



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

THE #1 HEALTH INSURER
IN ILLINOIS NOW OFFERS
AFFORDABLE SHORT-TERM,
HEALTH INSURANCE COVERAGE

SelecTEMP[®] PPO

INDIVIDUAL AND FAMILY HEALTH INSURANCE

it just fits.

SelecTEMP[®] PPO

Individual, Family and Children's Temporary Health Insurance Coverage from Blue Cross and Blue Shield of Illinois

We are pleased to present our unique range of temporary health insurance plans for individuals and families. Each plan is backed by the financial strength and stability of Blue Cross and Blue Shield of Illinois.

While each of our health care plans is tailored to the needs and budgets of Illinois individuals and families, all of the plans have a number of features and benefits in common, including: \$5,000,000 in lifetime benefits, hospital and surgical services, emergency benefits, and membership card recognition nationwide.

We are confident that Blue Cross and Blue Shield of Illinois has a health care plan that is right for you. Regardless of the plan you select, you will benefit from the experience, expertise and stability of the leading health insurer in Illinois.

Specific Product Highlights

- Apply online today, you may have coverage as soon as tomorrow
- Get basic protection against unexpected accidents or illness
- Choose from one or up to six months of coverage
- Freedom to choose providers from one of the largest contracting hospital and physician networks in Illinois
- Up to \$5,000,000 in lifetime coverage



