

# ENROLLMENT

## FAX COVER LETTER

FOR FASTER PROCESSING AND

\*\*IF COMPLETING THE ENCLOSED BANK DRAFT AUTHORIZATION, FAX TO:

**TOLL FREE: 800.848.4201**

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Please contact me at this phone number \_\_\_\_\_  
after you have reviewed my application for completeness and accuracy.

I will call 800.856.6556 to verify receipt of my application.

\*\*IF FAXED OVER THE WEEKEND, HOLIDAY OR AFTER 5:00PM CST APPLICATION  
WILL NOT BE REVIEWED UNTIL THE FOLLOWING BUSINESS DAY.

I UNDERSTAND IF PAYING BY CHECK - APPLICATION MUST BE MAILED TO:

ENROLLMENT

ATTN: BLUECROSS APPLICATION

7 SWITCHBUD PL.

BLDG. C192, STE. 250

THE WOODLANDS, TX 77380

## **Application Instructions for Blue Cross and Blue Shield of Texas**

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter

### **HELPFUL TIPS:**

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

### **IMPORTANT:**

\* BE CERTAIN TO PROVIDE THE \$30 ONE- TIME APPLICATION FEE ALONG WITH THE FIRST MONTH'S PREMIUM. THIS MAY BE ACCOMPLISHED BY COMPLETING THE BANK DRAFT AUTHORIZATION FORM IF FAXING OR BY CHECK IF MAILING.



P.O. Box 3236 Naperville, IL 60566-7236 888-697-0683

Prem: \_\_\_\_\_ Fee: \_\_\_\_\_ For Home Office Use

To help us process your application promptly, please remember to:

- Print all answers in black ink. Pencil will not be accepted.
• Make sure you personally sign the application as the Primary Applicant.
• If you are downgrading (decreasing benefits), you do not need to complete Part Two, Sections A and B.

PART ONE Check one: [ ] New Policy [ ] Add Dependent [ ] Cancel Dependent [ ] Upgrade (increase of benefits) [ ] Downgrade (decrease of benefits)

SECTION A - PERSON(S) APPLYING FOR COVERAGE (please print)

In addition to having a permanent residence in Texas, all persons applying for coverage must be a United States citizen, or if not a citizen, must be able to provide medical records from a licensed U. S. Physician, including but not limited to, a health evaluation conducted within the past two years.

PRIMARY APPLICANT

Form with fields for First Name, Middle Initial, Last Name, Social Security #, Sex (M/F), Age, Date of Birth (mo/day/yr), Height (ft., in.), Weight (lbs.), Home Phone #, Business Phone #, Fax #, Occupation/Duties, Spouse's Business #, Residence Street Address, City/State/ZIP, County, Email, and Best place and time to call.

Spouse and dependent child(ren) you wish to cover (dependents must be under age 26).

If one or more family member(s) is ineligible for coverage, would you consider coverage for the remaining family member(s)? [ ] Yes [ ] No

Table with 10 columns: Name (First, Middle Initial, Last), Relation (spouse or child), Sex (M/F), Height (ft., in.), Weight (lbs.), Date of Birth (mo/day/yr), Social Security Number, Court Ordered for Dependents (Yes/No).

Is any dependent coverage required by court order? [ ] Yes [ ] No If "yes," was it effective within the last 30 days? [ ] Yes [ ] No

If "yes," to apply for court-mandated coverage for dependent children, contact Blue Cross and Blue Shield of Texas for the appropriate form.

SECTION B - COVERAGE APPLIED FOR (please choose only one plan)

PPO Select Blue Advantage

Deductible Plan: I [ ] \$250 II [ ] \$500 III [ ] \$1,000 IV [ ] \$1,500 V [ ] \$2,500 VI [ ] \$3,500 VII [ ] \$5,000 VIII [ ] \$10,000

PPO Select Saver

Deductible Plan: I [ ] \$500 II [ ] \$1,000 III [ ] \$1,500 IV [ ] \$2,500 V [ ] \$3,500 VI [ ] \$5,000 VII [ ] \$10,000

PPO Select Choice

Deductible Plan: I [ ] \$250 II [ ] \$500 III [ ] \$1,000 IV [ ] \$1,500 V [ ] \$2,500 VI [ ] \$3,500 VII [ ] \$5,000 VIII [ ] \$10,000

[ ] DENTAL INSURANCE COVERAGE I (We) hereby apply for Dental coverage and understand that all applicants and dependents approved for health coverage will be covered under the Dental coverage.

