or chemical dependency; 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. Within the past 10 years, have you or any person applying had any application for insurance declined, deferred or restricted in any way, for health reasons? 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
 [If YES, when will existing coverage expire? / /]
MO DAY YR

Please note, coverage cannot start until prior coverage has terminated.

* IF YOU ANSWERED YES TO ANY OF QUESTIONS 4 THROUGH 12, PLEASE ANSWER BELOW.

NOTE: SUCH PERSON(S) IS/ARE EXCLUDED FROM COVERAGE:

Question No. _____ Person(s) to whom it applies: _____

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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 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 CA	ZIP

AUTHORIZATION, TERMS & CONDITIONS:

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

- Authorize any provider of care, insurer or health plan, to disclose to Blue Shield Life, its representatives or designated agents, and vice versa, all personal and medical record information, regarding me or any applying family member, including any medical information for substance abuse and mental or emotional conditions. This information is collected for the purposes of evaluating my application, determining eligibility for benefits, and administrative functions reasonably related to executing and managing this policy. In addition, I authorize Blue Shield Life to obtain personal and medical record information from an institutional source or an insurance support organization that gathers this type of information, for the purposes of determining eligibility for coverage. This authorization will remain valid for 2-1/2 years from the date below, with the exception that it shall remain in effect for as long as may be necessary for processing claims incurred during the term of this coverage. My authorized representative or I am entitled to receive a copy of this authorization, and a photocopy of this authorization is as valid as the original.
- 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. 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 signature (If spouse is 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 _____

DID YOU REMEMBER TO INCLUDE:

- Applicant’s signature (and spouse’s, if applicable)?
- The premium payment?
 - Verify premium by using the rate table
 - Be sure correct rates for region and age are used
- Applicant’s Social Security Number? If not available, please explain:

- Applicant’s birth date?
- Enrolling family members’ birth dates?
- Answers to eligibility questions?
- AD&D beneficiary information? (Only available for primary applicant, 18 years of age or over).
- Information about previous health insurance carrier(s)? (Required, if applicable).

Incomplete applications, or applications received with no, or partial, premium payment will delay processing and your effective 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 Phone Number _____
Agent’s Name (Printed) _____	Agent’s Fax Number _____
Agency Name & Complete Address <input type="checkbox"/> (Please check if new address) _____ _____	Agent’s Email _____ Agent’s Signature _____