

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: Fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – Be sure to remit your check for the entire premium with your application. You may also choose to pay by credit card authorization.

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: CareAmerica

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...



ANSWER THE FOLLOWING QUESTIONS COMPLETELY AND ACCURATELY IN ORDER TO DETERMINE ELIGIBILITY.

IF THE ANSWER TO ANY QUESTION FROM 1 – 8 IS YES, YOU ARE NOT ELIGIBLE FOR THE PLAN.

1. Have you or any person applying resided outside the United States in the past six months? **YES** **NO**

2. Is either the applicant or spouse, or any female dependent, whether or not listed on the application, currently pregnant? **YES** **NO**

3. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on the application? **YES** **NO**

4. Have you or any person applying received any medical or surgical consultation, advice or treatment, including medication, within the last 5 years for: heart disorders, including heart attack; disorders of the arteries, including stroke; disorders of the blood, including hemophilia and leukemia; diabetes; cancer; alcohol or drug dependency or abuse; or non-AIDS related immune system disorders? **YES** **NO**

5. Have you or any person applying been treated for or diagnosed with acquired immune deficiency syndrome (AIDS)? **YES** **NO**

6. Have you or any person applying enrolled in training for or engaged in an occupation involving unusual hazards, and not covered by Workers' Compensation Insurance? **YES** **NO**

7. During the policy term, will you or any person applying train for or participate in: **YES** **NO**
 (1) A team or individual sports activity as a professional; or, (2) National or international competition as an amateur; or, (3) A collegiate sports activity?

8. Do you or any person applying have any hospital, major medical, group health, or medical insurance coverage in force that will not terminate prior to the effective date of this coverage? **YES** **NO**
 [If YES, when will existing coverage expire? _____ / _____ / _____]

MM DD YY

[Please note, coverage cannot start until prior coverage has terminated.]
 If you or any person applying were covered by a health insurance plan during the past 63 days, please provide the name(s) and telephone number(s) of all health insurance carrier(s) and the respective coverage period(s) for the past twelve months. (If available, please attach I.D. cards or letters of creditable coverage. Please list most recent coverage first.)

Health Plan _____ Phone # _____ I.D. # _____

Insured's Name _____ Coverage Period _____ to _____

Health Plan _____ Phone # _____ I.D. # _____

Insured's Name _____ Coverage Period _____ to _____

*** If you answered YES to any of questions 4 through 8, please answer below.**
Note: Such person(s) is excluded from coverage:

Question No. _____ Person(s) to whom it applies: _____

Question No. _____ Person(s) to whom it applies: _____



www.careamerica.com

Application for Option Twelve Monthly Payment Plan

Complete both sides of this form in full. Mail application along with your check (payable to CareAmerica) or your Credit Card Authorization to:

Please print or type:

APPLICANT'S LAST NAME		FIRST	MI	
DATE OF BIRTH	SOCIAL SECURITY NO.	HOME TELEPHONE	EMAIL	
HOME ADDRESS		CITY		
COUNTY	STATE	ZIP CODE		
AZ				
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)				
ARE YOU EMPLOYED? IF YES, COMPLETE NAME AND ADDRESS OF EMPLOYER				
YES <input type="checkbox"/> NO <input type="checkbox"/>				
ARE YOU APPLYING FOR A BCBSAZ INDIVIDUAL PLAN TO BEGIN WHEN OPTION TWELVE COVERAGE ENDS? YES <input type="checkbox"/> NO <input type="checkbox"/>				

Please Note:

- If parents/guardians are not applying for coverage, a separate application must be completed for each child.
- This policy will not cover anyone who is under 15 days of age, or over 64 years and 6 months of age on the policy effective date.

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS TO BE COVERED BELOW:				SEX	BIRTHDAY	PREMIUM
LAST NAME	FIRST	MI	SOCIAL SECURITY NO.	M	F	MO/DAY/YR
1. APPLICANT						\$
2. SPOUSE						\$
3. CHILD						\$
4. CHILD						
5. CHILD						

PLAN SELECTIONS:

- A. DEDUCTIBLE**
- \$250 \$500 \$1,000 \$1,500 \$2,000
- B. POLICY EFFECTIVE DATE**

If you are approved, coverage will begin at 12:01 a.m. on the date following the U.S. Postal Service postmark date stamped on the envelope or, if application is faxed, the day after fax is received. Coverage can also begin on a future effective date that you specify (within 45 days):

Effective Date: _____
 (Postmark date must precede requested effective date. Exceptions are not permitted.)

PAYMENT METHOD:

- Check VISA
 Mastercard American Express

IMPORTANT – Total premium due by check or credit card authorization must accompany application and will be held in trust while this application is evaluated by CareAmerica.

IF PAYING BY CREDIT CARD – I authorize CareAmerica to bill my account for the Total Premium Due.

