



# Monthly Premiums

## ShortTermMedical<sup>SM</sup>

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	115.32	N/A	N/A	N/A
2-13	65.16	N/A	N/A	N/A
14-19	73.27	114.91	258.11	363.22
20	74.41	116.57	260.59	366.80
21	74.41	116.57	264.29	372.00
22	74.41	116.57	267.96	377.20
23	76.42	119.70	267.96	377.20
24	78.43	122.84	267.96	377.20
25	79.95	125.05	266.84	375.67
26	81.93	128.18	266.84	375.67
27	83.93	131.28	266.84	375.67
28	84.06	131.47	261.32	367.92
29	84.06	131.47	255.83	360.19
30	83.60	130.60	249.05	350.73
31	83.72	130.79	243.58	343.01
32	83.72	130.79	238.11	335.29
33	83.98	131.18	235.08	331.04
34	84.10	131.37	232.02	326.75
35	83.79	130.74	228.21	321.41
36	83.91	130.94	225.19	317.15
37	84.15	131.33	222.46	313.32
38	87.11	135.93	223.07	314.17
39	90.05	140.53	223.98	315.45
40	92.66	144.48	223.79	315.24
41	95.72	149.24	224.71	316.52
42	98.66	153.83	225.62	317.78
43	104.53	163.00	233.44	328.84
44	110.53	172.33	241.61	340.31
45	116.20	181.02	249.09	350.88
46	122.06	190.14	257.23	362.33
47	128.05	199.47	265.33	373.76
48	139.38	217.14	283.70	399.61
49	150.74	234.82	301.75	425.05
50	161.61	251.59	319.20	449.73
51	172.92	269.21	337.51	475.49
52	184.23	286.82	355.80	501.29
53	197.74	307.85	387.63	546.10
54	211.37	329.07	419.42	590.89
55	224.22	348.87	449.99	634.02
56	237.81	370.02	481.71	678.72
57	251.39	391.16	513.41	723.39
58	265.47	413.06	553.21	779.47
59	279.54	434.95	593.02	835.53
60	292.91	455.49	631.07	889.23
61	306.95	477.31	670.78	945.17
62	320.99	499.16	710.48	1001.12
63	335.03	520.98	750.18	1057.06
64	349.07	542.82	789.88	1113.01

\*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).



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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	90.00	N/A	N/A	N/A
2-13	50.85	N/A	N/A	N/A
14-19	57.17	90.00	201.23	283.01
20	57.88	90.92	202.41	284.74
21	57.88	90.92	205.26	288.76
22	57.88	90.92	208.13	292.79
23	59.43	93.37	208.13	292.79
24	60.98	95.81	208.13	292.79
25	61.95	97.17	206.56	290.70
26	63.49	99.59	206.56	290.70
27	65.04	102.00	206.56	290.70
28	65.13	102.15	202.30	284.71
29	65.13	102.15	198.05	278.71
30	64.58	101.13	192.25	270.62
31	64.68	101.29	188.03	264.67
32	64.68	101.29	183.80	258.70
33	64.88	101.58	181.46	255.41
34	64.97	101.73	179.10	252.10
35	64.56	100.95	175.72	247.38
36	64.67	101.12	173.38	244.09
37	64.85	101.41	171.29	241.14
38	67.11	104.96	171.74	241.79
39	69.39	108.51	172.44	242.78
40	71.22	111.26	171.93	242.08
41	73.57	114.93	172.61	243.06
42	75.82	118.45	173.31	244.06
43	80.35	125.52	179.34	252.52
44	84.95	132.71	185.60	261.35
45	89.12	139.08	190.97	268.95
46	93.62	146.10	197.19	277.72
47	98.20	153.25	203.42	286.51
48	106.90	166.83	217.48	306.31
49	115.62	180.44	231.32	325.79
50	123.74	192.93	244.31	344.13
51	132.41	206.45	258.33	363.86
52	141.07	219.94	272.34	383.59
53	151.42	236.08	296.68	417.88
54	161.85	252.35	321.01	452.16
55	171.44	267.06	343.89	484.44
56	181.83	283.24	368.12	518.57
57	192.22	299.43	392.36	552.71
58	202.98	316.20	422.77	595.56
59	213.74	332.96	453.17	638.40
60	223.64	348.16	481.67	678.58
61	234.35	364.85	511.96	721.26
62	245.07	381.54	542.27	763.95
63	255.80	398.22	572.58	806.65
64	266.52	414.91	602.88	849.34

\*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).



