CONDITIONAL RECEIPT

THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

Blue Cross and Blue Shield of Georgia (BCBSGA) has received from the named Applicant an advance deposit equal to the first 30 day's premium together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

> Subject to the provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by Medical Underwriting, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first 30 day's premium and provided that BCBSGA determines that as of the date of the application all proposed covered persons were acceptable for coverage and for the benefits applied for.
>
> If the application is not approved by BCBSGA said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the applicant.
>
> No one has the authority to waiver or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 30 days, please contact Blue Cross and Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We need your answers to decide if you qualify for coverage. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

ALL DATA CONFIDENTIAL. We are required by law to keep such data confidential. It will be seen only by employees and authorized agents. This data may in certain circumstances be disclosed without your authorization. We may furnish such data to authorized federal or state agencies, consumer investigative service bureaus or others if part of our standard business practice or required by law.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Blue Cross and Blue Shield of Georgia Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

Short Term Medical Application

Short Term Medical Application

Mail Code: G00302
3350 Peachtree Road, NW
Atlanta, GA 30326

Requested Effective Date

Month	Day	Year

NOTE: The actual effective date is contingent upon the receipt of your properly completed application and the correct payment.

APPLICANT'S NAME (LAST, FIRST, MIDDLE)	SEX	BIRTHDATE (MM/DD/YY)	APPLICANT SOCIAL SECURITY NUMBER
		/ /	– –

RESIDENTIAL ADDRESS	CITY	STATE	ZIP

COUNTY	DAY TELEPHONE	EVENING TELEPHONE
	( ) –	( ) –

	Yes	No
Are you applying for other medical coverage with BCBSGA?	☐	☐
Have you or any person applying for coverage lived in the USA for less than the past 6 months?	☐	☐

Please answer the following questions completely and accurately. If you check **Yes** to any of the questions you are **not eligible** for coverage.

	Yes	No
1. Will you or any person to be insured have any other hospital, major medical or group health insurance in force on the effective date of this plan?	☐	☐
2. Have/ are you:		
• Been denied insurance due to health reasons?	☐	☐
• Now pregnant, an expectant parent or in the process of adopting a child? ***Note: Pregnant women are not eligible to apply***	☐	☐
• Over 300 pounds if male, or over 250 pounds if female?	☐	☐
3. For any of the following conditions, within the last 5 years, have you received any abnormal test results or medical or surgical treatment, or consulted a health care professional or taken medication for:		
• Heart disorder including but not limited to heart attack or chest pain; chronic respiratory conditions including asthma, chronic obstructive pulmonary disease or emphysema; stomach or ulcer symptoms; colitis or Crohn's disease; liver, hepatitis, acquired immune deficiency syndrome (AIDS) and related immune system disorders, or tested positive for HIV?	☐	☐
• Uncorrected gall bladder disease or gall stones; stroke or circulatory system disorders; leukemia; kidney disease, undergoing kidney dialysis; diabetes type I or type II; cancer, tumor or internal cyst; female disorders; alcoholism or alcohol abuse, chemical/substance dependency or drug abuse; a mental, nervous or emotional disorder?	☐	☐

PLAN SELECTION

Benefit Period	Deductible Amount	Plan Pays After Deductible
☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 150 days ☐ 180 days	☐ $500 ☐ $1,000 ☐ $2,500	☐ 80%

Note: Please make a copy of the signed application for your records prior to submitting to Blue Cross and Blue Shield of Georgia.

FOR INTERNAL USE	DCN	ACN

REP NO.	CITY CODE	AREA	DEDUCTIBLE	30 DAY PREMIUM	AGENT SIGNATURE	E-MAIL ADDRESS:
				AMT RECEIVED	PRINT NAME:	FAX NO.:

Independent Licensee of the Blue Cross Blue Shield Association

Please continue →

APPLICANT SOCIAL SECURITY NUMBER

			–			–				

Short Term Medical Application

continued

Notice to Applicant Concerning Personal Health and Financial Information: This is to notify you that BCBSGA has the right to collect personal health and financial information about you listed on this form and to use and disclose that information as described in the Notice of Privacy Practices.

