

## Your Information

Applicant's First Name, M.I., Last Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Age	Social Security Number
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Street Address	City	State	ZIP Code
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Home Telephone Number	Work Telephone Number
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Dependents to be Covered (First Name, M.I., Last Name)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Age	Social Security Number
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	<input type="checkbox"/> M <input type="checkbox"/> F			
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	<input type="checkbox"/> M <input type="checkbox"/> F			
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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.

1a. Is any dependent coverage required by court order?  Yes  No

1b. If "Yes," was the court order effective within the last 31 days?  Yes  No

2. 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?  Yes  No

*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 a one-time option to reapply for an additional 1, 2, 3, 4, 5, or 6 month benefit period. This one-time 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 Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.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 1-6 month benefit periods. The entire premium must be submitted with the application.

Monthly Bank Draft Available for 2-6 month benefit periods. The first month of premium must be submitted with the application along with a completed Bank Draft Authorization Request Form and a blank check marked "VOID."

## Health Information – Tell us about yourself.

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

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?  Yes  No

**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 which existed or occurred within six months 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 twenty-four months from the date of my application. I may revoke this authorization in writing, which I may do 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
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Spouse's Signature	Date Signed
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Dependent's Signature (Age 18-24)	Date Signed
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Agency Name	Producer Signature	Date Signed
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Producer Printed Name	Hallmark 4-Digit Producer Number	Producer Telephone Number
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## How to Calculate Rates

- Step 1** Record the monthly rates in the spaces at right for people to be covered.
- The monthly rate tables below are labeled by ZIP Code. Select the table that corresponds to your home address.
  - Find the rate for the chosen deductible (\$500, \$1,000, or \$2,000), your gender, and your age band. Write the rate in the Applicant Rate blank at right.
  - If applicable, find your spouse's rate by chosen deductible, gender and age. Write the rate in its blank at right.
  - For unmarried dependent children under age 25, use the bottom row ("Dependent child") of the rate table. Find the rate by deductible and gender, multiply this rate by the number of dependent children to be covered; and write this figure in its blank at right. *Note: If only a child is applying, use the correct age band near the top of the rate table (Under 1, 1-4, 5-12...). If two or more siblings are applying, submit a separate application for each child.*

Applicant Rate \$ \_\_\_\_\_  
 +  
 Spouse's Rate \$ \_\_\_\_\_  
 +  
 Child(ren) Rate \$ \_\_\_\_\_  
 =  
 Total Monthly Rate \$ \_\_\_\_\_  
 X  
 Coverage Period  
 (1, 2, 3, 4, 5, or 6 months) \_\_\_\_\_ months  
 =  
 Total Premium Due \$ \_\_\_\_\_

- Step 2** Add the rates for you, your spouse, if applicable, and your child(ren), if applicable.

- Step 3** Multiply the total from Step 2 by the number of months of coverage you need (1, 2, 3, 4, 5 or 6 months).

- Step 4** This is the total premium for the selected benefit period.

### IMPORTANT

- Step 5** The total premium must be submitted with the application unless you have chosen the Monthly Bank Draft option. The Monthly Bank Draft option is available to the applicant who selects a 2 to 6 month benefit period. A check for the first month of premium must accompany the application. A blank check marked "VOID" and Bank Draft Authorization Request Form **MUST** also be included with the application. **A deposit slip is not acceptable.**

**Make your check payable to: Blue Cross and Blue Shield of New Mexico.**

**Note:** Deductibles are per person, per benefit period. There is no deductible credit or carry over from one Benefit Period to another.

### Albuquerque Metro, Zip Codes: 87000 - 87299

Age Band	\$500 Deductible		\$1000 Deductible		\$2000 Deductible	
	Male	Female	Male	Female	Male	Female
Under 1	\$182	\$197	\$155	\$168	\$134	\$146
1-4	\$68	\$53	\$58	\$45	\$50	\$39
5-12	\$59	\$44	\$50	\$37	\$44	\$32
13-19	\$62	\$71	\$53	\$61	\$46	\$53
20-24	\$79	\$102	\$67	\$87	\$59	\$76
25-29	\$82	\$109	\$70	\$93	\$61	\$81
30-34	\$91	\$123	\$77	\$105	\$67	\$91
35-39	\$104	\$140	\$89	\$119	\$77	\$104
40-44	\$124	\$159	\$106	\$136	\$92	\$118
45-49	\$150	\$181	\$127	\$154	\$110	\$133
50-54	\$181	\$204	\$154	\$174	\$134	\$150
55-59	\$238	\$227	\$203	\$193	\$176	\$167
60-64	\$302	\$258	\$257	\$219	\$223	\$190
65-69	\$337	\$317	\$287	\$270	\$249	\$234
Dependent Child	\$63	\$63	\$54	\$54	\$47	\$47

### All Other New Mexico Zip Codes

Age Band	\$500 Deductible		\$1000 Deductible		\$2000 Deductible	
	Male	Female	Male	Female	Male	Female
Under 1	\$200	\$217	\$171	\$185	\$147	\$161
1-4	\$75	\$58	\$64	\$50	\$55	\$43
5-12	\$65	\$48	\$55	\$41	\$48	\$35
13-19	\$68	\$78	\$58	\$67	\$51	\$58
20-24	\$87	\$112	\$74	\$96	\$65	\$84
25-29	\$90	\$120	\$77	\$102	\$67	\$89
30-34	\$100	\$135	\$85	\$116	\$74	\$100
35-39	\$114	\$154	\$98	\$131	\$85	\$114
40-44	\$136	\$175	\$117	\$150	\$101	\$130
45-49	\$165	\$199	\$140	\$169	\$121	\$146
50-54	\$199	\$224	\$169	\$191	\$147	\$165
55-59	\$262	\$250	\$223	\$212	\$194	\$184
60-64	\$332	\$284	\$283	\$241	\$245	\$209
65-69	\$371	\$349	\$316	\$297	\$274	\$257
Dependent Child	\$69	\$69	\$59	\$59	\$52	\$52