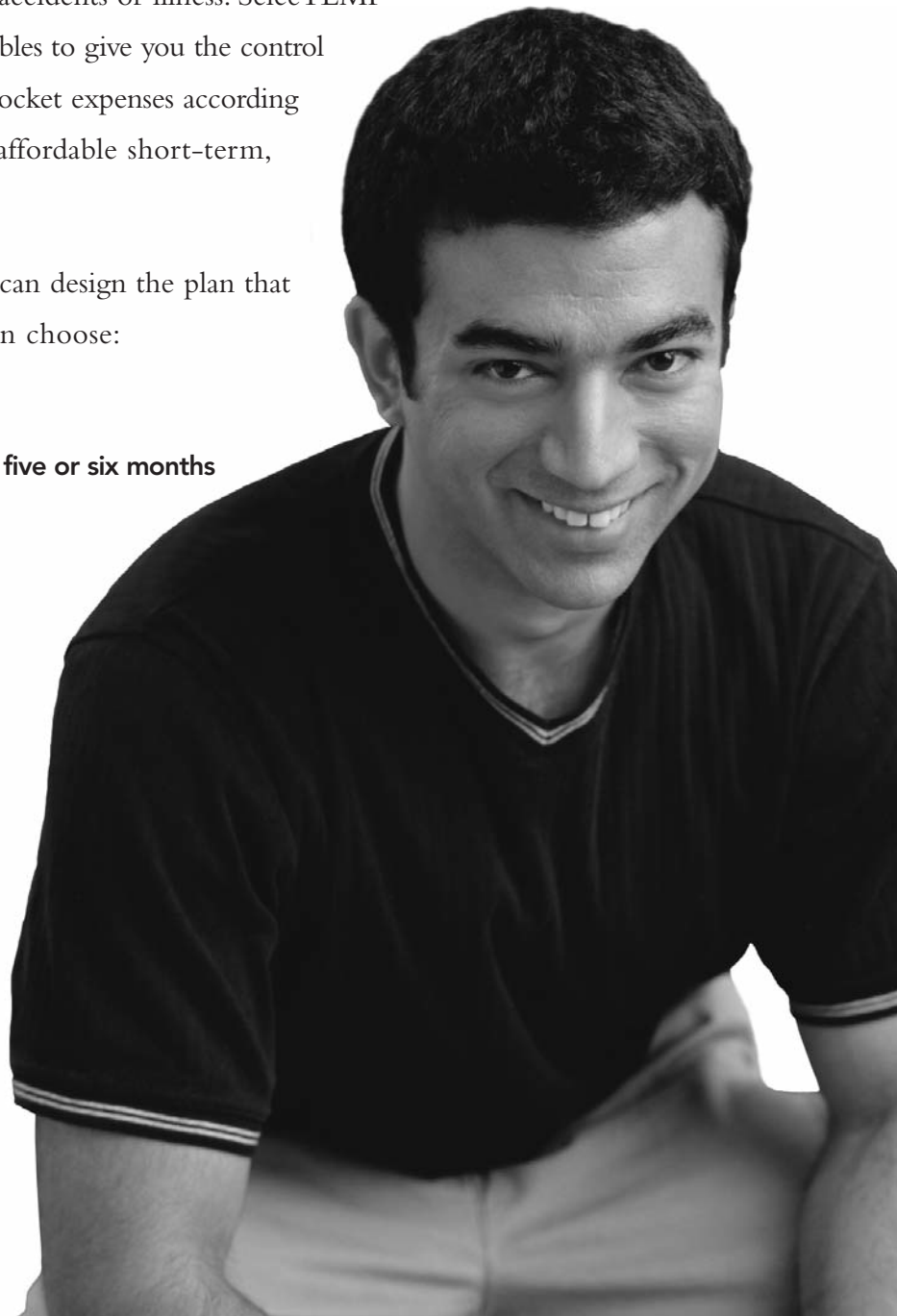
**BlueCross BlueShield
of Illinois**

If you find yourself temporarily without health insurance coverage because COBRA is too expensive, you are in between jobs, or waiting for employer coverage to begin, SelecTEMP PPO is the plan for you.

No matter how well you take care of yourself, unexpected health issues sometimes arise. SelecTEMP PPO is individual health insurance coverage that provides you, your spouse and your children essential, basic protection against unexpected accidents or illness. SelecTEMP PPO offers various benefit periods and deductibles to give you the control to tailor coverage, premium rates and out-of-pocket expenses according to your own needs. SelecTEMP PPO is an affordable short-term, limited duration insurance plan.

With SelecTEMP PPO you get choices. You can design the plan that best fits your time frame and budget. You can choose:

- **The date you want the coverage to begin**
- **The coverage period – one, two, three, four, five or six months**
- **The deductible – from \$500 to \$5,000**



SelecTEMP PPO

SHORT-TERM, LIMITED DURATION HEALTH INSURANCE COVERAGE FOR MANY OF THE MOST COSTLY HEALTH CARE SERVICES

Strong benefits for hospitalization, surgery and more

SelecTEMP PPO provides benefits for the hospital and medical/surgical services you need to help protect your financial security. SelecTEMP PPO offers you:

- Inpatient/outpatient medical/surgical services
- Inpatient/outpatient hospital services
- Diagnostic services (lab and X-ray)
- Physical, occupation and speech therapy
- Emergency care
- Office visits
- Prescription drug coverage

A Choice of Benefit Periods and Deductibles to Fit Your Budget

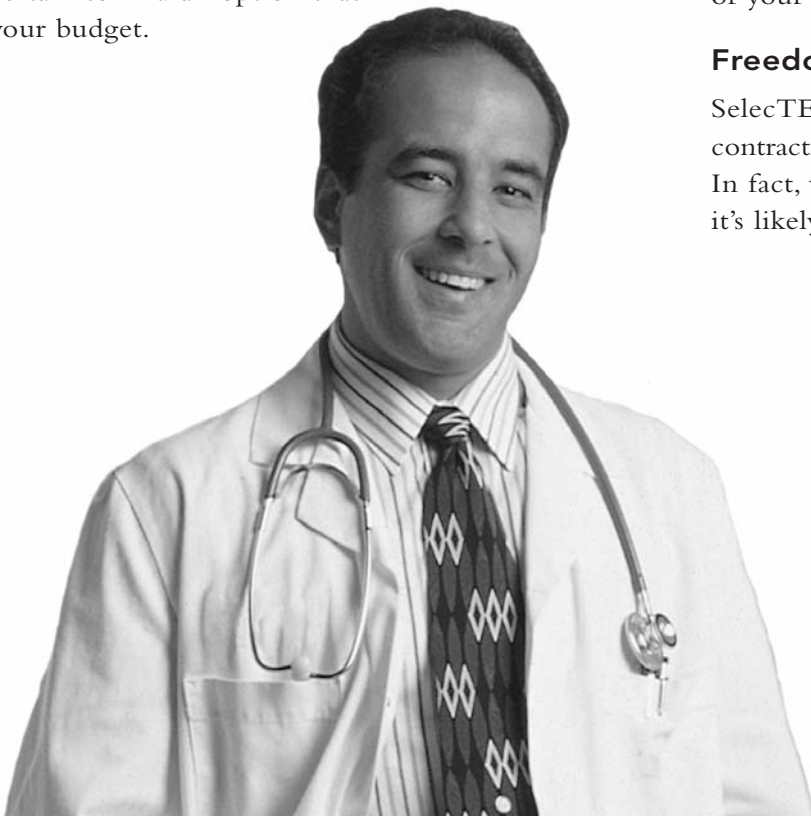
You can choose a benefit period of one, two, three, four, five or six months, depending on your needs. A deductible is the amount for which you are responsible before the plan begins to pay benefits for covered services. SelecTEMP PPO gives you the flexibility of choosing a \$500, \$1,000, \$1,500, \$2,000, \$2,500 or \$5,000 deductible. Given this range of choice, you are certain to find an option that fits your budget.

