Non-Renewable Short Term PPO℠ Enrollment Application

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

APPLICANT INFORMATION (PLEASE COMPLETE EACH SECTION OF THIS APPLICATION IN INK)

Your Name (first, initial, last)	Social Security Number	Date of Birth (mm/dd/yy)	Age	❑ Male ❑ Female
Physical Address	City, State, Zip Code			County
Mailing Address (street or route)	City, State, Zip Code			County
Billing Address (if different from mailing address)	City, State, Zip Code			County
Idaho Resident ❑ Yes ❑ No / Preferred Phone	Alternate Phone	❑ I don't have a phone		Marital Status ❑ Single ❑ Married

List all eligible dependents you wish to enroll, including any child who is under the age of 26, or who is medically certified as disabled and dependent on parent for support (copy of certification required). If you have more dependents to include, please include the information on a separate sheet of paper.

Family Member's Name (first, initial, last)	Relationship to Applicant (spouse, child, stepchild, etc.)	Date of Birth	Social Security Number	Age	❑ Male ❑ Female
Family Member's Name (first, initial, last)	Relationship to Applicant	Date of Birth	Social Security Number	Age	❑ Male ❑ Female
Family Member's Name (first, initial, last)	Relationship to Applicant	Date of Birth	Social Security Number	Age	❑ Male ❑ Female
Family Member's Name (first, initial, last)	Relationship to Applicant	Date of Birth	Social Security Number	Age	❑ Male ❑ Female
Family Member's Name (first, initial, last)	Relationship to Applicant	Date of Birth	Social Security Number	Age	❑ Male ❑ Female
Family Member's Name (first, initial, last)	Relationship to Applicant	Date of Birth	Social Security Number	Age	❑ Male ❑ Female

3000 E. Pine Ave. • Meridian, Idaho 83642 • 208-345-4550
Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

Form No. 20-042 (10-21)

Benefit Period Desired: ❑ 1 month ❑ 2 months ❑ 3 months ❑ 4 months ❑ 5 months ❑ 6 months

Deductible and Coinsurance Option: ❑ $1,500/20% ❑ $1,500/50% ❑ $3,000/20% ❑ $3,000/50%

Requested Effective Date_____ Total Payment $ _____

When your application is approved, your coverage will begin at 12:01 a.m. the day after we receive your completed application, or the effective date you request, whichever is later. You must submit your first month's payment with this application. If your benefit period extends beyond one month, and you choose not to pay in full, you must complete the Authorization Agreement for Automatic Withdrawal found at ***members.bcidaho.com/resources/pdfs/03/3-449-Authorization-Agreement-for-Automatic-Withdrawal.pdf*** and include it with this application.

Please answer each question below. If any question is answered YES, you are not eligible for Short Term PPO coverage.

1. Has anyone listed on this application been refused or denied health insurance coverage? ❑ YES ❑ NO
2. Does anyone listed on this application currently have Medicare, Medicaid, or other health insurance coverage that will remain in force beyond the effective date of this coverage? ❑ YES ❑ NO
3. Are you, your spouse, or any eligible dependent, whether or not listed on this application, now pregnant or have reason to suspect you or they might be pregnant? ❑ YES ❑ NO
4. Is anyone on this application over 275 pounds? ❑ YES ❑ NO
5. Is anyone listed on this application currently admitted to a healthcare facility, or has planned inpatient treatment or inpatient/outpatient surgery? ❑ YES ❑ NO
6. Within the past two years, has anyone listed on this application had a problem for which medical advice hasn't been sought? ❑ YES ❑ NO
7. Within the last five years, have you or any family member listed on this application ever seen a doctor, been diagnosed with, had treatment, surgery, hospitalization, medications, tests or been advised to have treatment, or shown signs of having any of the following: ❑ YES ❑ NO
   a. AIDS or tested positive for HIV
   b. Emphysema, chronic obstructive pulmonary disease (COPD)
   c. Coronary artery disease (CAD), heart attack or a heart procedure
   d. Stroke, transient ischemic attack (TIA) or carotid artery disease
   e. Crohn's disease, ulcerative colitis
   f. Cirrhosis, hepatitis, chronic kidney disease, end-stage renal disease (ESRD)
   g. Hemophilia
   h. Alcoholism, alcohol or chemical dependency, drug or alcohol abuse
   i. Cancer or tumor
   j. Rheumatoid or psoriatic arthritis
8. Has anyone listed on this application had a short term policy within the past 63 days with Blue Cross of Idaho or any other carrier? ❑ YES ❑ NO

SMOKER DESIGNATION AND CERTIFICATION

Has any person listed on this application used tobacco during the past 12 months?

❑ YES ❑ NO

If yes, list name(s) of individual(s):

_____ _____

_____ _____

_____ _____

PAYMENT OPTIONS

❑ Pay in full

❑ Automatic bank withdrawal (no service fee). Please complete the section below.

Please send either the first month's premium OR payment in full for the life of the policy when you return the application to Blue Cross of Idaho.

To set up your checking account to automatically withdraw your monthly premium payment, complete the form below:

- Please include a voided check. (No deposit slips.)
- We will draft the total amount due (not to exceed two months' premium).
- Payments are withdrawn on the 28th or the 5th of the month. If you choose the 28th, the payment will apply to your next month's premium. If you choose the 5th, the payment will apply to the current month's premium.

