BlueCross BlueShield of Nebraska
An Independent Licensee of the Blue Cross and Blue Shield Association.

TempCare Application

Primary applicant must be age 19 or older to be eligible for coverage.

A check for the first month's premium is required with the application. ***Please print and press firmly using black ink.***

Section I — Insured Information

a. Social Security Number - -	**b.** Insured's Name (Last, First, M.I., Title)	**c.** Date of Birth (mm/dd/yyyy)
d. Gender: ☐ Female ☐ Male	**e.** Address (Street, P.O. Box, Apt. #, City, State, Zip + 4 Code)	
f. Telephone Number ( )	**g.** Your Place of Employment	**h.** E-mail Address

Section II — Spouse and Dependent Information

+List below your spouse and dependent(s) applying for coverage. List in order of age – oldest first. Children under age 26 are eligible if they meet eligibility requirements. Documentation of eligibility may be requested by us.

Full Name	Date of Birth (mm/dd/yyyy)	Gender	Relation to Proposed Insured
	/ /	☐ Male ☐ Female	
	/ /	☐ Male ☐ Female	
	/ /	☐ Male ☐ Female	

Section III — Coverage Information

1. Have/Are you, your spouse or any dependent applying for this coverage:
- a. ever been a Blue Cross and Blue Shield member? ☐ Yes ☐ No
- b. currently a Blue Cross and Blue Shield member? ☐ Yes ☐ No
- c. ever previously applied for Blue Cross and Blue Shield coverage? ☐ Yes ☐ No
- d. currently eligible for Blue Cross and Blue Shield coverage under a group plan? ☐ Yes ☐ No

If "Yes," please provide details below.

Blue Cross Blue Shield Plan	ID Number(s)	Group or Individual	Are you replacing this coverage?	If replacing group coverage, termination date and reason
☐ BCBS – Nebraska ☐ BCBS – Other: _____		☐ Group ☐ Individual	☐ Yes ☐ No	

2. Are you, your spouse or any dependent applying for this coverage eligible for or enrolled in Medicare..... ☐ Yes ☐ No

If "Yes," please provide details below.

Part A Effective Date	Part B Effective Date

Section IV — Plan Information

Type of Coverage:

☐ Single ☐ Single Parent (Applicant + child(ren))

☐ Family Coverage (Applicant + spouse + child(ren))

Calendar Year Deductible: (Select one)

☐ 500 / 1000 ☐ 1000 / 2000

☐ 1500 / 3000 ☐ 5000 / 10000

Effective Date:

☐ I elect my effective date to be the 1st of the month following application approval

☐ I elect++ my effective date to be: _____

For Internal Use Only

Effective Date_____

Term Date_____

++I hereby request the effective date specified above. I understand that I cannot later request a change of this date. I further understand that upon my acceptance of this contract, I must pay premiums to Blue Cross and Blue Shield of Nebraska retroactive to the requested effective date.

Section V — Payment Information – Payment Type

☐ **Monthly Direct Bill**

☐ **Monthly Automatic Debit** (Please complete the below information)

Name of Bank: _____

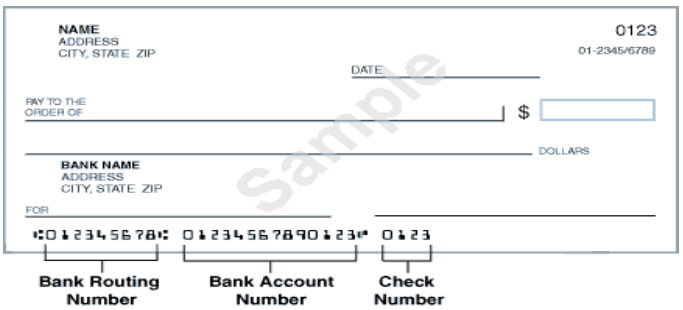
Town/City: _____

Account Number: _____

Type of Account: ☐ Checking ☐ Savings

Routing/ABA Number: ☐☐☐☐☐☐☐☐☐

Name of Payor as shown on bank account: _____



Please note: Payor must also sign last page of application if different from applicant.

