



**REMINDER**  
Your full premium is due with your completed application. Payment must be for the entire period of coverage.

**Short-Term Personal Health Coverage for Individuals Application for Coverage**

**Primary Applicant and Dependents** (Primary applicant must be oldest person on application. Please use black ink only.)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Street Address (No P.O. Boxes accepted) \_\_\_\_\_ Mailing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Are you a citizen or legal resident of the U.S.?  Yes  No *You must reside in the State of Tennessee and legally reside in the United States to be eligible for this coverage.*

Are you or anyone you are applying for currently pregnant / expectant parent (including fathers)?  Yes  No

Spouse Last Name \_\_\_\_\_ Spouse First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_

Dependent Last Name \_\_\_\_\_ Dependent First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Natural Child/Stepchild  Adopted/Legal Ward  Other (specify) \_\_\_\_\_

Dependent Last Name \_\_\_\_\_ Dependent First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Natural Child/Stepchild  Adopted/Legal Ward  Other (specify) \_\_\_\_\_

Dependent Last Name \_\_\_\_\_ Dependent First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Natural Child/Stepchild  Adopted/Legal Ward  Other (specify) \_\_\_\_\_

*To include additional dependents, please record information on a separate sheet of paper and attach it to this application.*

**Selected Coverage**

**Term of Coverage:**

Length of Coverage (Check One):  1 month  2 months  3 months  
Deductible Option (Check One):  \$ 250  \$ 500  \$ 1,000  \$ 2,500

Requested Effective Date:

\_\_\_\_\_|\_\_\_\_\_|20|\_\_\_\_\_|\_\_\_\_\_|

**Payment Information**

\$ Amount Authorized \_\_\_\_\_  eCHECK

Bank Routing Number \_\_\_\_\_ Checking Account Number \_\_\_\_\_

**Please read carefully and sign below**

- I/We hereby declare that persons to be covered as listed above do not have other health care coverage or insurance as of the requested effective date.
- I/We 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/our knowledge.
- that any contract which may be issued to me/us shall be binding only if each statement included in this application is complete and true.
- that any contract which may be issued to me/us will be effective, subject to all the terms and conditions of the contract issued to me/us.
- that a broker or agent may receive a portion of my/our premium as commission. For more information, I/We will contact my/our broker or agent.
- that any contract issued to me/us is directly between BlueCross BlueShield of Tennessee, Inc. and me/us 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 benefits for any condition for which I or my dependents have had medical treatment (including taking prescription medication), symptoms, or any manifestations thereof, before the effective date of this contract. A policy will not be activated if payment is not approved by my financial institution.

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.

(This application is not acceptable unless completely filled out and signed by the applicant, parent or guardian if the applicant is a minor.)

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_|20|\_\_\_\_\_

Guardian Name: \_\_\_\_\_ (If primary applicant is under age 18)

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_|20|\_\_\_\_\_

Agent's Signature: \_\_\_\_\_ Agent's ID: \_\_\_\_\_ Date: \_\_\_\_\_|20|\_\_\_\_\_