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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	74.60	N/A	N/A	N/A
2-13	42.15	N/A	N/A	N/A
14-19	47.40	74.81	166.60	234.21
20	47.81	75.30	167.04	234.90
21	47.81	75.30	169.40	238.23
22	47.81	75.30	171.75	241.56
23	49.08	77.32	171.75	241.56
24	50.37	79.35	171.75	241.56
25	51.05	80.23	170.00	239.17
26	52.32	82.23	170.00	239.17
27	53.58	84.22	170.00	239.17
28	53.66	84.34	166.49	234.24
29	53.66	84.34	163.00	229.31
30	53.08	83.29	157.84	222.15
31	53.16	83.40	154.39	217.25
32	53.16	83.40	150.90	212.38
33	53.32	83.65	148.98	209.66
34	53.39	83.78	147.06	206.95
35	52.92	82.91	143.94	202.60
36	53.01	83.03	142.04	199.92
37	53.16	83.29	140.33	197.50
38	55.02	86.20	140.71	198.06
39	56.88	89.11	141.28	198.85
40	58.28	91.18	140.60	197.92
41	60.21	94.19	141.16	198.72
42	62.04	97.08	141.73	199.51
43	65.75	102.85	146.66	206.46
44	69.52	108.76	151.78	213.67
45	72.79	113.77	155.92	219.53
46	76.47	119.49	161.00	226.69
47	80.21	125.36	166.09	233.84
48	87.32	136.47	177.56	250.03
49	94.45	147.58	188.88	265.93
50	100.92	157.55	199.18	280.50
51	107.98	168.59	210.60	296.58
52	115.05	179.62	222.02	312.65
53	123.48	192.80	241.86	340.60
54	131.99	206.08	261.71	368.55
55	139.62	217.75	279.99	394.35
56	148.08	230.95	299.72	422.16
57	156.55	244.15	319.45	449.95
58	165.32	257.81	344.21	484.82
59	174.07	271.48	368.98	519.70
60	181.93	283.52	391.74	551.86
61	190.66	297.11	416.39	586.58
62	199.37	310.70	441.04	621.29
63	208.08	324.30	465.69	656.03
64	216.82	337.88	490.34	690.74

\*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).



# ShortTermMedical EnrollmentForm

For office use only

Sys. Number	Rep. Number	Date
Business Name		

Applicant Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
First M.I. Last

Address \_\_\_\_\_ Social Security No. \_\_\_\_\_

\_\_\_\_\_  
Street  
 \_\_\_\_\_  
City State ZIP

Gender:  Male  Female

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_  
Area Code Area Code

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				
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

- Will this certificate replace present coverage?  Yes  No  
 If "Yes," state termination date \_\_\_\_\_
- Will there be any other health insurance in force on the certificate effective date?  Yes  No
- Is proposed insured, spouse or any dependent child (whether applying or not) now pregnant?  Yes  No
- 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 \_\_\_\_\_
- 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 persons proposed for coverage are eligible and 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 if at any time it is determined a person listed on this application did not meet the Contract's definition of dependent, or information requested herein was incomplete or incorrect; BCBSKS has the right to cancel or rescind coverage for that person or for all persons covered under the contract, and to recover any benefit payments for such ineligible person or persons. I authorize health care providers, insurers, health plans, claim administrators and employers to provide to Blue Cross and Blue Shield of Kansas or its representatives (BCBSKS), 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. **(PARENT OR GUARDIAN SIGNATURE REQUIRED FOR MINORS UNDER THE AGE OF 18.)** I hereby subscribe to apply for Short Term Medical insurance.

Signature of Applicant 

Date 

Applicant (Signature of parent if other than applicant)

Signature of Applicant's Spouse \_\_\_\_\_

Date \_\_\_\_\_

Proxy (Optional)

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.

Dated this \_\_\_\_\_

Month

Day

Year

Signature 