



ShortTerm Medical Enrollment Form

For office use only

Sys. Number	Rep. Number	Date
Business Name		

Applicant Name _____ Male Female
Last First M.I.

Residential Address _____
Street

City County State ZIP Code + 4

Mailing Address _____
Street/P.O. Box

City State ZIP Code + 4

Home Phone (_____) _____ Daytime Phone (_____) _____ Cell Phone (_____) _____
Area Code Area Code Area Code

Social Security No. _____ Date of Birth ____/____/____

I am applying for coverage for: (check one)

- Myself Myself and my child(ren) Myself and my spouse My family

List all persons applying for coverage

Relationship	Full Name	Date of Birth	Gender	Social Security No.
Spouse				
Child				
Child				
Child				
Child				

Coverage Information

Effective date of coverage will be the first of the month following receipt of payment OR if after that date, requested **effective date** _____ (Cannot be more than 90 days after signed enrollment form)

Coverage term: 1 Month 2 Months 3 Months 4 Months 5 Months 6 Months

Deductible: \$500/\$1,500 \$1,000/\$3,000 \$2,500/\$7,500

Health Questions

1. Will this replace present coverage? Yes No
 If "Yes," state termination date _____
2. Will there be any other health insurance in force on the effective date? Yes No
3. Is proposed insured, spouse or any dependent child (whether applying or not) now pregnant? Yes No
4. Within the last 5 years, have you or any proposed insured above ever received any medical or surgical consultation, advice or treatment including medication for: heart or circulatory system disorder, including heart attack or chest pain; stroke; diabetes; cancer or tumor; infertility; alcoholism or alcohol abuse; drug abuse or chemical dependency?
 Yes No If "Yes," give name _____
5. In the past 5 years, have you or any proposed insured above ever received medical services from a physician or other health care provider for HIV infection, AIDS, AIDS Related Complex or tested positive for AIDS virus or other diseases related to the immune system other than HIV? Yes No If "Yes," give name _____

I understand that, if coverage is offered: (1) the effective date of coverage will be the later of; the first of the month following receipt of payment by Blue Cross and Blue Shield of Kansas (BCBSKS) or the effective date I request. In no event will the effective date be more than 90 days after I sign this enrollment form; (2) pre-existing conditions will not be covered; (3) coverage is renewable one time upon underwriting approval; and (4) deductible changes cannot be made after coverage is in effect. I understand that any incomplete or incorrect statement on this enrollment application may result in a denial of a claim and/or discontinuance of coverage. I understand that BCBSKS will terminate or rescind the contract for the following conditions: 1) if the information received from future claims or supporting records within two years after the date the contract becomes effective indicates information provided on this enrollment form was incorrect; 2) if such information received at any time indicates the information provided in this enrollment form intentionally misrepresented a material fact or was fraudulent. I understand no representative of BCBSKS has the authority to waive any information required on this enrollment form; or to bind BCBSKS to provide coverage for me or any of my dependents or to waive, alter or change the provisions of the contract which may be issued. I authorize health care providers, insurers, health plans, claim administrators and employers to provide to BCBSKS or its representatives, any information available about me, and/or my dependents' employment and/or medical history, condition and treatment. This authorization also specifically applies to any information relating to psychiatric histories and treatment, or positive HIV status.

I understand all coverage is subject to the health of all applicants on this form remaining unchanged to the effective date of coverage. If any change in health occurs before the effective date of coverage, I understand I must notify the BCBSKS Underwriting Department at 1-800-432-0216. (A photographic copy of this authorization shall be as valid as the original.)

I represent that all statements made herein are complete and true to the best of my knowledge. I understand that failure to provide any material information, or if I intentionally misrepresent any material fact, such omission or intentional misrepresentation may result in the termination or rescission of my health care coverage and/or criminal prosecution. I hereby apply for Short Term Medical insurance.

Proxy

I hereby appoint the board of directors ("Board") of Blue Cross and Blue Shield of Kansas, Inc., ("Company") as my proxy to act on my behalf at all annual meetings of the policyholders of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy give the Board, or its designee, full power to vote for me on all matters that may be voted upon at any annual meeting. This proxy, unless revoked, shall remain in effect during my membership in the Company. I may revoke this proxy in writing by advising the Company of such at least five (5) days prior to any meeting. I may also revoke my proxy by attending and voting in person at any annual meeting.