Payment Method: *Bank draft option complete form on page 3.	**1st Month Payment**	☐ Check	☐ Credit Card
	Subsequent Payments	☐ Bank Draft	☐ Credit Card
	ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO BLUE CROSS AND BLUE SHIELD OF GEORGIA		
Credit Card Information	☐ MC ☐ Visa ☐ Discover Credit Card # ______ Exp. Date ______ (month/year)		
	Name as it appears on Credit Card ______		

I, the undersigned, hereby apply for the coverage indicated for myself. I understand and agree that coverage will not be effective, nor will Blue Cross and Blue Shield of Georgia (BCBSGA) have any liability, unless and until this application is accepted and approved by Medical Underwriting, and a contract issued with identification cards showing effective dates. I understand that BCBSGA may require a physical examination of anyone listed on this application. BCBSGA reserves the right to change any applicable premiums for new coverage issued after the expiration date of this policy. I declare that all statements made hereon are complete and true to the best of my knowledge and belief, and agree that BCBSGA may cancel the coverage in its entirety, if fraudulent or intentionally misleading information has been submitted, personally assuming liability for reimbursement to BCBSGA for any benefit payment made on behalf of any such member. Ineligible persons may be removed at any time.

I understand and agree that under this contract:

- You may request an effective date. If BCBSGA receives the properly completed application and correct payment before the date you requested, and your application is approved, your coverage will begin at 12:01 a.m. on the day you request.
- If you do not request a specific effective date and you or your agent/broker mails or delivers your application and correct payment to BCBSGA, and your application is approved, BCBSGA will assign the effective date as 12:01 a.m. the day after receipt by BCBSGA.
- When issued, will replace and supersede all similar contracts which may have been issued previously by BCBSGA or any of its affiliates.
- No agent has the authority to bind coverage or waive the answer to any question in this application, to pass insurability, to waive any of BCBSGA's rights or requirements or to make or alter any contract.
- I acknowledge that I have read, or have had read to me, the completed application. I realize that if I omit any information or provide any false, intentionally misleading or incomplete information that is considered fraud or material misrepresentation, this can result in claim denial and/or cancellation of this coverage. I agree to repay promptly any benefit payment to which I was not entitled. I understand that the program applied for will not provide benefits for any expenses incurred on account of any condition that manifested itself before the program date, as explained in the "Exclusions" section of my marketing brochure. I also understand that this is not a continuation of any previous medical program, including any prior Short Term Medical program.

Check the appropriate box:

☐ **I DO UNDERSTAND** ☐ **I DO NOT UNDERSTAND**

Applicant's Signature ______________________ Date __________

APPLICANT SOCIAL SECURITY NUMBER

			–			–				

BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize **Blue Cross and Blue Shield of Georgia, Inc.** to draw checks, drafts, orders or electronic funds transfer (EFT) upon my account at the:

Name of Bank ______________________ Checking Account Number __________

Street Address of Bank ______________________ City, State, Zip Code of Bank __________

for the purpose of paying premiums on insurance issued by Blue Cross and Blue Shield of Georgia, Inc.

I understand if any check, draft, order or EFT transmission is returned due to **payment stopped** or **authorization cancelled**, this constitutes cancellation of the policy.

Contract Holder's Name ______________________ Social Security Number __________

Contract Holder's Address ______________________ City, State, Zip Code __________

______________________ X ______________________ __________

Printed Name of Account Holder — Signature of Account Holder — Date

NOTE: A VOIDED CHECK MUST BE ATTACHED TO THIS APPLICATION.

Complete entire form and attach a voided check.

INSTRUCTIONS FOR COMPLETING THE BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

Automatic Premium Payment Plan

What is it - A special arrangement for payment of premiums automatically each month to relieve you of concern with due dates and the possibilities of having your insurance lapse unintentionally.

Who can use it - Bankdraft is an extra convenience for you. It is available if you maintain a regular checking account at your bank and make arrangements with your bank to honor automatic checks and electronic fund transfers.

How it works - To initiate the bankdraft, you must complete the authorizations above. ***Please note: Draft will occur on Friday after payment is due.***

INSTRUCTIONS

1. **Complete as follows:**
   A. Fill in the name of your bank, branch, branch number *(if any)* and the city or state in which the bank or the branch is located.
   B. Print the name of your account exactly as it appears on your bank statement or check.
   C. Include your checking account number. It will usually be found below the signature line of your personal checks.
   D. Sign your name exactly as imprinted on your personal checks. If there is more than one depositor, all should sign.
   E. Include the date you signed the authorizations.
2. **Attach a VOIDED check and this completed form.** Please be sure the sample check is drawn on the same account as will be used for the automatic premium payment plan.
3. The Bank Draft Agreement provided by this policy may be terminated by calling BCBSGA's Customer Service at least 7 days in advance of your next due date.

FOR INTERNAL USE

DCN #: __________

BANK #: __________