80% Coverage Level Helps Control Your Costs

The coverage level (percentage) that SelecTEMP PPO pays for covered services after you meet your deductible is called coinsurance. SelecTEMP PPO will pay 80% of covered expenses after you've met your deductible when you use PPO hospitals and physicians. That means you pay 20% of your eligible bills until you've paid \$1,000. When you reach that point, SelecTEMP PPO will pay 100% of covered services for the remainder of your contract term.

Freedom of Choice

SelecTEMP PPO is supported by one of the largest contracting hospital and physician networks in Illinois. In fact, with more than 200 Illinois hospitals included, it's likely that hospitals near you participate.



Who is Eligible?

Illinois residents may apply for family coverage if the applicants are at least 60 days of age and under 65 years of age. Applicants must not be entitled to Medicare benefits. For an individual children's policy, the child must be at least one year of age. Each child applying for coverage will need a separate application.

You can choose coverage for yourself, your spouse and children under a single contract. You can also select coverage for a spouse-only or children-only contract. Coverage is not renewable. However, you may purchase up to two successive policies if you meet eligibility requirements for the health care plan. You must complete a new application for each policy and send it in for approval with the appropriate premium. If you answer "yes" to any of the health questions on the application you will be declined. If you are not a legal U.S. citizen, or a non-resident alien who has not lived in the United States for two years your application will also be declined.

Pre-existing Conditions Limitation

Pre-existing condition means any disease, illness, sickness, malady or condition which was diagnosed or treated by a Provider within 12 months prior to your Coverage Date, or which produced symptoms within 12 months prior to your Coverage Date which would have caused an ordinarily prudent person to seek medical diagnosis or treatment. Pre-existing conditions are not covered under this policy.

When does SelectTEMP PPO coverage begin?

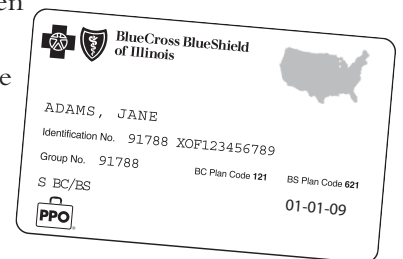
The benefit period begins on the date requested by the applicant after signing the application and within 45 days of the signature date. If no specific date for coverage is requested, then the policy will become effective the day after the postmark date affixed by the U.S. Post Office.

If the envelope containing the application is not postmarked by the U.S. Post Office, or if the postmark is not legible, the effective date will be the later of:

- the requested effective date; or
- the date received by Blue Cross and Blue Shield of Illinois

Your completed signed and dated application and the entire premium must be received by Blue Cross and Blue Shield of Illinois within 10 days of the signature date.

You must include the entire premium for your term of coverage with your submitted application. If we do not receive the entire premium payment amount, the processing of your application will be delayed.



**BlueCross BlueShield
of Illinois**



SelecTEMP PPO Includes This Unique Combination of Features from Blue Cross and Blue Shield of Illinois

THE SECURITY OF \$5,000,000 IN LIFETIME PROTECTIONS

With SelecTEMP PPO, each person will be eligible for up to \$5,000,000 in lifetime benefits. That's substantial protection for a limited, short-term durability plan.

Travel with Confidence – You're Covered Away from Home

As a member of Blue Cross and Blue Shield of Illinois, you'll have access to a program called BlueCard PPO. This is a nationwide network of contracting providers that allows you to receive benefits for covered services when you travel. Simply present your Blue Cross and Blue Shield of Illinois ID card to a participating BlueCard PPO provider wherever you are. To find a participating provider while you're away, just call the toll-free number on the back of your card. It's that easy!