SECTION C - PAYOR AND BILLING INFORMATION

Requested Effective Date (mo/day/yr) \_\_\_\_/\_\_\_\_/\_\_\_\_ (Note: Day cannot be 29th, 30th or 31st)

Premium Mode: [ ] Monthly Bank Draft (Submit Authorization form with application) [ ] Monthly Direct Bill [ ] Two Month Direct Bill [ ] Quarterly Direct Bill [ ] List Bill Monthly (Available for two or more applicants billed at the same address)

A \$30.00 NONREFUNDABLE Application Fee must be submitted with completed application.

Please make check payable to Blue Cross and Blue Shield of Texas.

Payor of premium (if different than applicant) Will your employer be contributing towards the premium for this policy? [ ] Yes [ ] No

Table with 2 columns: Application Fee \$30.00, Premium (if enclosed) \$, TOTAL enclosed \$

Name: \_\_\_\_\_ Address/City/State/ZIP: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Please complete all pages 1-4.

**PART TWO – STATEMENT OF HEALTH**

All health history/medical questions must be completed for all individuals (including dependents) applying for coverage unless you are downgrading benefit plans. You can skip Part Two Sections, A and B.

**SECTION A – HEALTH HISTORY/MEDICAL QUESTIONS**

**Please Complete the Following Health Questions:** For this insurance to be in force, you must answer the following health questions fully and truthfully and provide all of the health information asked for, including routine physical examinations, and Blue Cross and Blue Shield of Texas must approve this application. No one may change this requirement for you in any way. An act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. You will be provided with at least 30 days' advance written notice before you or your dependent's coverage may be rescinded, retroactive to the effective date of coverage. **Please do not mark over or strike out any signature, date or health question information. Important! Do not cancel any existing health coverage until notified of your acceptance.**

If you answer "Yes" to ANY questions on this page, please give details on the next page. Please note the timeframe reference for each question.

