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

Application for SHORT TERM

READ ALL INSTRUCTIONS BEFORE COMPLETING THIS APPLICATION.
APPLICATION MUST BE COMPLETED IN ITS ENTIRETY IN ORDER TO BE PROCESSED.

SECTION 1 | WHO IS APPLYING

- Oldest person applying for coverage should be listed on the first line of the application. If applicant is under the age of 19, parent or guardian information should be indicated in Section 2 *(Parent/Guardian)*.
- Social Security numbers are **required** for every applicant. If you are applying for coverage for a child less than one year old who does not yet have a Social Security number, you may apply; however, you will be required to submit the Social Security number within 90 days.
- If applying for Individual and Spouse coverage, primary applicant must be age 19 or older and spouse must be age 14 or older.
- If applying for Individual, Spouse and Child(ren) coverage or Individual and Child(ren) coverage, primary applicant must be age 19 or older.
- In "*Relationship*" box, indicate "spouse, son, daughter, stepson, stepdaughter, or dependent child" beside each dependent's name.
  - "Eligible Short Term dependents must be permanent residents of Arkansas and must be between the ages of 6 months and age 19."
- If applying for coverage for dependent child other than son, daughter, stepson, or stepdaughter, submit copy of appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.
- If primary applicant is under age 19 and does NOT reside with the Parent/Guardian named on this application, custodial parent must also sign the application (see *Signature Section* on Page 3).
- If any dependents are under age 19 and do NOT reside with the primary applicant, the custodial parent must also sign the application (see *Signature Section* on Page 3).

SECTION 2 | PARENT/GUARDIAN (If policy is only for a child under age 19)

- If applicant is under the age of 19, parent or guardian information must be indicated in this section.
- If applying for coverage as the "Guardian" of a dependent child under the age of 19, please submit appropriate dependent documentation (legal guardianship, custodial relationship, etc.) when submitting the application.

SECTION 4 AND 5 | ADDRESS INFORMATION

- You are required to provide address information when submitting this application. Please note there are three separate listings for this information. Complete all that apply.
  - **Residential** – This address will be noted as your physical place of residence.
  - **Mailing** – Correspondence such as letters and Explanations of Benefits (EOBs) will be mailed to this address.

SECTION 8 | U.S. CITIZENSHIP STATUS

- For any applicant who is not a U.S. citizen, a copy of his/her Permanent Resident VISA or Green Card issued by the U.S. Citizenship and Immigrant Services must be submitted with the application.
- Applicants must reside in the U.S. at least one year and must have a primary care physician in the U.S. prior to being eligible to apply for coverage.
- Applicants who are not U.S. citizens will also be contacted by phone to complete a Foreign National Questionnaire.

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SECTION 1 | WHO IS APPLYING

Read all instructions for Section 1 before completing.

First Name	M.I.	Last Name	Suffix	Relationship	Sex	Date of Birth	Social Security No.
				Self			

SECTION 2 | PARENT/GUARDIAN (If policy is only for a child under age 19)

Additional information may be required. Read instructions for Section 2 before completing.

First Name	M.I.	Last Name	Relationship (**Check One**)
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

SECTION 3 | MARITAL STATUS

☐ Single (including widowed or divorced) ☐ Married (including separated)

SECTION 4 | RESIDENTIAL ADDRESS (Must be permanent address - No P.O. box, please)

*Street | City | State | Zip

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SECTION 5 | MAILING ADDRESS (Complete only if different from residential address)

*Street or P.O. Box | City | State | Zip

SECTION 6 | CONTACT INFORMATION*

Primary Phone Number	Alternate Phone Number	E-mail Address	How do you prefer we communicate with you?
( )	( )		☐ E-mail ☐ Phone

*Arkansas Blue Cross and Blue Shield may contact you, either directly or through a business associate, using your postal or email addresses,telephone numbers or other personal information, regarding your health insurance plan, healthcare providers participating in our networks,disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Arkansas Blue Cross.

SECTION 7 | HOUSEHOLD INFORMATION

☐ Yes ☐ No a. Do all applicants under the age of 19 reside in the same household?

If "no," please provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

☐ Yes ☐ No b. Are all applicants permanent, legal residents of Arkansas?

If "no," please provide reason and his/her name and address:

Name: _____ Address: _____

Reason: _____

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SECTION 8 | U.S. CITIZENSHIP STATUS

Additional information may be required. Read instructions for Section 8 before completing. Documentation may also be required upon request.

☐ Yes ☐ No Are all applicants U.S. citizens? If "No", please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name:_____

Type of Permanent Visa or Permanent Green Card

USCIS Category: _____ Issue Date / / Mo. Day Yr. Expiration Date / / Mo. Day Yr.

Registration No.: _____

OFFICE USE ONLY | (Do Not Write In This Space)

I.D. No.	Group No.	Effective Date

Short Term is a short-term, limited-duration health insurance policy that provides health insurance coverage for 30 to 88 days.

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage."

