

## Applying for a Blue Cross Short-Term Plan is Simple.

Just Follow 3 Easy Steps...

**Step 1** Print the application and complete in black or blue ink.

**Step 2** Call or fax in to pre-screen your application.

**Step 3** Mail or fax the application with first month's payment to the address below.

*To assist you with completing the application here is a checklist:*

\_\_\_ Effective date can be as soon as next day.

\_\_\_ Short-Term plans do not cover pre-existing conditions & have a 5-year look back period.

\_\_\_ Family Applications – Each family member must apply separately

\_\_\_ Plans are not renewable – You must reapply once your plan terminates

- We suggest you apply for the longest period – 180 days
- You are only required to pay for 1 month at a time, you can cancel at any time

\_\_\_ Payment options:

1. Credit card is the quickest processing method
2. By Check – The plan will not be effective until after payment for 1<sup>st</sup> month is received by Blue Cross. You can only pay by check for the 1<sup>st</sup> month.

*Please call with any questions; office hours are 9am – 9pm, Monday thru Friday*

404 575-1960

800 910-1507

404 575-1967 fax

Please call us or fax your completed application, so that we may pre-screen it for detail and completeness before you mail it. After the pre-screen review is completed, please mail the application with payment information to:

HealthPlanStore  
817 West Peachtree Street  
Suite 915  
Atlanta, Ga 30308



# Short Term Medical Application

Mail Code: G00302

3350 Peachtree Road, NE Atlanta, GA 30326

Fax: (404) 682-3237

## Requested Effective Date

Month	Day	Year
-------	-----	------

NOTE: The actual effective date is contingent upon the receipt of your properly completed application and the correct payment.

APPLICANT'S NAME (LAST, FIRST, MIDDLE)	SEX	BIRTHDATE (MM/DD/YY)	APPLICANT SOCIAL SECURITY NUMBER		
RESIDENTIAL ADDRESS	CITY	STATE	ZIP		
COUNTY	DAY TELEPHONE	EVENING TELEPHONE			

Are you applying for other medical coverage with BCBSGa?  Yes  No

Please answer the following questions completely and accurately. If you check **Yes** to questions 1-4 you are **not eligible** for coverage. Yes No

- Will you or any person to be insured have any other hospital, major medical or group health insurance in force on the effective date of this plan?  Yes  No
- Have/ are you: Now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?  Yes  No  
**Note: Pregnant women are not eligible to apply**
- Is your weight greater than the maximum weight as indicated in the charts below?  Yes  No

Height	Max Weight	Height	Max Weight	Height	Max Weight
4'0"	122	5'0"	196	6'0"	257
4'1"	126	5'1"	199	6'1"	273
4'2"	132	5'2"	202	6'2"	281
4'3"	138	5'3"	207	6'3"	291
4'4"	142	5'4"	211	6'4"	298
4'5"	149	5'5"	215	6'5"	307
4'6"	154	5'6"	219	6'6"	314
4'7"	161	5'7"	229		
4'8"	166	5'8"	235		
4'9"	172	5'9"	241		
4'10"	189	5'10"	246		
4'11"	193	5'11"	252		

Height	Max Weight	Height	Max Weight	Height	Max Weight
4'6"	158	5'6"	230	6'6"	322
4'7"	165	5'7"	234	6'7"	332
4'8"	170	5'8"	249	6'8"	338
4'9"	177	5'9"	256	6'9"	349
4'10"	182	5'10"	262	6'10"	355
4'11"	189	5'11"	270	6'11"	366
5'0"	195	6'0"	277	7'0"	374
5'1"	202	6'1"	285	7'1"	384
5'2"	215	6'2"	292	7'2"	391
5'3"	218	6'3"	300	7'3"	401
5'4"	222	6'4"	307		
5'5"	226	6'5"	316		

4. For any of the following conditions, within the last 5 years, have you received any abnormal test results or medical or surgical treatment, or consulted a health care professional or taken medication for:
- Heart disorder including but not limited to heart attack or chest pain; chronic respiratory conditions including, chronic obstructive pulmonary disease or emphysema; ulcers; colitis or Crohn's disease; liver, hepatitis, Rheumatoid Arthritis, acquired immune deficiency syndrome (AIDS) and related immune system disorders, or have tested positive for HIV?  Yes  No
  - Uncorrected gall bladder disease or gall stones; stroke or circulatory system disorders; leukemia; kidney disease, undergoing kidney dialysis; diabetes type I or type II; cancer, tumor or internal cyst; alcoholism or alcohol abuse, chemical/substance dependency or drug abuse?  Yes  No

PLAN SELECTION		
<b>Benefit Period</b> <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 150 days <input type="checkbox"/> 180 days	<b>Deductible Amount</b> <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500	<b>Plan Pays After Deductible</b> <input type="checkbox"/> 80%

- Do you currently have health care coverage?  Yes  No
- Did you have creditable coverage within the past 63 days?  Yes  No

**Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross Blue Shield of Georgia.**

**CONDITIONAL RECEIPT** – THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET. Blue Cross Blue Shield of Georgia (BCBSGa) has received from the named Applicant an advance deposit equal to the first 30 day's premium together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

- Subject to the provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by Medical Underwriting, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first 30 day's premium and provided that BCBSGa determines that as of the date of the application all proposed covered persons were acceptable for coverage and for the benefits applied for.
- If the application is not approved by BCBSGa said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the applicant.
- No one has the authority to waive or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 30 days, please contact Blue Cross Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

**ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

**PRIVACY ACT.** Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We need your answers to decide if you qualify for coverage. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

**ALL DATA CONFIDENTIAL.** We are required by law to keep such data confidential. It will be seen only by employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. We may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of our standard business practice or required by law.

**ACCESS TO YOUR DATA.** You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Blue Cross Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