Financial Stability You Can Count On

Today one American in three carries a Blue Cross and Blue Shield membership card. In fact, over 6.5 million residents across Illinois trust Blue Cross and Blue Shield of Illinois to give them more health care value for their premium dollar.

Blue Cross and Blue Shield of Illinois has been servicing the health insurance needs of Illinois residents for more than 65 years. We're one of the largest and most financially secure insurance companies in the state. A.M. Best, one of the leading rating agencies of the insurance industry, has awarded us an "A+" (Superior) rating.* We're here to stay!

No Paperwork – Your Claims are Handled For You

In most cases, all you have to do is show your Blue Cross and Blue Shield ID card at the doctor's office or hospital, and your claim will be filed for you. We want you to concentrate on regaining your health – not worrying about hospital and doctor bills.

*As of November 2007

NEW BUSINESS CHECKLIST

IMPORTANT!

Use this checklist to make sure you've completed all needed information.

Assure quick processing of all applications...

In order to process your application, you must include a check for the entire premium payment.

Have you:

- ✓ Reviewed each application to verify that it is complete and legible?
- ✓ Included all the necessary signatures on the application?
- ✓ Determined your premium by using the zip code table and rate table contained in this booklet and the rate worksheet on the back of the application?
- ✓ Enclosed a check for the entire premium amount, made payable to Blue Cross and Blue Shield of Illinois?

**Any Questions?
Call 1-800-654-7385 Toll-Free**

**Apply on-line
www.bcbsil.com/temp**

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SM Service Mark of Health Care Service Corporation



P.O. Box 3236, Naperville, IL 60566-7236
Apply via fax: 1-630-328-4505

Empty box for Home Office Use Only

APPLICATION FOR MAJOR MEDICAL INSURANCE

Please print all information in blue or black ink. Pencil will not be accepted.

Requested Effective Date / / Mo. / Day / Yr.

PERSON(S) APPLYING FOR COVERAGE (please print)

IMPORTANT: Are all persons to be insured U.S. citizens or permanent residents living in the United States for at least 2 years? [] Yes [] No
If the answer is "No" the coverage cannot be issued to any person not meeting this requirement.

Form with fields for Primary Applicant (Name, Sex, Birth Date, Age, Social Security Number, Address, City, State, ZIP Code, Home Phone, Work Phone, Cell Phone, Fax #, E-mail) and Spouse/Dependents (Name, Sex, Birth Date, Age, Social Security Number, Full Time Student).

Information for additional dependent children must be provided on a separate page and be signed and dated. Children must be unmarried, at least 60 days of age, under age 26, or under age 30 if in the military. For child only coverage the child must be at least one year of age.

DEDUCTIBLE SELECTION AND BENEFIT PERIOD (please choose one benefit period and one deductible amount)

I (we) hereby apply for: Benefit Period: [] 1 month [] 2 months [] 3 months [] 4 months [] 5 months [] 6 months
Deductible Amount: [] \$500 [] \$1,000 [] \$1,500 [] \$2,000 [] \$2,500 [] \$5,000

HEALTH INFORMATION - Every question must be answered.

If the answer is "Yes" to any of the following questions, this coverage cannot be issued.

- 1. Do you or any person to be covered have hospital, major medical, group health, government or medical insurance coverage that will not terminate prior to the effective date of this coverage? [] Yes [] No
2. Is any female to be covered now pregnant or is any male to be covered an expectant parent? [] Yes [] No
3. In the past five years, has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized, taken medication for, or been recommended for treatment for any of the following: heart or circulatory disorder... [] Yes [] No
4. Has any person applying for coverage ever been diagnosed or treated by a physician for, acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)... [] Yes [] No
5. Has any person applying for coverage been declined for insurance due to health reasons within the past 18 months? [] Yes [] No

Representations, Acknowledgments and Authorizations: I have read all statements on this application and represent that they are true and complete. I understand that failure to disclose information on this application may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of Blue Cross and Blue Shield of Illinois. I understand that fraud or any intentional misrepresentation of a material fact may result in the loss of coverage under this contract. I also understand that: 1) Blue Cross and Blue Shield of Illinois will provide no coverage until my application is accepted and the correct premium is received by Blue Cross and Blue Shield of Illinois; 2) this contract will pay no benefits for any illness, accident or physical impairments which existed or occurred within 12 months prior to the effective date; 3) if the contract is issued, it will not be a continuation of any previous medical plan, including any prior short term coverage; 4) if my completed application is approved, the coverage will take effect on the later of: (a) the requested effective date; or (b) the day after the postmark date affixed by the U.S. Postal Office. If the envelope containing the application is not postmarked, or the postmark is not legible, the effective date will be the later of: (a) the requested effective date; or (b) the date the completed application is received by Blue Cross and Blue Shield of Illinois; (c) the date an online application is submitted.