ACCOUNT NO. _____
PLEASE PRINT CREDIT CARD NUMBER CLEARLY

EXP. DATE _____ / _____ CARDHOLDER NAME: _____

SIGNATURE _____

IMPORTANT INFORMATION — PLEASE READ:

I understand that:

- No benefits are payable for any expenses incurred as the result of a pre-existing condition as defined.
- If any person applying is hospital confined on the effective date, benefits will take effect on the first day following the hospital stay.
- Once a policy is issued, under no circumstances will I/we be allowed to make any changes, terminate coverage for any dependents, nor will any refunds be issued **beyond the 10-day-free-look period.**
- If I/we allow my/our Option Twelve Plan to terminate due to lack of payment, it will not be reinstated or continued. Should I/we later determine that my/our need for temporary health coverage continues, I/we may apply for an **Option One Plan** provided that the total days of coverage for all plans combined (Option One and/or Option Twelve), does not exceed 365 days. Once the 365-day limit has been reached, there is a mandatory 6-month waiting period before I/we may re-apply for any short-term health plan offered by CareAmerica.
- Acceptance of an Option Twelve policy may impact my eligibility for individual guaranteed issue health insurance according to the requirements within the Health Insurance Portability and Accountability Act of 1996. However, the duration of my policy term may be considered creditable coverage, which can reduce the length of a pre-existing condition exclusion of a future health insurance policy.

I have read this application and declare that the information shown on it is true and complete to the best of my knowledge or belief. I understand that there is no insurance in effect unless my application is approved and that CareAmerica will not be liable for any medical bills before the effective date of my policy. I understand that this is NOT a continuation of any previous Option One or Option Twelve Short-Term Health Insurance policy. I understand that the policy is not renewable. I also understand that if any information stated in this application is incorrect, the policy may be voided.

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION

I authorize any provider of health care, Insurance Carrier or Health Plan to disclose to CareAmerica Insurance or its designated agents, all medical information, including any medical information for substance abuse and mental or emotional disorders, regarding me or any applying family member. This information is collected for the purposes of evaluating my application and determining eligibility for benefits. This authorization will remain valid for 2½ years from the date below. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization. I understand that coverage does not become effective until this and my application have been approved by CareAmerica.

PLEASE PROVIDE THE NAME AND ADDRESS OF YOUR ATTENDING PHYSICIAN OR ANY PHYSICIAN YOU HAVE SEEN IN THE LAST 12 MONTHS:

(If more than two names, attach a separate sheet)

APPLICANT NAME	PHYSICIAN	ADDRESS
APPLICANT NAME	PHYSICIAN	ADDRESS

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFICIARY INFORMATION:

BENEFICIARY	RELATIONSHIP TO APPLICANT	DATE OF BIRTH	SOCIAL SECURITY NO.
STREET ADDRESS	CITY	STATE	ZIP

APPLICANT'S SIGNATURE*

X _____ DATE _____ CITY _____ STATE AZ

*NOTE: SIGNATURE MUST BE THAT OF THE APPLICANT ONLY AND MUST BE SIGNED IN ARIZONA.

X _____

SPOUSE'S SIGNATURE (IF SPOUSE IS APPLYING FOR COVERAGE)

PARENTAL OR GUARDIAN CONSENT (TO BE COMPLETED IF APPLICANT IS 15 DAYS OF AGE OR OLDER BUT UNDER 18 YEARS OLD).

THIS WILL SERVE TO NOTIFY YOU THAT MY CHILD (PLEASE PRINT NAME OF CHILD) _____ WHO IS 15 DAYS OF AGE OR OLDER BUT UNDER 18 YEARS OF AGE IS APPLYING FOR CAREAMERICA SHORT-TERM HEALTH INSURANCE, WITH MY FULL KNOWLEDGE AND CONSENT, AND I REQUEST THAT YOU CONSIDER MY CHILD FOR SUCH COVERAGE.

SIGNATURE _____ PRINT NAME _____

SOCIAL SECURITY NO. _____ RELATIONSHIP _____ DATE _____

**PLEASE COMPLETE THIS FORM IN FULL.
MAIL OR FAX TO CAREAMERICA.**

Did you remember to include:

- 1. Applicant's signature (and spouse's, if applicable)?
- 2. The premium?
 - Check premium by using the rate table.
 - Be sure correct rates for region and age are used.
- 3. Applicant's Social Security Number?
If not available, please explain.

- 4. Applicant's birthdate?
- 5. Dependents' birthdates?
- 6. Answers to eligibility questions?
- 7. AD&D beneficiary information? (Only available for primary applicant, 18 years of age or over.)
- 8. Information about previous health insurance carrier(s), if available?

AGENT INFORMATION

Agent's Producer Number or Tax ID Number	Date
Agent's Name (Printed)	
Agency Name & Complete Address <input type="checkbox"/> (Please check if new address)	
Agent's Phone Number	
Agent's Fax Number	
Agent's Email	
Agent's Signature	

\$250 DEDUCTIBLE	
Age*	Rate
29 & Under	\$75
30-39	97
40-49	134
50-59	209
60-64	292
Children**	75

\$500 DEDUCTIBLE	
Age*	Rate
29 & Under	\$56
30-39	73
40-49	100
50-59	156
60-64	218
Children**	56

\$1,000 DEDUCTIBLE	
Age*	Rate
29 & Under	\$45
30-39	58
40-49	80
50-59	125
60-64	176
Children**	45

\$1,500 DEDUCTIBLE	
Age*	Rate
29 & Under	\$41
30-39	53
40-49	74
50-59	114
60-64	160
Children**	41

\$2,000 DEDUCTIBLE	
Age*	Rate
29 & Under	\$38
30-39	50
40-49	69
50-59	107
60-64	150
Children**	38

* Age: Rates are per adult insured based on the age on the policy effective date.

- ** Children:
- A single rate is charged for all children insured under your policy.
 - Application for child alone is rated on age 29 and under and a separate application for each child is required.
 - Newborn children under 15 days of age are not eligible for coverage.