



Short-Term PPO Enrollment Application

1. Please print in blue or black ink or type.
2. Complete both sides of this application.
3. Send completed application and payment in full to BC Life & Health Insurance Company. (See Section 8).

1. Applicant Information

Primary Applicant's Last Name		First Name		M.I.	Primary Applicant's Social Security No.	
Street Address (Must be completed: P.O. Box not acceptable)					Home Phone No. ()	
City		State		ZIP Code		Daytime Phone No. ()
County Applicant Resides in					Fax No. ()	
Mailing Address (If different than above) or P.O. Box			City		State	ZIP Code
E-mail Address				If possible, do you want e-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ethnic Code (Optional)		4 <input type="checkbox"/> Asian		A <input type="checkbox"/> Amerasian		K <input type="checkbox"/> Korean
1 <input type="checkbox"/> Caucasian		5a <input type="checkbox"/> Native American Indian		C <input type="checkbox"/> Chinese		M <input type="checkbox"/> Samoan
2 <input type="checkbox"/> Hispanic		5b <input type="checkbox"/> Alaskan Native		H <input type="checkbox"/> Cambodian		N <input type="checkbox"/> Asian Indian
3 <input type="checkbox"/> Black/African American		7 <input type="checkbox"/> Filipino		J <input type="checkbox"/> Japanese		P <input type="checkbox"/> Hawaiian
				R <input type="checkbox"/> Guamanian		T <input type="checkbox"/> Laotian
				V <input type="checkbox"/> Vietnamese		Z <input type="checkbox"/> Other

2. Plan Selections

A. Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000
B. Policy Term: No. of Days _____ (minimum of 30 up to a maximum of 185 days)

3. Effective Date

▶ If you are approved, coverage automatically begins at 12:01 a.m. on the date following the postmark date stamped on the envelope.
If application is faxed or submitted online, coverage begins the day after application is received.

▶ Or coverage (upon approval) may begin on a specific future date within 30 days of signature.
(Please specify) _____ (Mo/Day/Yr). Postmark date must precede requested effective date. **Exceptions are not permitted.**

4. Applicants for Coverage

Please list ALL applicants applying for coverage. (Including applicant listed in Section 1)
If a family member's last name is different than yours, please explain on a separate page.
Newborn children under 15 days of age are not eligible for coverage. Services for Well Baby and Well Child Care for insureds up to and including 6 years of age are not covered under this policy.
Dependents between the ages of 19 through 22 are eligible as dependents only if they are claimed on your Federal Income Tax.
BC Life and Health will enroll all eligible family members unless otherwise instructed.

Sex	Last Name	First Name	M.I.	Social Security No.	Date of Birth (Mo/Day/Yr)
<input type="checkbox"/> M <input type="checkbox"/> F	Applicant				
<input type="checkbox"/> M <input type="checkbox"/> F	Spouse				
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent				
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent				
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent				



5. Application Questions Answer the following questions completely and accurately.

Note: If the answer to any question from 2-10 is YES, the policy cannot be issued. Answering NO to questions 2-10 does not guarantee coverage. All answers will be validated and a brief review of claims history will be completed.

<p>1. (a) Have all applicants resided within the United States continuously for the past 3 months? (If yes, skip to Question 2.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) If any applicant has not resided continuously within the U.S. for the past 3 months, are such applicants U.S. citizens or permanent residents? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy? ... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on the application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. 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 disorder including heart attack or chest pain; stroke; disorders of the blood, including hemophilia and leukemia; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency; or non-AIDS related immune system disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. 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 disorder or liver disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you or any person applying been treated for or diagnosed with Acquired Immune Deficiency Syndrome (AIDS)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>7. Within the past 10 years, has any person applying had any application for insurance declined, deferred or restricted in any way, for health reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. In the past 30 days, have you or any person applying:</p> <p>a. Been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Been seen by a medical professional for any medical condition (excluding consultation for birth control pills, hormone replacement therapy or Synthroid)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Taken prescription medication (excluding birth control pills, hormone replacement therapy or Synthroid)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. In the past 12 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>a. 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, when will existing coverage expire? (Mo/Day/Yr) _____</p>
---	--

6. Prior Insurance History

BC Life & Health Insurance Company credits prior coverage toward the pre-existing 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 BC Life & Health Short-Term policies) as specified by law. To obtain credit toward the pre-existing period, please complete the following:

Health Plan	Phone No.	ID No.	Insured's Name	Coverage from (Mo/Day/Yr)	Coverage to (Mo/Day/Yr)

To provide further information, please use additional sheets if necessary. List the section name and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

No. of sheets attached

7. Accidental Death and Dismemberment Insurance Beneficiary Information

If beneficiary is not listed and Policy is issued, death benefits will be paid in accordance with the Beneficiary Provision on page 32 of the Policy.

Beneficiary	Relationship to Applicant	Date of Birth
Street Address	City	State ZIP Code



8. Payment Method

Premium must be paid in full and submitted with application and will be held in trust while this application is evaluated. If the application is approved and the policy is issued, no refund is permitted.

_____	x	_____	=	_____
Amount of premium (per day rate)		no. of days		premium

Payment by Credit Card

Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover			Card No.	Exp. Date
Cardholder's Name	Relationship to Applicant	Signature of Authorized Cardholder X		Date

If paying by credit card, you may fax applications to Blue Cross at 1-800-327-9255.