- 1. Has any person applying for coverage been advised to seek treatment for alcohol use or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism within the last **10 years**? .....  Yes  No
- 2. Has any person applying for coverage used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use or dependency within the last **10 years**? .....  Yes  No
- 3. Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last **10 years** for the following: Please check  Yes or  No. If any boxes are checked "Yes" ( Yes), also circle the condition, e.g. (**migraines**) and give details on the next page.
  - A. Migraines; headaches; carpal tunnel syndrome; seizure disorder; paralysis; multiple sclerosis; any neurological disorder, or any disorder of the central nervous system? .....  Yes  No
  - B. Attention deficit disorder; anxiety, depression or chemical imbalance; any behavioral, emotional or eating disorder; mental retardation; bipolar disorder or psychosis; psychotherapy; marital or any form of counseling or therapy? .....  Yes  No
  - C. Chest pain or palpitations; heart murmur; mitral valve prolapse; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? .....  Yes  No  
If "Yes" to HBP, provide 3 readings and their dates w/in the last year \_\_\_\_\_ and \_\_\_\_\_ and \_\_\_\_\_
  - D. Varicose veins/spider veins/varicosities; elevated cholesterol or lipids; anemia; blood clot or any other blood disorder? .....  Yes  No
  - E. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; or any breathing difficulty, lung or respiratory disease, disorder or condition? .....  Yes  No
  - F. Hernia; colitis; chronic diarrhea or intestinal problems; hemorrhoids or rectal disorder; gastroesophageal reflux; any disorder of the esophagus; ulcer of the stomach or duodenum, or any other digestive disorder or condition? .....  Yes  No
  - G. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? (indicate type of hepatitis \_\_\_\_\_) .....  Yes  No
  - H. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? (indicate diagnosis and location \_\_\_\_\_) ...  Yes  No
  - I. Acne; keratosis; psoriasis; basal cell carcinoma; lesions of the skin or mouth, or any other skin disorder? .....  Yes  No
  - J. Kidney stones; reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? .....  Yes  No
  - K. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? . . . .  Yes  No
  - L. Arthritis (osteo, rheumatoid, psoriatic); bursitis; herniated, bulging or slipped disc; gout; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the spine, back, knees, jaw, bones, muscles, or joints; bunions; joint replacement; or manipulation therapy? .....  Yes  No
  - M. Thyroid disorder; goiter; Graves disease; diabetes; lupus; pituitary or adrenal disorder? .....  Yes  No
  - N. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose or throat disorder? .....  Yes  No
  - O. Has anyone applying for coverage ever been diagnosed as having or told by a medical doctor that you have AIDS, HIV, or ARC disorders?  Yes  No
  - P. Have you or any person applying for coverage ever been tested positive for antibodies for the AIDS virus? .....  Yes  No
  - Q. Has any person applying been diagnosed by a member of the medical profession as having AIDS and/or has any proposed insured received treatment from a member of the medical profession for AIDS? .....  Yes  No
  - R. **Questions for male applicants** Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; impotence; infertility or any other disease or disorder of the genital or reproductive system? .....  Yes  No
  - S. **Questions for female applicants** Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele/rectocele; abnormal pap smear; infertility; sexually transmitted disease; genital warts; herpes; or any other disease or disorder of the genital or reproductive system? .....  Yes  No
- 4. During the last **5 years**, has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist? .....  Yes  No
- 5. Has any person applying for coverage been prescribed or taken any medications due to sickness, disease, disorder, condition, injury or counseling or for smoking cessation or weight loss in the last **12 months**? .....  Yes  No
- 6. Have you, your spouse (if to be insured), or any child (if to be insured) smoked or used any tobacco products – such as cigarettes, pipes, cigars, snuff or chewing tobacco – in the last **12 months**? YOU  Yes  No YOUR SPOUSE  Yes  No YOUR CHILD  Yes  No.  
If Yes, Name(s) \_\_\_\_\_
- 7. A. **Question for female applicants:** Is any female applying for coverage now pregnant? .....  Yes  No  
B. **Question for male applicants:** Is any male applying for coverage now an expectant parent? .....  Yes  No  
For policies with an initial effective date prior to March 23, 2010, if you answered either question "Yes", coverage cannot be offered. For policies with an initial effective date on or after March 23, 2010, if you answered either question "Yes" and the applicant is age 19 and over, coverage cannot be offered.
- 8. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin or penile implant), internal fixation (e.g. pins, plates or screws), prosthesis, pacemaker, valve replacement, shunt or monitoring device? .....  Yes  No
- 9. Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery which has not yet been performed? .....  Yes  No
- 10. Has any person applying for coverage **ever** been hospitalized or been treated in the emergency room or had any physical impairment, deformity, congenital anomaly, sickness, operation, injury or hospitalization other than admitted to on this page? .....  Yes  No
- 11. Is each person applying for coverage a permanent resident of Texas, except for court-ordered dependents? .....  Yes  No

**PART TWO – CONTINUED**

**SECTION B – DETAILS OF HEALTH HISTORY**

If you answered "Yes" to ANY questions on the previous page, please provide further information using the chart below. Be sure to use the "correct" example as your guide. (If more space is needed, attach a separate page which must be signed and dated.)

	Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Types of Treatment, Advice Given, and Medications Prescribed	Name, Address and Phone Number of Doctors and Hospitals
			What is it?	Date that is Started	Date of Recovery (if applicable)			
Correct Example:	3C	Joe Smith	high blood pressure	1/10	none	no, ongoing	40mg Atenolol once	Dr. Jones St. Mary's Peoria, IL (309) 555-1212

**Other Coverage Information**

1. Does any person applying for coverage currently have, or did they previously have **within the last 5 years**, Blue Cross and Blue Shield of Texas coverage, either as a primary insured, spouse or as a dependent?  Yes  No **If "Yes", please complete the following:**

Applicant Name \_\_\_\_\_ Name on Previous Policy (if applicable) \_\_\_\_\_ Member/Group No. (optional) \_\_\_\_\_

Applicant Name \_\_\_\_\_ Name on Previous Policy (if applicable) \_\_\_\_\_ Member/Group No. (optional) \_\_\_\_\_

2. Does any person applying for coverage currently have, or did they previously have **within the last 5 years**, health or major medical insurance coverage with any other Insurer, including other Blue Cross and Blue Shield plans?  Yes  No **If "Yes", please complete the following:**

Name(s) of all individuals covered: \_\_\_\_\_

Insurer Name(s): \_\_\_\_\_ Location / State: \_\_\_\_\_

Policy Effective Date: \_\_\_\_\_ Policy Termination Date: \_\_\_\_\_

**Replacement of Coverage** Will this insurance replace any health insurance currently in force?  Yes  No  
 If "Yes," read the statement below and complete the following:

**List all coverage that will be replaced**

Insured	Name of Company	Policy Number	Termination Date

**Notice to Applicant Regarding Replacement of Accident and Sickness Insurance**

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Blue Cross and Blue Shield of Texas. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

1. Health conditions which you may presently have may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning the medical/health history of any person applying for coverage. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Blue Cross and Blue Shield of Texas.

**Acknowledgements:** The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows: 1. This application does not provide coverage of any kind unless approval is provided by Blue Cross and Blue Shield of Texas (the Company); and the application, if not previously approved or declined, will be considered withdrawn on the 60th day after its date. 2. Medical expense coverage will not be available until the effective date of the health contract and payment, in full, of the first month's premium. 3. The medical expense benefits applied for and if issued, shall not cover any illness, accident, or physical impairment which existed or occurred prior to the effective date of the Applicant's coverage until the Applicant shall have held coverage under the contract for a period of 12 months if PPO Select Saver or PPO Select Choice is selected, or 18 months if PPO Select Blue Advantage is selected. (This limitation does not apply to participants under 19 years of age for policies with an initial effective date on or after March 23, 2010.) 4. No agent can accept risks or modify policies or requirement of the Company. 5. The Company is not bound by any statement not written in this application. 6. If a spouse is included for medical expense coverage, the premium will be calculated based on the age of each adult. 7. I understand that an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days' advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage.

The undersigned Applicant further acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an Individual Policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by the Company in connection with the issuance of the Individual Policy, they should contact the agent.

**Agreement:** I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following underwriting approval and payment in full of the first months premium and receipt and acceptance by the Company of any required Amendatory Endorsement and/or Coverage Exclusion Rider, if applicable. The undersigned Applicant and agent acknowledge that the Applicant has read the completed application and that he/she realizes that any false statement material to the risk or misrepresentations therein may result in loss of coverage under the policy.

**Medical Authorization:** I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

**Signatures:** I acknowledge receipt of the Required Outline of Coverage and I certify that:

- 1. Premiums are being paid by me as a personal expense. 2. My employer is not contributing to any part of the premium, either directly or through reimbursement. 3. Since my employer does not sponsor an employee health plan, neither my employer nor I deduct any part of the premiums from gross income under section 106 or section 162 of the Internal Revenue Code.

The Disclosure Statement will be provided upon request. (Also available at www.bcbstx.com)

**Important:** Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing.

Primary Applicant's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Spouse's Signature (ONLY if to be insured) \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Parent/Guardian Signature (if Primary Applicant is a Minor): \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Dependent's Signature (ONLY if 18 or over and only to be insured): \_\_\_\_\_ Date Signed: \_\_\_\_\_  
Dependent's Signature (ONLY if 18 or over and only to be insured): \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Agent's Certification:** I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the Required Outline of Coverage, and if requested, the Disclosure Statement.

Policy(ies) should be mailed to  Agent  Applicant

Agent  Agency # 00002911 100 %  
BCBSTX Assigned Agent # percent Tax I.D.

