

# Single-Term Comprehensive Major Medical Individual PPO Coverage without a Gatekeeper



**PLEASE PRINT**

|                                  |  |            |      |                |            |                        |  |
|----------------------------------|--|------------|------|----------------|------------|------------------------|--|
| Applicant's Last Name            |  | First Name |      | Middle Initial | Birth Date | Social Security Number |  |
| Home Address                     |  |            | City | State          | Zip Code   | County                 |  |
| Home Phone Number<br>( ) ( ) ( ) |  |            |      | Home E-mail    |            |                        |  |
| Work Phone Number<br>( ) ( ) ( ) |  |            |      | Work E-mail    |            |                        |  |

**Please answer the following questions completely and accurately. Coverage will not be issued to you if you answer "Yes" to any part of questions 1 and 2.**

**1. Have (Are) you:**

- a) Been denied insurance for health conditions that are still present?  
 Medical policies..... Yes  No  
 Life policies ..... Yes  No
- b) Now in the process of adopting a newborn (31 days or younger) child or undergoing infertility treatment?..... Yes  No
- c) Been medically diagnosed or treated by a licensed medical professional for current pregnancy?..... Yes  No
- d) Using any medical equipment (such as a walker, wheelchair, cane or hospital bed)?..... Yes  No
- e) Currently receiving home health care?..... Yes  No
- f) Gained or lost more than 20 pounds over the past three (3) months?  
 Yes  No
- g) Enrolled in or eligible for Medicare due to age or disability?..... Yes  No
- h) Ever been diagnosed, treated or otherwise told by a licensed medical professional that you have a disease, injury, illness or other chronic health care condition that may require ongoing, continuing or other future medical treatment?..... Yes  No

**2. For any of the following conditions within the last five (5) years, have you been notified by your physician of any abnormal test results; received medical or surgical treatment; consulted with a licensed medical professional; or taken medication?**

- Yes  No
- a) Heart disorder including but not limited to heart attack or chest pain
  - b) Alcoholism, chemical dependency or drug and/or alcohol abuse
  - c) Crohn's disease, ulcerative colitis or hepatitis, GERD or gastritis
  - d) AIDS or tested positive for HIV
  - e) Emphysema
  - f) Diabetes
  - g) Stroke
  - h) Mental health issues
  - i) Kidney disorder, excluding kidney stones
  - j) Migraines
  - k) Cancer or tumor

**3. Is this coverage for which you are applying intended to replace any other accident or health insurance you currently have in force? (This includes any current Blue Cross and/or Blue Shield or Keystone Health Plan West policy.)**

- Yes** – If you answered "Yes" to Question 3, please proceed to Item 3a.
- No** – If you answered "No" to Question 3, please skip Item 3a.

a) If you answered "Yes" to Question 3, please provide the insurance company name and applicable group and identification numbers:

|              |                     |
|--------------|---------------------|
| Company Name |                     |
| Group Number | Agreement/ID Number |

**4. Length of Coverage**

Select first and last dates of coverage. Once selected, Length of Coverage (# of days) cannot be changed.

Requested first date of coverage \_\_\_\_\_

Requested last date of coverage \_\_\_\_\_

Requested # of days of coverage \_\_\_\_\_

**5. Select Deductible (check one) .....**  \$250  \$500  \$1,000

**6. Total Payment**

|            |           |               |  |
|------------|-----------|---------------|--|
| \$ _____   | X         | = \$ _____    |  |
| DAILY RATE | # OF DAYS | TOTAL PAYMENT |  |

Total payment must be sent with application. Payment is non-refundable. The policy cannot be terminated once payment is received with the exception of the 10-Day Satisfaction-Guaranteed Period.

|                                    |              |
|------------------------------------|--------------|
| Payment Enclosed                   | Group Number |
| \$ _____                           | 039000-00    |
| Applicant's Social Security Number |              |

**If you answered "Yes" to any part of questions 1 or 2, you are not eligible for coverage in the Short Term product. Do not complete the rest of this form.**

**PO BOX 382555**

# Conditions of Enrollment

I, the undersigned, hereby apply for coverage.

I represent, to the best of my knowledge and belief, that:

- 1. I have read and have supplied all the requested information on this form.
- 2. No material information has been withheld or omitted about the past or present state of my health.
- 3. The information provided on this Application is true and correct.

I understand and agree that:

- 1. This Application will be submitted electronically by my insurance producer.
- 2. Receipt of my credit card payment does not constitute enrollment; and
- 3. Coverage is provided only to residents of the geographical area of western Pennsylvania served by Highmark Blue Cross Blue Shield (referred to herein as "Highmark"); and
- 4. The terms and conditions of coverage are controlled by the written Agreement with Highmark and that it may adopt reasonable policies, procedures, rules and interpretations, consistent with the language of the Agreement, to administer the program; and
- 5. Coverage will only apply to admissions that occur and services that are provided on or after the Effective Date of coverage.

I also understand and agree that Highmark may:

- 1. Deny this Application, in which case any premium submitted will be refunded and accepted by me; or
- 2. Terminate this Agreement if I perform an act or practice constituting fraud or intentional misrepresentation of a material fact; or
- 3. Void this Agreement or deny a claim for loss incurred or disability (as defined in the Agreement) within two (2) years of the Effective Date of this Agreement if I have made a fraudulent misstatement or a material misrepresentation in the Application

**Pre-Existing Conditions.** I understand and agree that the Agreement will not provide benefits for pregnancy and any condition for which medical advice, care, treatment or diagnosis has been recommended or received from a health care provider within the five (5) years immediately prior to the Effective Date of coverage.

I acknowledge and agree that any personally identifiable health information ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy laws, and that, in accordance with those laws, Highmark

may use and disclose Protected Health Information for payment, treatment and health care operations. A copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

**Premium Payment.** The total premium amount payable to Highmark must be submitted with the Application. I understand that I cannot terminate this policy once payment is received by Highmark with the exception of the 10-Day Satisfaction Guaranteed Period.

**Nonrenewable Coverage.** This plan is not renewable. To obtain coverage after a Coverage Period ends, you must submit a new Application. You may enroll for two consecutive Coverage Periods. Coverage Periods are considered consecutive only if there are **60 days or less** between the end of one Coverage Period and the beginning of the next Coverage Period. There can be no overlap of days between Coverage Periods. For example, if the last day of your first Coverage Period is the 15th of the month, the earliest your second Coverage Period can start is the 16th of the same month. You must wait **90 days**, after enrolling in consecutive Coverage Periods, before you can apply for a third Coverage Period.

**Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

**Minors.** If applicant is under age 18, a parent or guardian must sign this Application.

This is my first Application for ShortTermBlue.

Under no circumstances can coverage become effective prior to the day after the date this Application is submitted electronically.

Applicant's Signature

Date