BlueCross BlueShield of Tennessee

801 Pine Street
Chattanooga, Tennessee 37402-2555

www.bcbst.com

Reminder
Premium for the coverage period requested must be included with this application.

Short-Term Personal Health Coverage for Individuals

Application for Coverage

TYPE OR PRINT

Last Name	First Name	MI

Street Address (PO Box can not be accepted - please provide address of residence.)

City	State	ZIP code

Applicant's Social Security Number	Applicant's Birthday

❑ Male ❑ Female	❑ Single ❑ Married	Are you a United States citizen? ❑ Yes ❑ No

Daytime Telephone Number	E-Mail Address
[ ]	

Are you covered by Worker's Compensation?
❑ Yes ❑ No

Plan's Use Only

ID No. _____

Group No. _____ Class _____

Plan ID _____

EffectiveDate ____ / ____ / ____

Term of Coverage:
Requested Effective Date: _____
Mo. Day Year

Length of Coverage: ❑ 1 month ❑ 2 months ❑ 3 months

Type (Check One)
❑ Individual ❑ Family

Deductible Option (Check One)
❑ $250 ❑ $500 ❑ $1,000 ❑ $2,500

❑ Payment Amount Enclosed $_____
❑ Charge Premium to Credit Card
(Complete Credit Card Authorization)

You may request a coverage period for 1 month, 2 months or 3 months. Coverage will be effective at 12:01 a.m. on the date after the postmark or on the requested effective date, whichever is later. This date may not be later than 60 days after the date of this application. Coverage will end on 12:01 a.m. at the end of the term.

Dependent Information

First Name	MI	Last Name (If Different)	Relationship	Sex	Birthdate Mo.	Day	Year	Social Security Number
Spouse			Spouse					
Dependent								
Dependent								
Dependent								

Please read carefully and sign below

I hereby declare that persons to be covered as listed above:
- **Do not have any other health care coverage or insurance as of the requested effective date**
- **Are not pregnant**

I understand and agree
- that BlueCross BlueShield of Tennessee, Inc. is entitled to rely solely on the statements made on this Application, which are complete and correct to the best of my knowledge.
- that any contract which may be issued to me shall be binding only if each statement included in this Application is complete and true.
- that any contract which may be issued to me will be effective, subject to all the terms and conditions of the contract issued to me.
- that my signature on this Application will authorize any doctor, hospital, or other provider of treatment to furnish BlueCross BlueShield of Tennessee, Inc. any and all medical records pertaining to any person who is to be covered by the contract, and I am responsible for any fee for these records.
- **that any contract issued to me is directly between BlueCross BlueShield of Tennessee, Inc. and me and affirm that no third party is involved.**

I also declare that I understand that coverage is limited. I understand that the Short-Term Personal Health Coverage does not provide for any condition for which I or my dependents have had medical treatment, symptoms, or any manifestations thereof, before the effective date of this contract.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Date: _____ **Sign X** _____ **Relationship to Applicant** _____

(This application is not acceptable unless completely filled out and signed by the applicant, parent or guardian if the applicant is a minor. If relationship is guardian, please provide copy of legal guardianship paper, finalized by court / agency.)

I certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Licensed Agent's Name: GERALD G. LAMBERSON (Print Clearly!)

Agent's I.D. Number: **6171**

Agent's Signature: X Gerald G. Lamberson Date: _____

Arrangement Code: [ ] [ ] [ ] - [ ] [ ] - [ ] [ ] [ ] [ ] - [ ] [ ] [ ] [ ]

APP-110 (11/01) A scanned, imaged or photocopied version of this completely executed application will have the same force and effect as the original document.