ANSWER THE FOLLOWING QUESTIONS COMPLETELY AND ACCURATELY IN ORDER TO DETERMINE ELIGIBILITY.

1. a. Have all applicants resided within the United States continuously for the past six months? YES ❑ NO ❑

[If YES, skip to question 2. If NO, please answer question 1b.]

b. If any applicant has not resided continuously within the U.S. for the past six months, are such applicants U.S. citizens or permanent residents ("Green Card" holders)? YES ❑ NO ❑

[If YES, continue to question 2. If NO, you are not eligible for the plan.]

2. Is either the applicant or spouse, or any female dependent, whether or not listed on the application, currently pregnant? YES ❑ NO ❑
3. Is any male listed on this application expecting a child with anyone, even if the mother is not listed on the application? YES ❑ NO ❑

[If YES to questions 2 or 3, you are not eligible for the plan. Otherwise, please continue with questions 4-10.*]

IF THE ANSWER TO ANY QUESTION FROM 4 – 10 IS YES, YOU ARE NOT ELIGIBLE FOR THE PLAN.

4. Have you or any person applying received any medical or surgical consultation, advice or treatment, including medication, within the last 5 years for: heart disorders, including heart attack; disorders of the arteries, including stroke; disorders of the blood, including hemophilia and leukemia; diabetes; cancer, not including breast cancer; alcohol or drug dependency or abuse; or non-AIDS related immune system disorders? YES ❑ NO ❑
5. Have you or any person applying been diagnosed with or received treatment, including medication, for breast cancer within the last 5 years? YES ❑ NO ❑
6. Have you or any person applying been treated for or diagnosed with acquired immune deficiency syndrome (AIDS)? YES ❑ NO ❑
7. Within the past 10 years, has any person applying had any application for insurance declined, deferred or restricted in any way, for health reasons? YES ❑ NO ❑
8. Have you or any person applying enrolled in training for or engaged in an occupation involving unusual hazards, and not covered by Workers' Compensation Insurance? YES ❑ NO ❑
9. During the policy term, will you or any person applying train for or participate in: (1) A team or individual sports activity as a professional; or, (2) National or international competition as an amateur; or, (3) A collegiate sports activity? YES ❑ NO ❑
10. Do you or any person applying 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? **[If YES, when will existing coverage expire?** ______/______/______**]** (MM / DD / YY) YES ❑ NO ❑

[Please note, coverage cannot start until prior coverage has terminated.]

If you or any person applying were covered by a health insurance plan during the past 63 days, please provide the name(s) and telephone number(s) of all health insurance carrier(s) and the respective coverage period(s) for the past twelve months. (If available, please attach I.D. cards or letters of creditable coverage. Please list most recent coverage first.)

Health Plan ____________ Phone # ____________ I.D. # ____________

Insured's Name ____________ Coverage Period ________ to ________

Health Plan ____________ Phone # ____________ I.D. # ____________

Insured's Name ____________ Coverage Period ________ to ________

*** If you answered YES to any of questions 4 through 10, please answer below. Note: Such person(s) is excluded from coverage:**

Question No. ______ Person(s) to whom it applies: ____________

Question No. ______ Person(s) to whom it applies: ____________

An Independent Licensee of the Blue Shield Association

www.cpiclife.com

Application for Option One Single Payment Plan (30–185 Days)

Complete both sides of this form in full. Mail application along with your check (payable to CPIC *Life*) or your Credit Card Authorization to:

CPIC *Life*
P.O. Box 750309
Petaluma, CA 94975-0309

Fax: 707-778-0425
(Use fax # only when paying by credit card)
Phone: 800-443-8284

Please print or type:

APPLICANT'S LAST NAME		FIRST		MI
DATE OF BIRTH	SOCIAL SECURITY NO.	HOME TELEPHONE	EMAIL	
HOME ADDRESS		CITY		
COUNTY		STATE CA	ZIP CODE	
ARE YOU EMPLOYED? YES ❑ NO ❑	IF YES, COMPLETE NAME AND ADDRESS OF EMPLOYER			
ARE YOU APPLYING FOR A BLUE SHIELD HMO OR INDIVIDUAL OR FAMILY PLAN TO BEGIN WHEN OPTION ONE COVERAGE ENDS? YES ❑ NO ❑				

Please Note:
- If parents/guardians are not applying for coverage, a separate application must be completed for each child.
- This policy will not cover anyone who is under 15 days of age, or over 65 years old on the policy effective date.