For Internal Use Only	Group Number:

Social Security Number:	Insured's Name (Last, First):

Section VI Certification of Non-Applicability of the Health Insurance Portability and Accountability Act

Will an employer be paying any part of this premium through contribution, bank debit or Section 125 arrangements?..... ☐ Yes ☐ No

If "Yes," please have <u>your employer</u> check the applicable box and sign where indicated:

I certify that employer contribution to the Proposed Insured's health insurance policy does not violate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) because:

- ☐ This is the only employee for whom I am contributing to insurance coverage.
- ☐ This policy is being purchased to cover a business owner only and is not part of an employee benefit plan.
- ☐ The premiums being debited from the business account are being totally reimbursed by means of payroll deduction.

I certify the truthfulness of the above statement. I understand that fines and penalties may be imposed upon an employer and an insurer for violation of HIPAA provisions relating to creditable coverage, nondiscrimination, and limitations on pre-existing conditions. I agree to hold Blue Cross and Blue Shield harmless from any fines or liability if the above certifications are incorrect.

Name of Business Entity	Address of Business Entity (Street, City, State, Zip + 4)

Signature and Title ×	Date

Section VII Acknowledgement and Authorizations

Acknowledgement

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN.

In applying for this coverage, I understand that:

1) This policy is payable monthly and will automatically end ten (10) months after the effective date.
2) There are no benefits for any illness or injury for which I or a listed eligible dependent have had symptoms or been treated within twelve (12) months prior to the effective date (pre-existing conditions).
3) There are no maternity benefits, except limited benefits for certain complications of pregnancy if enrolled under a Single-Parent or Family Membership. (Complications do not include a caesarean section.)
4) There are no benefits for treatment of mental illness, alcoholism or drug abuse.
5) There are no benefits for organ transplants.
6) There are no benefits for treatment of birth abnormalities existing at the time this Contract comes into effect.

This application contains only a partial list of the exclusions that apply to the TempCare coverage. Please see the Contract for a complete listing and explanation.

I represent that my answers and statements in this application are true and complete to the best of my knowledge and belief. If an effective date is requested and approved, I understand that I cannot request a change of that date, and that premiums are owed from that date forward. The Preadmission Certification Program has been explained to me. I understand that all inpatient hospitalizations must be precertified by Blue Cross and Blue Shield of Nebraska, or benefits will be reduced. I authorize providers of health care to furnish Blue Cross and Blue Shield of Nebraska with medical information to the extent necessary for processing claims.

If my application was taken by a depositor bank agent, I have been verbally told the following: The insurance product is not a deposit or other obligation of or guaranteed by, any bank or affiliate of any bank; and the insurance product is not insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank, or an affiliate of the bank.

Automatic Debit Authorization

If Payment Type is Monthly Automatic Debit – I authorize Blue Cross and Blue Shield of Nebraska to initiate debit entries (charges) to the account indicated, and the named Financial Institution to charge the said account. This authority is to remain in effect until the Financial Institution has received written notification from me of its termination in such time as to afford the Financial Institution a reasonable opportunity to act on it. The current premium is to be charged to my account on or after the **20th** day of each month. (The first debit may be for more than one month's premium depending on the effective date of your coverage and the date your initial debit is processed.) I understand that premiums will continue to be withdrawn unless or until Blue Cross and Blue Shield of Nebraska receives a written request to terminate the charges or stop payment is made. In that event, insurance coverage will be terminated unless a replacement debit authorization is received. Termination will take effect the last day of the month after receipt of the request for termination.

Section VIII Signatures

× Signature _____ Date _____

× Signature of Spouse (if family coverage) _____ Date _____

× Signature of Payor as shown on bank account _____ Date _____
(If payment type is Monthly Automatic Debit <u>and</u> Payor is someone other than applicant)

× Signature of Agent _____ Date _____

Printed Name of Agent Chad Larson Agent Number AA68

For Agent Use Only	Insured: ☐ Male ☐ Female Age:_____ Premium:$_____	Spouse: Age:_____ Premium:$_____	Number of Children: _____ Premium: $_____