Payment by Check

Mail application with your check (payable to BC Life & Health Insurance Company) to:
BC Life & Health Insurance Company • P.O. Box 9051 • Oxnard, CA 93031-9051

To be completed by your Blue Cross-Appointed Agent

1. 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
2. Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? Yes No
3. Total funds collected: \$ _____
 (Premium must be paid in full and submitted with application.)

Name of Agent (Print name)		Agent's Street Address	Suite	No./Personal Mail Box(PMB) No.		
Agent I.D. No.	Sub-Agent I.D. No.	City		State	ZIP Code	Location No.
Phone No.	Fax No.	E-mail Address				
Signature of Agent (Required)		Date (Required)				

Mail Service Agreement to: Agent Primary Applicant

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the primary applicant's mailing address:

Agent: Please mail this application to the following address:

BC Life & Health Insurance Company • P.O. Box 9051 • Oxnard, CA 93031-9051

BC Life & Health Insurance Company is an Independent Licensee of the Blue Cross Association.
 The Blue Cross name and symbol are Registered Marks of the Blue Cross Association.



3968 2/03 03

BC Life & Health Insurance Company
Short Term Conditional Receipt and Special Instruction
 (To be completed by the agent and given to the applicant)
For information on eligibility, please call 800-333-0912

Received from _____ the amount of \$ _____ as the full premium payment for
 the Short Term Policy purchased for a period of _____ days, payable to BC Life & Health Insurance Company. (over)

9. Application Conditions and Agreement IMPORTANT: It is important that you carefully read and fully understand the following.

AUTHORIZATION

Authorization to Obtain or Release Medical Information: I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give BC Life & Health Insurance Company, its affiliates ("Blue Cross"), their respective agents, employees, designees, or representatives, including my BC Life & Health agent, or broker, and any information or records relating to medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol or substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-Related Complex), of me or any of my dependents applying for or having BC Life & Health coverage. I understand that this information may be collected in connection with the review, investigation or evaluation of an enrollment form or of any claim for benefits.

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.

I also authorize BC Life & Health to disclose all such medical or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purpose of investigating or evaluating any claim for benefits. This authorization is effective immediately and shall remain in effect for a period of thirty (30) months except that it shall remain effective for use in connection with any claim for benefits for as long as any BC Life & Health coverage may be in effect. A photocopy of this authorization is as valid as the original, and my BC Life & Health agent or broker and I, are entitled to receive a copy of this form.

Signatures (Required)

IMPORTANT: All applicants over age 18 must sign and date.

Applicant/Parent or Legal Guardian X	Today's Date
Applicant's Spouse X	Today's Date
Applicant age 18 or over X	Today's Date

AGREEMENT (all applicants)

By applying for coverage, I, the undersigned, agree to the following:

1. BC Life & Health may decline my application. No coverage comes into effect until BC Life & Health approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be indicated on the identification card and/or assigned by BC Life & Health at its discretion.
2. Cashing my check does not mean my application is approved. If this application is declined, neither BC Life & Health nor any affiliated company shall have any liability to me or any one else listed on it, except for the obligation to return the money submitted with this application.
3. The selling agent has no authority to promise me coverage or to modify BC Life & Health underwriting policy or the terms of any BC Life & Health coverage.
4. Any of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this

application. Also, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete to the best of my knowledge and belief. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if any information is false or incomplete and that BC Life & Health may revoke coverage if it discovers that any information on this application is incomplete or false.

5. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
6. I understand BC Life & Health Insurance Company may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between BC Life & Health and me. Any enrolled family members and I agree to abide by the terms of that contract. I understand that no benefits will be provided for any preexisting condition as defined in the policy. Preexisting condition means an illness, injury, disease, or physical condition for which medical advice, diagnosis, care or treatment, including the use of prescription drugs, was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the member's effective date of coverage. This is not a continuation of any previous BC Life & Health policy. This policy is not renewable.

Arbitration: I agree that any dispute between me or any enrolled family member and BC Life & Health Insurance Company and/or its affiliates, including claims for medical malpractice, must be resolved by binding arbitration if the amount in dispute exceeds the jurisdictional limits of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both I and my enrolled family, and BC Life & Health Insurance Company and its affiliates, are giving up the right to have any dispute decided in a court of law before a jury. BC Life & Health Insurance Company and I also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Policy.

Signatures (Required)

IMPORTANT: All applicants over age 18 must sign and date.

Applicant/Parent or Legal Guardian X	Today's Date
Applicant's Spouse X	Today's Date
Applicant age 18 or over X	Today's Date
For BC Life & Health Insurance Company use only - Do not write below	
Effective Date	End Date



3968 2/03 04

This amount is tendered with the application for the referenced Policy as a deposit against the premium due, subject to the following: **IN NO EVENT SHALL BC LIFE HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT ACCEPTED BY BC LIFE AT ITS HOME OFFICE, AND NEITHER SHALL ANY COVERAGE EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THE APPLICATION IS APPROVED BY BC LIFE.** If the application is accepted, the applicant shall be advised in writing by BC Life. If the application is not accepted, BC Life will advise the applicant and promptly refund the deposit paid; and refund of such deposit will fully discharge any and all obligations of BC Life to the applicant.

Dated this _____ day of _____.

Agent acknowledges receipt of money and delivery of conditional Receipt.

By: _____ Signature of Agent _____ Agent ID Number _____