I accept

I do not accept

Applicant's Signature Required

Applicant (Parent or guardian signature required for minors under the age of 18.)

Date _____

Print Your Name: _____



Monthly Premiums

ShortTermMedicalSM

Select the coverage benefit period that best meets your needs by choosing from one to six months of coverage. **Full payment for the period you select will be required at the time of application.** Make your check for the appropriate amount payable to Blue Cross and Blue Shield of Kansas. Please mail to P.O. Box 517, Topeka, KS 66601

Option 1: \$500 Individual/\$1,500 Family Deductible

Ages	Monthly Premium for Myself	Monthly Premium for Myself and My Child(ren)	Monthly Premium* for Myself and My Spouse	Monthly Premium* for Myself and My Family
3 months – 1 year	130.31	204.39	291.66	410.44
2-13	73.63	115.47	291.66	410.44
14-19	82.80	129.85	291.66	410.44
20	84.08	131.72	294.47	414.48
21	84.08	131.72	298.65	420.36
22	84.08	131.72	302.79	426.24
23	86.35	135.26	302.79	426.24
24	88.63	138.81	302.79	426.24
25	90.34	141.31	301.53	424.51
26	92.58	144.84	301.53	424.51
27	94.84	148.35	301.53	424.51
28	94.99	148.56	295.29	415.75
29	94.99	148.56	289.09	407.01
30	94.47	147.58	281.43	396.32
31	94.60	147.79	275.25	387.60
32	94.60	147.79	269.06	378.88
33	94.90	148.23	265.64	374.08
34	95.03	148.45	262.18	369.23
35	94.68	147.74	257.88	363.19
36	94.82	147.96	254.46	358.38
37	95.09	148.40	251.38	354.05
38	98.43	153.60	252.07	355.01
39	101.76	158.80	253.10	356.46
40	104.71	163.26	252.88	356.22
41	108.16	168.64	253.92	357.67
42	111.49	173.83	254.95	359.09
43	118.12	184.19	263.79	371.59
44	124.90	194.73	273.02	384.55
45	131.31	204.55	281.47	396.49
46	137.93	214.86	290.67	409.43
47	144.70	225.40	299.82	422.35
48	157.50	245.37	320.58	451.56
49	170.34	265.35	340.98	480.31
50	182.62	284.30	360.70	508.19
51	195.40	304.21	381.39	537.30
52	208.18	324.11	402.05	566.46
53	223.45	347.87	438.02	617.09
54	238.85	371.85	473.94	667.71
55	253.37	394.22	508.49	716.44
56	268.73	418.12	544.33	766.95
57	284.07	442.01	580.15	817.43
58	299.98	466.76	625.13	880.80
59	315.88	491.49	670.11	944.15
60	330.99	514.70	713.11	1,004.83
61	346.85	539.36	757.98	1,068.04
62	362.72	564.05	802.84	1,131.27
63	378.58	588.71	847.70	1,194.48
64	394.45	613.39	892.56	1,257.70

*Family premiums are based on the age of the male insured, the male spouse or the female head of household (if no male spouse exists).



Monthly Premiums

ShortTermMedicalSM

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Option 2: \$1,000 Individual/\$3,000 Family Deductible

