



**BlueCross BlueShield
of Minnesota**

An independent licensee of the Blue Cross and Blue Shield Association

Insta-Care

Contract Schedule and Application

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Contract Schedule and Application

Blue Cross and Blue Shield of Minnesota
P.O. Box 64024
St. Paul, MN 55164-0024

FOR AGENTS USE ONLY	
Agency Code	Agent's Number
_____	_____
Agent's Name (Last, First, M.I.) Type or Print	

We will not process applications unless they are fully completed and accompanied by the full payment. Your check must be payable to Blue Cross and Blue Shield of Minnesota.

If applying for children only, please list the youngest child as the applicant.

1. **Applicant Name** _____

Last	First	Middle	DATE OF BIRTH
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Address _____

Street	City	State	Zip Code
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Home Phone # _____ **Work Phone #** _____

Sex Male Female **Marital Status** Single Married Divorced

Applicant's Social Security Number **Spouse's Social Security Number**

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2. **Contract Duration** (check one) 30 days 60 days 90 days

Deductible and Out-of-Pocket (select one):

- \$300 Individual Deductible (or \$900 Family Deductible)
\$940 Individual Out-of-Pocket Maximum (or \$2,820 Family Out-of-Pocket Maximum)
- \$500 Individual Deductible (or \$1,500 Family Deductible)
\$1,400 Individual Out-of-Pocket Maximum (or \$4,200 Family Out-of-Pocket Maximum)
- \$1,000 Individual Deductible (or \$3,000 Family Deductible)
\$1,800 Individual Out-of-Pocket Maximum (or \$5,400 Family Out-of-Pocket Maximum)

Total amount paid with this application \$_____ (You must submit the full payment)

3. I was (we were) previously covered under a Blue Cross and Blue Shield of Minnesota contract.

Identification Number _____ Group Number _____

4. Have you or any family members included in this application been covered by short-term coverage by any health carrier within the past 555 days? **Yes** **No**

If Yes, how many days were you or your family members covered by short-term coverage? _____ **days**

Note: State law limits short-term health coverage to a maximum of 365 days, combined from all carriers, for any individual in any 555 day period. Blue Cross and Blue Shield of Minnesota offers Insta-Care in 30, 60, or 90 day increments up to the limits of state law. You are not eligible for coverage if the Insta-Care term you have chosen will exceed this limit.

5. **Chemical Dependency Option** (This option applies to all family members included on the application)

Benefits are requested for treatment or consultation for alcoholism, chemical dependency treatment, or drug addiction.

(check one): **Yes** **No**

6. **Requested Effective Date** _____:

- If you or the agent mail the application, the effective date is the day we receive the application in our **home office** or the requested effective date, whichever is later.
- If you or the agent deliver the application to our **home office**, the effective date is the day after the receipt date in our **home office** or the requested effective date, whichever is later.
- If you submit an electronic application, the effective date is the day after the receipt date of the electronic application in our **home office** or the requested effective date, whichever is later.
- The effective date cannot be greater than 60 days after the signature date.

7. **Starting with Applicant's name**, list each family member applying for coverage:

Full name	Relationship	Birth date	Sex	Social Security Number
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

8. **Are all age 19-24 dependent children listed above currently fulltime students?** Yes No

Note: If your dependent children age 19–24 are not fulltime students, they must complete an application under their own name.

Important information about this application for coverage. Read this section, sign and date the application.

I hereby declare that all applicants for this coverage:

- are not enrolled in any other health care coverage during the effective dates of this coverage;
- have not been turned down for coverage by any health carrier, including Blue Cross and Blue Shield of Minnesota;
- are not currently pregnant and do not have a wife or daughter (including family members not applying) who is currently pregnant;
- do not anticipate adding additional dependents to this coverage through birth or adoption;
- are not currently confined to or in any health care facility;
- are not less than 90 days of age, or over 65 years of age with Medicare coverage; and
- live in Minnesota.

I ALSO DECLARE THAT I UNDERSTAND COVERAGE IS LIMITED. I UNDERSTAND THAT INSTA-CARE DOES NOT PROVIDE COVERAGE FOR ANY CONDITION FOR WHICH I OR MY DEPENDENTS HAVE HAD MEDICAL TREATMENT, SYMPTOMS, OR ANY MANIFESTATIONS THEREOF, BEFORE THE EFFECTIVE DATE OF THIS CONTRACT. (INSTA-CARE IS A NON-QUALIFIED PLAN)

I acknowledge receipt of the Notice concerning my rights under the Minnesota Life and Health Insurance Guaranty Association.

X

Your signature

Date

NOTE: YOUR FULL PAYMENT MUST ACCOMPANY THIS APPLICATION. LACK OF FULL PAYMENT WILL VOID THIS APPLICATION.

If you have not received your identification card within 14 days, please call (651) 662-5030 or toll free 1-800-382-2000, extension 25030.

AGENT RETAINS THE PINK COPY, ATTACHES YELLOW COPY TO CONTRACT FOR SUBSCRIBER, AND MAILES ORIGINAL TO BLUE CROSS AND BLUE SHIELD OF MINNESOTA.