Please PRINT Name **Donald Kenton Henry**  
Address **7 SWITCHBUD PLACE, BLDG. C192, STE. 2!**  
City, State, Zip **THE WOODLANDS, TX 77380**  
Phone **800.856.6556** Fax **800.848.4201**  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent  Agency # 00002911 %  
BCBSTX Assigned Agent # percent Tax I.D.

Please PRINT Name **Donald Kenton Henry**  
Address **7 SWITCHBUD PLACE, BLDG. C192, STE. 2!**  
City, State, Zip **THE WOODLANDS, TX 77380**  
Phone **800.856.6556** Fax **800.848.4201**  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**PROXY** The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Primary Applicant's Signature: **X** \_\_\_\_\_  
Print Your Name as You Signed It: \_\_\_\_\_ Date Signed: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

FC849a7/83 REV. 0203

Changes in state or federal law, or regulations or interpretations thereof, may change the terms and conditions of coverage.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

# Automatic Premium Payment Authorization Agreement



BlueCross BlueShield  
of Texas

## Take these simple steps for hassle-free monthly premium payments:

- Verify with your financial institution that they can accept automated electronic withdrawals.
- Complete, sign and return this authorization form.
- If submitting by fax, please fax this form toll-free to: (888) 697-0686
- If submitting by mail, please send to:

Blue Cross and Blue Shield of Texas  
P.O. Box 3236  
Naperville, IL 60566-7236

If you have any questions about this program, please call our Customer Service Department toll-free at (888) 697-0683.

### AGREEMENT

I request and authorize Blue Cross and Blue Shield of Texas (BCBSTX) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts; or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. As the account holder, by signing below, I also certify, in the event that this draft is being drawn from a company checking account, that I am authorized to approve this transaction, that the company is not paying any portion of the premium for this subscriber, either directly, or through reimbursement, and that the employer/company is not deducting any part of the premium from gross income under section 106 or section 162 of the Internal Revenue Code. I understand that both the financial institution and BCBSTX reserve the right to terminate this payment program and/or my participation therein. I also understand that I may discontinue this payment program (except for SelectTEMP<sup>®</sup> PPO) at any time with at least 10 days advance notice to Blue Cross and Blue Shield of Texas by telephone prior to a scheduled withdrawal date.

### Please complete the following ~ Print or Type information

**Yes**  **No** Deduct ongoing monthly premium payments from my designated checking or savings account. Drafts will be drawn on the preferred draft day specified below (does not apply to SelectTEMP PPO). For SelectTEMP PPO and when a preferred draft day is not specified for other products, drafts will be drawn on the premium due date. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day. (Please note that coverage cannot be issued until the first month of premium has been received in our office, unless you have authorized Blue Cross and Blue Shield of Texas to deduct the initial payment upon receipt of your application.)

**Yes**  **No** Please deduct a \$30.00 Non-Refundable application fee from my checking account **upon receipt of my application** for permanent coverage. The application will not be processed without the non-refundable application fee.

**Yes**  **No** Upon receipt of my application, deduct the initial premium payment from my checking or savings account.

Preferred Draft Day. It must be on or prior to the premium due day. If the selected preferred draft day falls after the premium due day, the monthly premium will be drawn on the day premium is due. (Cannot be the 29th, 30th or 31<sup>st</sup>.)

**Yes**  **No** For SelectTemp PPO applicants only: upon receipt and approval of my SelectTEMP PPO application, please deduct the premiums due for the designated benefit period.

Policy Identification Number/Applicant's Social Security Number: \_\_\_\_\_

Please check one:  Checking Account  Savings Account

Name of applicant/member: \_\_\_\_\_

Name of depositor(s) if other than the applicant: \_\_\_\_\_

Name of bank where account is authorized: \_\_\_\_\_

Address of bank: \_\_\_\_\_

Bank transit number: \_\_\_\_\_

Depositor's account number: \_\_\_\_\_

Memo _____	
I: 184002763 I:	14570720 I I:
↑	↑
Bank Transit Number	Depositor's Account

I have read and accept the above agreement.

Depositor's signature: \_\_\_\_\_ Date: \_\_\_\_\_