BlueCross BlueShield of Oklahoma

P.O. Box 3236, Naperville, IL 60566–7236
1–866–520–2507 / Fax: 1-888-223-1988

HOME OFFICE USE ONLY

Blue Transitions[SM]
Temporary Individual Coverage

Requested Effective Date: _______________
(MM / DD / YYYY)

PERSONAL INFORMATION Please print all information in blue or black ink

FIRST NAME, MIDDLE INITIAL, LAST NAME	SEX ☐M ☐F	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
RESIDENTIAL ADDRESS, NO P.O. BOXES (STREET, CITY, STATE, ZIP+4)		E–MAIL		
MAILING ADDRESS (STREET, CITY, STATE, ZIP+4) *if different than above*		HOME PHONE		WORK PHONE

DEPENDENT(S) TO BE COVERED (dependent children must be unmarried, at least 60 days of age, and under age 25)

FIRST NAME, MIDDLE INITIAL, LAST NAME	SEX	DATE OF BIRTH	AGE	SOCIAL SECURITY NO.
	☐M ☐F			
	☐M ☐F			
	☐M ☐F			

BENEFIT PERIOD and DEDUCTIBLE SELECTION Select which plan you would like and for how long you need it

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 ☐ $5,000

Total Premium Due: $ _______________ *Make check payable to Blue Cross and Blue Shield of Oklahoma. Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.*

METHOD OF PAYMENT Select the method of payment you prefer

☐ SINGLE PAYMENT PLAN Available for 1–6 month benefit periods. The entire premium must be submitted with the application through a check or a bank draft. If choosing the bank draft option, please complete and submit the Bank Draft Authorization Request Form along with including a blank check marked "VOID" or a banking deposit slip.

☐ MONTHLY BANK DRAFT Available for 2–6 month benefit periods. The first month's premium must be submitted with the application through a check or bank draft. Subsequent months will be drafted. Please complete a Bank Draft Authorization Request Form along with including a blank check marked "VOID" or a banking deposit slip.

HEALTH INFORMATION Tell us about yourself.

If the answer is "Yes" to any of the following questions, 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, stroke or uncontrolled blood pressure, but excluding elevated cholesterol or lipids); 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 the HIV virus (ELISA or Western Blot)? . . . . ☐Yes ☐No
4. Do you or anyone else who will be insured by this contract plan to reside outside of Oklahoma during this coverage? . ☐Yes ☐No

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

REPRESENTATIONS, ACKNOWLEDGEMENTS AND AUTHORIZATIONS

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 Oklahoma (the Company) will provide no coverage until my application is accepted and the correct premium is received by the Company; 2) this contract will pay no benefits for any illness, accident or physical impairments which existed or occurred within 12 months 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 the Company.**

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 Oklahoma (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. **The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease.**

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.This authorization is valid from the date signed and shall remain valid for 24 months, unless revoked by me in writing, which I may do at any time by sending a written request to the Company. 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.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Applicant's Signature X____________________ Date Signed: __________
(if applicant is under age 18, parent or guardian's signature)

Spouse's Signature (if applying) X____________________ Date Signed: __________

Dependent's Signature (only if 18 or over and to be insured) X____________________ Date Signed: __________

Dependent's Signature (only if 18 or over and to be insured) X____________________ Date Signed: __________

AGENT INFORMATION (if applicable)

AGENCY NAME	AGENT ADDRESS (CITY, STATE, ZIP)	
FAX	AGENT'S PHONE	AGENT'S NAME
AGENT ID NUMBER	AGENT'S SIGNATURE	DATE