Ages	Monthly Premium for Myself	Monthly Premium for Myself and My Child(ren)	Monthly Premium* for Myself and My Spouse	Monthly Premium* for Myself and My Family
3 months – 1 year	101.70	160.10	227.39	319.80
2-13	57.46	90.46	227.39	319.80
14-19	64.60	101.70	227.39	319.80
20	65.40	102.74	228.72	321.76
21	65.40	102.74	231.94	326.30
22	65.40	102.74	235.19	330.85
23	67.16	105.51	235.19	330.85
24	68.91	108.27	235.19	330.85
25	70.00	109.80	233.41	328.49
26	71.74	112.54	233.41	328.49
27	73.50	115.26	233.41	328.49
28	73.60	115.43	228.60	321.72
29	73.60	115.43	223.80	314.94
30	72.98	114.28	217.24	305.80
31	73.09	114.46	212.47	299.08
32	73.09	114.46	207.69	292.33
33	73.31	114.79	205.05	288.61
34	73.42	114.95	202.38	284.87
35	72.95	114.07	198.56	279.54
36	73.08	114.27	195.92	275.82
37	73.28	114.59	193.56	272.49
38	75.83	118.60	194.07	273.22
39	78.41	122.62	194.86	274.34
40	80.48	125.72	194.28	273.55
41	83.13	129.87	195.05	274.66
42	85.68	133.85	195.84	275.79
43	90.80	141.84	202.65	285.35
44	95.99	149.96	209.73	295.33
45	100.71	157.16	215.80	303.91
46	105.79	165.09	222.82	313.82
47	110.97	173.17	229.86	323.76
48	120.80	188.52	245.75	346.13
49	130.65	203.90	261.39	368.14
50	139.83	218.01	276.07	388.87
51	149.62	233.29	291.91	411.16
52	159.41	248.53	307.74	433.46
53	171.10	266.77	335.25	472.20
54	182.89	285.16	362.74	510.94
55	193.73	301.78	388.60	547.42
56	205.47	320.06	415.98	585.98
57	217.21	338.36	443.37	624.56
58	229.37	357.31	477.73	672.98
59	241.53	376.24	512.08	721.39
60	252.71	393.42	544.29	766.80
61	264.82	412.28	578.51	815.02
62	276.93	431.14	612.77	863.26
63	289.05	449.99	647.02	911.51
64	301.17	468.85	681.25	959.75

*Family premiums are based on the age of the male insured, the male spouse or the female head of household (if no male spouse exists).



Monthly Premiums

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Option 3: \$2,500 Individual/\$7,500 Family Deductible

Ages	Monthly Premium for Myself	Monthly Premium for Myself and My Child(ren)	Monthly Premium* for Myself and My Spouse	Monthly Premium* for Myself and My Family
3 months – 1 year	84.30	133.08	188.26	264.66
2-13	47.63	75.17	188.26	264.66
14-19	53.56	84.54	188.26	264.66
20	54.03	85.09	188.76	265.44
21	54.03	85.09	191.42	269.20
22	54.03	85.09	194.08	272.96
23	55.46	87.37	194.08	272.96
24	56.92	89.67	194.08	272.96
25	57.69	90.66	192.10	270.26
26	59.12	92.92	192.10	270.26
27	60.55	95.17	192.10	270.26
28	60.64	95.30	188.13	264.69
29	60.64	95.30	184.19	259.12
30	59.98	94.12	178.36	251.03
31	60.07	94.24	174.46	245.49
32	60.07	94.24	170.52	239.99
33	60.25	94.52	168.35	236.92
34	60.33	94.67	166.18	233.85
35	59.80	93.69	162.65	228.94
36	59.90	93.82	160.51	225.91
37	60.07	94.12	158.57	223.18
38	62.17	97.41	159.00	223.81
39	64.27	100.69	159.65	224.70
40	65.86	103.03	158.88	223.65
41	68.04	106.43	159.51	224.55
42	70.11	109.70	160.15	225.45
43	74.30	116.22	165.73	233.30
44	78.56	122.90	171.51	241.45
45	82.25	128.56	176.19	248.07
46	86.41	135.02	181.93	256.16
47	90.64	141.66	187.68	264.24
48	98.67	154.21	200.64	282.53
49	106.73	166.77	213.43	300.50
50	114.04	178.03	225.07	316.97
51	122.02	190.51	237.98	335.14
52	130.01	202.97	250.88	353.29
53	139.53	217.86	273.30	384.88
54	149.15	232.87	295.73	416.46
55	157.77	246.06	316.39	445.62
56	167.33	260.97	338.68	477.04
57	176.90	275.89	360.98	508.44
58	186.81	291.33	388.96	547.85
59	196.70	306.77	416.95	587.26
60	205.58	320.38	442.67	623.60
61	215.45	335.73	470.52	662.84
62	225.29	351.09	498.38	702.06
63	235.13	366.46	526.23	741.31
64	245.01	381.80	554.08	780.54

*Family premiums are based on the age of the male insured, the male spouse or the female head of household (if no male spouse exists).