



FOR AGENT USE ONLY (Please print legibly)			
Agency Code	_____	_____	_____
Agent Number	_____	_____	_____
Agent Name	_____		

Insta-Care Contract Schedule and Application

A Reason for Application

___ I am a new applicant, not currently a Blue Cross and Blue Shield of Minnesota (Blue Cross) member

___ I have or have had other Blue Cross coverage and I am applying for Insta-Care: Blue Cross ID# _____

Application instructions

1. Please complete this entire application including all explanations as requested. Print clearly using black or blue ink. Incomplete applications will be returned to you to be completed.
2. Sign and date this application.
3. If you or the agent mails the application, the effective date is the day we receive the application in our home office (Eagan location) or the requested effective date, whichever is later. If you or the agent delivers 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.
4. Submit this application with full payment to Blue Cross and Blue Shield of Minnesota, P.O. Box 64024, St. Paul, MN 55164. If paying by check, make your check payable to Blue Cross and Blue Shield of Minnesota. When I provide a check as payment, I authorize Blue Cross either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Cross uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Cross receives my payment and I will not receive my check back from my financial institution.
5. Agent retains the pink copy of the application, attaches the yellow copy to the contract for the subscriber, and mails the original to Blue Cross.

General application information

- Resident Status - You must be a resident of Minnesota to be eligible for Insta-Care coverage.
- Dependents - If applying for a family plan, all dependent children must be over 90 days old, under the age of 25 and unmarried to be eligible for coverage. If your dependent is age 25 or older, they must complete an application under their own name. New dependents, including newborns, may NOT be added for the duration of this contract.
- Children as applicants - If applying for children only, please list the youngest child as the applicant. The youngest child must be over 90 days old and all older siblings must be under the age of 18 to be eligible for coverage.
- Previous short-term coverage - State law limits short-term coverage to a maximum of 365 days, combined from all carriers, for any individual in any 555 day period. You will not be eligible for coverage if the Insta-Care contract duration you selected will exceed this limit.
- Preexisting conditions - Insta-Care does not provide coverage for any preexisting conditions. A preexisting condition is any injury, illness or condition for which you or your eligible dependent have had medical treatment, symptoms or any manifestations of the injury, illness or condition before the effective date of this contract. Any injury, illness or condition treated under a previous Insta-Care contract is a preexisting condition and will not be covered under a new Insta-Care contract.
- You may be contacted from Blue Cross for additional information.

Contract issuance

- This contract is issued for a specific number of days as stated in section C of the Contract Schedule and Application (30, 60 or 90 days). This contract cannot be renewed. You may be eligible to apply for a new contract term which requires you to complete a new application.
- If you have not received your identification (ID) card within 14 days, please call (651) 662-5030 or toll-free 1-800-531-6685.

How to contact us

- Please contact your agent for assistance or call 651-662-5050 or 1-800-262-0823 and one of our Blue Cross representatives will be happy to assist you.

Insta-Care Application

B Personal information

Applicant or Contractholder Name _____ Legal Marital Status ____ Single ____ Married
FIRST LAST

Applicant or Contractholder Social Security Number _____ Email address _____

Applicant address _____
Street including Apt#

City _____ State _____ Zip _____

Preferred telephone number () _____ Alternate telephone number () _____

Starting with Applicant, list each family member applying for coverage:

First	Name Last	# of Days of Short-term Coverage in last 555 days	Social Security Number	Relationship to Applicant	Birth Date mm/dd/yyyy	Sex M/F
				Applicant		

Additional family members on attached page (note: refer back to application page for link to additional page AFTER completing this form)

C Plan selection

Contract Duration (check one) 30 days 60 days 90 days

Deductible and Out-of-Pocket Maximum per contract term (select one):

In-Network: \$300 Individual Deductible (\$900 Family Deductible) / \$1,000 Individual Out-of-Pocket (\$3,000 Family Out-of-Pocket)
Out-of-Network: \$900 Individual Deductible (\$2,700 Family Deductible) / \$5,400 per Individual Out-of-Pocket

In-Network: \$500 Individual Deductible (\$1,500 Family Deductible) / \$1,500 Individual Out-of-Pocket (\$4,500 Family Out-of-Pocket)
Out-of-Network: \$1,500 Individual Deductible (\$4,500 Family Deductible) / \$9,000 per Individual Out-of-Pocket

In-Network: \$1,000 Individual Deductible (\$3,000 Family Deductible) / \$3,000 Individual Out-of-Pocket (\$9,000 Family Out-of-Pocket)
Out-of-Network: \$3,000 Individual Deductible (\$9,000 Family Deductible) / \$18,000 per Individual Out-of-Pocket

COVERAGE FOR SUBSTANCE ABUSE IS INCLUDED IN THE CONTRACT. YOU MAY CHOOSE TO DELETE SUBSTANCE ABUSE COVERAGE.

Your premium may be slightly reduced if you delete substance abuse coverage. Check this box if you want to **EXCLUDE** substance abuse coverage.

Your decision to retain or delete substance abuse coverage applies to all individuals applying for coverage under this contract. Insta-Care does not provide coverage for any illness, injury or condition for which you or your dependents have had medical treatment, symptoms, or any manifestations thereof, before the effective date of coverage.

D Payment

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

E Coordination of Benefits

Will you or any family member on this application have other health or medical coverage, including Medicare, once this policy is in force? Yes No

If the response is Yes, you may be contacted for more information.

F Effective date of coverage

- 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.

G Authorization and representation

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

I represent all applicants for this coverage:

- have not been declined for health coverage within the past year as a result of a medical condition;
- are not an expectant father, are not currently pregnant and do not have a wife or daughter (even if not applying) who is currently pregnant;
- are not in the process of adopting a child;
- are not currently confined in any health care facility;
- are not less than 90 days of age; and
- live in Minnesota.

I understand coverage is limited and Insta-Care is a nonqualified plan. I also understand Insta-Care does not provide coverage for any illness, injury or condition for which I or my dependents have had medical treatment, symptoms, or any manifestations thereof, before the effective date of this contract.

I understand each Insta-Care contract is a separate contract and cannot be renewed. I also understand any illness, injury or condition treated under a previous Insta-Care contract is a preexisting condition and will not be covered under this new contract.

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

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

Date
Applicant Signature
Date
Parent, Legal Guardian or Guarantor Signature
(if applicant is a minor)

As Parent, Legal Guardian, or Guarantor, I understand that: (1) the applicant is the contractholder; (2) I guarantee payment to Blue Cross; and (3) any Blue Cross issued payments will be made to the applicant or contractholder and not to me.