



P.O. Box 2031, Aurora, IL 60507-2031

Blue TransitionsSM

Temporary Individual Coverage

Please print all information in blue or black ink.

Home office use only

REQUESTED EFFECTIVE DATE: _____
MM/DD/YY

Your Information

Applicant's First Name, M.I., Last Name | Sex M F | Birth Date | Age | Social Security Number

Street Address | City | State | ZIP Code

Home Telephone Number | Work Telephone Number

Dependents to be Covered (First Name, M.I., Last Name) | Sex M F | Birth Date | Age | Social Security Number

| Sex M F | Birth Date | Age | Social Security Number

| Sex M F | Birth Date | Age | Social Security Number

For more dependents, use additional sheet. Sign and date the sheet. Children you wish to cover must be unmarried, at least 60 days of age, and less than 25 years of age. Newborn and adopted children may be covered from birth or date of adoption if coverage is court ordered.

- Yes No 1. Is any dependent coverage required by court order?
- Yes No 2. If "Yes," was the court order effective within the last 31 days?
- Yes No 3. Are you or any person to be insured a U.S. citizen or a permanent resident living in the United States for at least 2 years?
If the answer is "No," coverage cannot be issued.

Benefit Period, Deductible Selection, and Method of Payment

I (we) hereby apply for: Benefit Period: 1 month 2 months 3 months 4 months 5 months 6 months
(Members have an option to reapply for an additional 1, 2, 3, 4, 5, or 6 month benefit period. This reapplication is subject to Medical Underwriting).

Deductible Amount: \$500 \$1,000 \$2,000

Total Premium Due \$ _____ Make your check payable to **Blue Cross and Blue Shield of New Mexico**. Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.

Method of Payment

- Single Payment Plan Available for 1- to 6-month benefit periods. The entire premium must be submitted with the application.
- Monthly Bank Draft Available for 2- to 6-month benefit periods.

Health Information – Tell us about yourself

If the answer is "Yes" to any of the following questions, coverage cannot be issued.

- Yes No 1. Is any female to be covered now pregnant or is any male to be covered an expectant father?
- Yes No 2. In the past five years, have you or any family member to be covered ever received any medical or surgical consultation, advice, or treatment including medication for any of the following: heart or circulatory system disorder including heart attack or stroke; diabetes; cancer or tumors; disorder of the blood; mental or nervous conditions or disorders; alcoholism or alcohol abuse; drug abuse, addiction, or dependency?
- Yes No 3. Has any person applying for coverage been diagnosed as having acquired immune deficiency syndrome (AIDS) or AIDS-related complex; or has any person applying for coverage in the past five years tested positive for HIV virus (ELISA or Western Blot)?
- Yes No 4. Do you or any person named on this application plan on participating in motor vehicle or boat racing; mountain climbing; bungee jumping; hang gliding, skydiving, or rodeo activities during this coverage?
- Yes No 5. Has any person applying for coverage been declined insurance due to health reasons within the past 18 months?

Acknowledgment: I have read this application and to the best of my knowledge, the statements and answers are true and complete. I understand that fraud or any intentional misrepresentation of a material fact may result in the loss of coverage under this contract. I also understand that: 1) Blue Cross and Blue Shield of New Mexico will provide no coverage until my application is accepted and the correct premium is received by Blue Cross and Blue Shield of New Mexico; 2) this policy will pay no benefits for any illness, accident or physical impairments that existed or occurred prior to the effective date; 3) if the contract is issued, it will not be a continuation of any previous medical plan, including any prior short-term coverage; 4) if my completed application is approved, the coverage will take effect on the later of: (a) the requested effective date; or (b) the day after the postmark date affixed by the U.S. Postal Office. If the envelope containing the application is not postmarked, or the postmark is not legible, the effective date will be the later of: (a) the requested effective date; or (b) the date the completed application is received by Blue Cross and Blue Shield of New Mexico.

Health Authorization: I authorize any hospital, physician, provider, clinic or medical related facility, governmental agency, insurance carrier, group health plan or other entity to give Blue Cross and Blue Shield of New Mexico, the Company, or its authorized representative, upon request, any information concerning the health condition of any person listed on this application whenever such information is considered necessary by the Company for the proper disposition of this application.

I understand that this authorization is voluntary and that my signature is required for the Company to consider this application and to make a determination on whether to accept and issue the coverage applied for herein and that without my signed authorization, no action will be taken on this application. I also understand that I may revoke this authorization at any time in writing and that such revocation will have no effect on any actions taken by the Company prior to receipt of the revocation. I further understand the potential that any information disclosed pursuant to this authorization may be redisclosed and is no longer protected by the Federal privacy laws. A photographic copy of this authorization shall be as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

I understand this authorization is valid from the date signed and terminates on whichever date is later, when my application is denied or 24 months from the date of my application. I may revoke this authorization in writing at any time. A revoked authorization does not affect BCBSNM's or FDL's activities prior to receipt of the revocation. I should retain one duplicate of this authorization as my copy.

Applicant's Signature (If Applicant is under the age of 18, parent or guardian's signature) | Date Signed

Spouse's Signature | Date Signed

Dependent's Signature (Age 18 to 24) | Date Signed

Agency Name | Producer Signature | Date Signed

Producer Printed Name | Hallmark 4-Digit Producer Number | Producer Telephone Number