AUTOMATIC WITHDRAWAL AUTHORIZATION AGREEMENT

By completing and returning the information below, I authorize and request Blue Cross of Idaho to obtain payment for premiums by withdrawing the funds from my account. Blue Cross of Idaho assumes full responsibility for correctly informing the financial institution of the specific amount of each deduction. I may terminate this agreement at any time by notifying Blue Cross of Idaho or my financial institution. Blue Cross of Idaho will terminate automatic withdrawal within a reasonable time after receiving the request.

Complete account information below

Routing Number (9 digits) Account Number Check Number

If payment day is not selected, we will withdraw your payment on the 28th of each month.

Withdrawal Date ❑ 28th (for the next month's premium) ❑ 5th (for the current month's premium)

Would you like us to process a one-time eCheck for your first month's premium payment when we set up automatic withdrawal?

❑ YES, process a one-time eCheck with the bank information above. ❑ NO, I have submitted my payment by another method.

FOR INDEPENDENT BROKER'S USE ONLY

Broker Certification

1. Who actually completed this application?
   ❑ Applicant ❑ Broker ❑ Other
   If Broker or Other, please explain: _____
2. Were you present at the time the application was filled out?
   ❑ YES ❑ NO
   If NO, please explain: _____

I have explained the eligibility provisions to the applicant. I have not made any representations about benefits, conditions or limitations of the policy except through written material furnished by Blue Cross of Idaho. I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

_____	_____	_____	_____
Broker's Printed Name	*Broker's Signature*	*Date (mm/dd/yy)*	*Blue Cross of Idaho Number*

Type of Company Appointment ❑ *Personal* ❑ *Agency*

_____	_____
Name	*Business Phone*

This application is approved by Blue Cross of Idaho.

Benefit Period

_____	____/____/____	____/____/____	____/____/____
District Manager's Signature	Date (mm/dd/yy)	Effective Date (mm/dd/yy)	Expiration Date (mm/dd/yy)

(Dates assigned by District Manager

REPLACEMENT OF EXISTING COVERAGE

Will this policy replace any other accident and sickness insurance presently in force? ❑ YES ❑ NO

If YES, please read, sign and date the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to this application, you intend to allow to lapse or otherwise terminate existing accident and sickness insurance and replace it with a program to be issued by Blue Cross of Idaho. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the healthcare coverage available to you under the new program.

1. Health conditions which you may presently have (preexisting conditions), will not be covered under the new program. This could result in denial of a claim for benefits under the new program, whereas a similar claim might have been payable under your present program.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present program. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present program and replace it with new coverage, please be certain to completely and accurately answer all questions on this application. Failure to include all information on an application may provide a basis for the company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I confirm that a copy of "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance" was furnished to me.

X _____	_____
Applicant's Signature	Date (mm/dd/yy)

Parent or Guardian's signature (if applicant is under 18 years of age)

PARENTAL OR GUARDIAN CONSENT TO APPLICATION

I, the undersigned, represent that the person listed as the applicant on this application is under 18 years of age and is making application for Blue Cross of Idaho health coverage with my full knowledge and consent. I hereby accept full responsibility for the payment of premiums and for the answers and information provided in this application.

X_____ _____ _____ _____

Signature | Date (mm/dd/yy) | Print Name | Relationship

STATEMENT OF UNDERSTANDING

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No broker, agent, or employee of Blue Cross of Idaho can change any part of this application or waive the requirement that I answer all questions completely and accurately, nor can any such person change the terms of the policy, except by endorsement issued expressly for that purpose over the signature or facsimile signature of the President of Blue Cross of Idaho.
- Blue Cross of Idaho may review this application and, at its discretion, request supplemental information from me, any family member listed on this application or any healthcare providers before deciding whether to approve or reject the application.
- Blue Cross of Idaho may deny benefits or terminate or rescind my policy retroactive to its effective date for any misrepresentation, omission or concealment of fact by, concerning, or on behalf of any persons listed on this application that was or would have been material to Blue Cross of Idaho's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is not approved for the program applied for, any payment submitted with this application will be refunded. Upon the refund of the payment, Blue Cross of Idaho will have no further obligations to me or any family member listed on this application.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin 12:01 a.m. the day after we receive your completed application, or the effective date you request, whichever is later.
- I authorize any physician, hospital or other healthcare provider to furnish Blue Cross of Idaho information regarding the history, diagnosis or treatment of any symptom, condition, disease, illness or accidental injury of any person named on this application.
- On behalf of myself and all enrolled family members, I authorize Blue Cross of Idaho to release information to enrolled family members, healthcare providers, other insurers and government agencies to the extent required to process claims, coordinate benefits, conduct utilization review, and perform audits and fraud investigations.
- This program does not cover services received for any Preexisting Conditions. Preexisting Condition means any condition:
  - that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment within the six month period preceding the effective date
  - for which medical advice, diagnosis, care or treatment was recommended by or received from a healthcare provider within the six month period preceding the effective date
  - a pregnancy existing on the effective date of coverage, except for involuntary complications of pregnancy incurred after the effective date
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating healthcare treatment, payment or for the purpose of business operations necessary to administer healthcare benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at **bcidaho.com**.
- I affirm that I have reviewed all the answers given on this application and, regardless of whether a broker or other person has filled out the answers for me and on my behalf, I verify the answers accurately reflect all the information given by me.

I understand that this application will become part of any agreement or policy that Blue Cross of Idaho issues.

X_____ _____

Applicant's Signature | Date (mm/dd/yy)

(Parent or Guardian's signature if applicant is under 18 years of age)

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc., (collectively referred to as Blue Cross of Idaho) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Customer Service Department. Call 1-800-627-1188 (TTY: 711), or call the customer service phone number on the back of your card. If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievances&appeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html***.

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY:711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY:711）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टिटिवाइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).