

Premium Calculation Instructions

Please refer to the enclosed rate chart.

Step 1

List each applicant's rate.

a) Applicant rate _____
 b) Spouse rate _____ + _____
Subtotal = _____

Step 2

Enter the 1 Child rate if only one child _____
 Enter the 2+ Children rate if two or more children _____
Subtotal = _____

Step 3

Add the subtotals from Steps 1 and 2 = _____

Step 4

Enter the number of days of coverage (30 to 183) _____
 Multiply the number of days by the subtotal in Step 3 x _____

Step 5

Total (from Step 4) = _____

If the amount paid is less than the required amount for the number of coverage days requested, BCBSMT will reduce the days of coverage accordingly.

- Check or Money Order
- Visa/Discover/Master Card

I authorize Blue Cross and Blue Shield of Montana to charge my credit card the full payment for the Short Term Blue policy.

Card Number _____

Expiration Date _____/_____/_____

Authorized Amount _____

Enter the amount from Step 5 on the Premium Calculation Instructions table

Signature of Cardholder

Date

Short-Term Blue Application Form



REQUESTED EFFECTIVE DATE _____

APPLICANT'S NAME (Print Last, First, Middle)	Male/Female	DATE OF BIRTH MM DD YY	SOCIAL SECURITY NUMBER <small>Your SSN may be included in your subscriber identification number</small>
MAILING ADDRESS		CITY, STATE, ZIP CODE	
SPOUSE'S NAME (if to be covered) (Print Last, First, Middle)	Male/Female	DATE OF BIRTH MM DD YY	SOCIAL SECURITY NUMBER <small>Your SSN may be included in your subscriber identification number</small>
CHILDREN (if to be covered) NAME (Print Last, First, Middle)	Male/Female	DATE OF BIRTH MM DD YY	SOCIAL SECURITY NUMBER
1.			
2.			
3.			
4.			
5.			
6.			

BENEFIT PERIOD

Indicate number of days applying for 30-183 Days _____

Deductible Amount \$500 \$1,000 \$2,500

Copayment Amount 50/50 80/20

Answer the following questions completely and accurately.

(If additional space is needed to provide complete information, use a separate sheet of paper, signed and dated.)

- Do you or any person to be covered 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 or is any person expected to become eligible for medical coverage prior to the expiration of this coverage? **Yes No**
- With regard to you or any person to be covered, is there reason to believe anyone is an expectant mother or father through birth or adoption?
- Within the last ten years has any person to be covered sought treatment or medical advice for heart problems; stroke; diabetes; cancer or tumor; immune system disorder including HIV or AIDS; alcohol or drug use; nervous system disorder, including multiple sclerosis; or hepatitis C?
- Has any person to be covered been recommended to receive any medical treatment, diagnostic studies or follow-up that has not been performed?
- Has any person to be covered been declined for health coverage within the last three years?

OFFICE USE ONLY

Group Number	<input type="checkbox"/> Approved as Applied _____	Date Stamps
Package Number	<input type="checkbox"/> Declined (Reason) _____	
Medical Notes 7	<input type="checkbox"/> Modified Approval _____	
Effective Date		