Medical Authorization: I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, or other medical or medically related facility, governmental agency or other person or firm, to disclose to BCBSIL or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs or alcohol. I also authorize release of information relating to mental illness. In addition, I authorize BCBSIL 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.

APPLICANT'S SIGNATURE(S)

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 Signature: _____ **Date Signed:** ____/____/____
 Mo./Day/Yr.

Spouse Signature
 (ONLY if to be insured): _____ **Date Signed:** ____/____/____
 Mo./Day/Yr.

Parent/Guardian Signature
 (If Primary Applicant is UNDER the age of 18): _____ **Date Signed:** ____/____/____
 Mo./Day/Yr.

Dependent Signature
 (ONLY if 18 or over and ONLY if to be insured): _____ **Date Signed:** ____/____/____
 Mo./Day/Yr.

Dependent Signature
 (ONLY if 18 or over and ONLY if to be insured): _____ **Date Signed:** ____/____/____
 Mo./Day/Yr.

Dependent Signature
 (ONLY if 18 or over and ONLY if to be insured): _____ **Date Signed:** ____/____/____
 Mo./Day/Yr.

Dependent Signature
 (ONLY if 18 or over and ONLY if to be insured): _____ **Date Signed:** ____/____/____
 Mo./Day/Yr.

If any question(s), you may (1) call our Customer Service Department toll-free at **1-800-654-7385**, or (2) call your insurance agent at their number below, or (3) visit **www.bcbsil.com**.

PREMIUM PAYMENT

The entire premium must be submitted with the application. If faxing the application, be sure to include a completed Automatic Payment Authorization form.

HOW TO CALCULATE RATES

- Step 1** Determine your area based on the ZIP code from the ZIP code area listing in the book.
- Step 2** Select the rate chart that corresponds to your sex. Find the rate corresponding to the chosen deductible (\$500, \$1,000, \$1,500, \$2,000, \$2,500 or \$5,000), your area and age.
- Step 3** Select the rate chart that corresponds to your spouse's sex. Find the rate corresponding to the chosen deductible (\$500, \$1,000, \$1,500, \$2,000, \$2,500 or \$5,000), your spouse's area and age.
- Step 4** Find the appropriate child(ren) rate by checking the deductible, area and selecting: 1 child or 2+ children.
- Note: If only children are applying, use one application per child. Do not use the dependent rates.*
- Select the rate chart that corresponds to the child's sex. Find the rate corresponding to the chosen deductible (\$500, \$1,000, \$1,500, \$2,000, \$2,500 or \$5,000), the child's area and age.
- Step 5** Add the rates for you, your spouse, if applicable, and your child(ren), if applicable, using the rate calculator at right.
- Step 6** Multiply the total from Step 5 by the number of months of coverage you need (1, 2, 3, 4, 5 or 6 months).
- Step 7** This is the total premium for the coverage period selected.

RATE CALCULATOR

Applicant Rate	\$ _____
	+
Spouse's Rate	\$ _____
	+
Child(ren) Rate	\$ _____
	=
Total Monthly Rate	\$ _____
	X
Coverage Period (1, 2, 3, 4, 5, 6 months)	_____ months
	=
Total Premium Due	\$ _____
Make your check payable to: Blue Cross and Blue Shield of Illinois.	
Premium Amount Enclosed	\$ _____

Note: Deductibles are per person, per benefit period. There is no deductible credit or carry over from one Contract to another.

AGENT INFORMATION (if applicable)

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

Agent Signature: _____ **Date Signed:** ____/____/____
 Mo./Day/Yr.

Print Agent Name: _____ **Agent Code:** _____

Agent Phone Number: () _____ **Agent Fax Number:** () _____

Agent Email Address: _____ **Mail Policy(ies) to:** Agent Applicant

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