SECTION 9 | SHORT TERM COVERAGE INFORMATION

Deductible: ☐ $500 ☐ $1,000

Type of Coverage: ☐ Individual ☐ Individual and Spouse ☐ Individual and Child(ren) ☐ Individual, Spouse and Child(ren)

Requested Effective Date: __/__/__

The effective date cannot be more than 30 days from the sign date on the application.

Number of Days: _____ (30 minimum / 88 maximum) X Daily Rate _____ = $_____

* See rate calculation page in Short Term brochure.

Enclose a check made payable to Arkansas Blue Cross and Blue Shield in the amount of the premium for the entire term of the policy.

SECTION 10 | SHORT TERM ELIGIBILITY QUESTIONS

The following questions must be answered in relation to each person applying for coverage.

☐ Yes ☐ No 1. Is any male applying for coverage an expectant parent?
If you answer "Yes", you and any other family members who are not pregnant may apply for "**Individual**" coverage; however, you must complete separate applications.

The following questions must be answered in relation to each person applying for coverage.

☐ Yes ☐ No 2. Is any female applying for coverage pregnant?

☐ Yes ☐ No 3. Will there be any other health insurance in force on the effective date of this coverage?

☐ Yes ☐ No 4. Within the last five (5) years, have you or anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for **any of the following**: liver disorders, kidney disorders, chronic obstructive pulmonary disease (COPD), emphysema, diabetes, a syndrome, cancer (other than skin cancer), heart or circulatory system disorders, alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection?

PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) The agent or broker involved in this insurance transaction may receive compensation from Arkansas Blue Cross and Blue Shield (hereafter referred to as the COMPANY), or one of its affiliates, for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. In signing, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) agree that a photocopy of this application shall be as valid as the original, and I understand that a copy is available to me upon request.

SHORT TERM:
I UNDERSTAND that this application may be rejected. If persons proposed for coverage are eligible and coverage is offered, I understand: (1) The coverage shall not become effective until the date shown on my identification card and the premium is paid in full. (2) Once the policy is in effect and payment received, premiums will not be refunded for any reason. (3) Pre-existing conditions will not be covered. (4) No changes can be made to the policy after coverage is in effect. (5) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (6) Arkansas Blue Cross and Blue Shield may phone or e-mail me for additional information that may help with the timely processing of my application. **This application is valid for 30 days only when completed and signed.**

In signing, I: (a) understand that the COMPANY may, within three years of the date of this application, void or terminate this coverage or deny claims for coverage if intentional misrepresentations of material fact have been provided by me in this application; (b) understand that if intentionally fraudulent misstatements were made, the COMPANY may take legal action at any time; (c) understand my signature authorizes the COMPANY to coordinate benefits under this policy with other insurance I have which is subject to coordination; (d) agree that this application shall be valid without time limit. 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 fines and confinement in prison.

Please read below. Your application will not be accepted unless you check the box confirming you understand the following statement:

☐ **I certify that I am a resident and signed this application in the state of Arkansas.**

SIGNATURE SECTION | (Please sign appropriate line only)

Primary Applicant OR Parent/Legal Guardian **(if policy for a minor)**	**X**	Date Signed
Spouse **(required if applying)**	**X**	Date Signed
Dependent age 18 or older **(required if applying)**	**X**	Date Signed
Dependent age 18 or older **(required if applying)**	**X**	Date Signed

Comments:	**OFFICE USE ONLY**

PRE-AUTHORIZED BANK DRAFT | One-Time Bank Draft Form

Our monthly bank draft service makes premium payments easy and convenient for you. Just a few steps now help assure your payment is made accurately and timely.

Complete the information below.

THIS FORM IS NOT TO BE RETURNED. IT IS FOR OBTAINING ONLINE PAYMENT INFORMATION.

IMPORTANT: Please read before signing

I authorize Arkansas Blue Cross and Blue Shield and the BANK indicated below, to debit my Arkansas Blue Cross premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross coverage, UNLESS Arkansas Blue Cross has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

Insured's Information

First name_____ Last name_____

Address_____

Street Apartment number

_____

City State Zip code

Bank Account Information

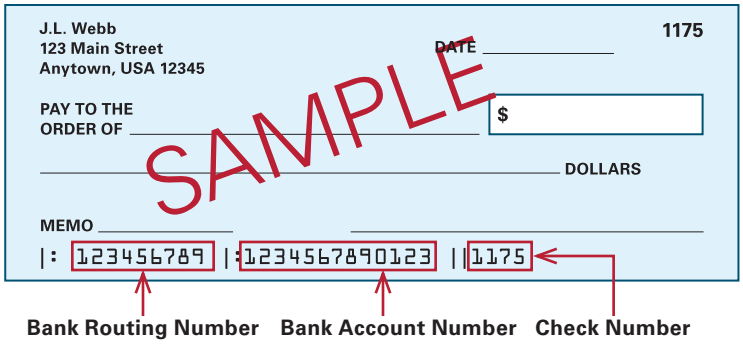
Bank name_____

Routing number_____

Name on account_____
(if different than the insured)

Account number_____

Type of account: ☐ Checking ☐ Savings



Signature

Signature_____ Date_____

Signature of bank account holder

We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

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For Office Use Only (please do not write in this space)

ID NO.	EFFECTIVE DATE