LIST APPLICANT AND ALL ELIGIBLE DEPENDENTS TO BE COVERED BELOW:

LAST NAME	FIRST	MI	SOCIAL SECURITY NO.	SEX M F	BIRTHDAY MO/DAY/YR	PREMIUM
1. APPLICANT						$
2. SPOUSE						$
3. CHILD						$
4. CHILD						
5. CHILD						

PLAN SELECTIONS:

A. DEDUCTIBLE

❑ $250 ❑ $500 ❑ $1,000 ❑ $1,500 ❑ $2,000

B. POLICY TERM: NO. OF DAYS

__________ (30–185 DAYS)

C. POLICY EFFECTIVE DATE

If you are approved, coverage will begin at 12:01 a.m. on the date following the U.S. Postal Service postmark date stamped on the envelope or, if application is faxed, the day after fax is received. Coverage can also begin on a future effective date that you specify (within 45 days):

Effective Date: ____________
(Postmark date must precede requested effective date. Exceptions are not permitted.)

PAYMENT METHOD: TOTAL PREMIUM DUE $ ________

❑ Check ❑ VISA
❑ Mastercard ❑ American Express

IMPORTANT – Total premium due by check or credit card authorization must accompany application and will be held in trust while this application is evaluated by CPIC *Life*.

IF PAYING BY CREDIT CARD – I authorize CPIC *Life* to bill my account for the Total Premium Due.

ACCOUNT NO. ____________
PLEASE PRINT CREDIT CARD NUMBER CLEARLY

EXP. DATE _____/_____ CARDHOLDER NAME: ____________

SIGNATURE ____________

IMPORTANT INFORMATION — PLEASE READ:

I understand that:

- No benefits are payable for any expenses incurred as the result of a pre-existing condition as defined.
- If any person applying is hospital confined on the effective date, benefits will take effect on the first day following the hospital stay.
- Once a policy is issued, under no circumstances will I/we be allowed to make any changes, terminate coverage for any dependents, nor will any refunds be issued.
- The total length of coverage under any combination of Short-Term Health Plans offered by CPIC *Life* (Option One - Single Payment Plan and/or Option Twelve - Monthly Payment Plan) may not exceed 365 days. Once the 365-day limit has been reached, there is a 6-month waiting period before I/we may re-apply.
- Acceptance of an Option One policy may impact my eligibility for individual guaranteed issue health insurance according to the requirements within the Health Insurance Portability and Accountability Act of 1996. However, the duration of my policy term may be considered creditable coverage, which can reduce the length of a pre-existing condition exclusion of a future health insurance policy.

I have read this application and declare that the information shown on it is true and complete to the best of my knowledge or belief. I understand that there is no insurance in effect unless my application is approved and that CPIC *Life* will not be liable for any medical bills before the effective date of my policy. **I understand that this is NOT a continuation of any previous Option One or Option Twelve Short-Term Health Insurance policy. I understand that the policy is not renewable. I also understand that if any information stated in this application is incorrect, the policy may be voided.**

Note: California Law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION

I authorize any provider of health care, Insurance Carrier or Health Plan to disclose to CPIC *Life* Insurance or its designated agents, all medical information, including any medical information for substance abuse and mental or emotional disorders, regarding me or any applying family member. This information is collected for the purposes of evaluating my application and determining eligibility for benefits. This authorization will remain valid for 2 1/2 years from the date below. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization. I understand that coverage does not become effective until this and my application have been approved by CPIC *Life.*

PLEASE PROVIDE THE NAME AND ADDRESS OF YOUR ATTENDING PHYSICIAN OR ANY PHYSICIAN YOU HAVE SEEN IN THE LAST 12 MONTHS:
(If more than two names, attach a separate sheet)

APPLICANT NAME	PHYSICIAN	ADDRESS
APPLICANT NAME	PHYSICIAN	ADDRESS

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFICIARY INFORMATION:

BENEFICIARY	RELATIONSHIP TO APPLICANT	DATE OF BIRTH	SOCIAL SECURITY NO.
STREET ADDRESS	CITY	STATE	ZIP

APPLICANT'S SIGNATURE*

X ______________________ DATE __________ CITY ______________ STATE CA ______

*NOTE: SIGNATURE MUST BE THAT OF THE APPLICANT ONLY AND MUST BE SIGNED IN CALIFORNIA.

X ____

SPOUSE'S SIGNATURE (IF SPOUSE IS APPLYING FOR COVERAGE)

PARENTAL OR GUARDIAN CONSENT (TO BE COMPLETED IF APPLICANT IS 15 DAYS OF AGE OR OLDER BUT UNDER 18 YEARS OLD).

THIS WILL SERVE TO NOTIFY YOU THAT MY CHILD (PLEASE PRINT NAME OF CHILD) ______________________
WHO IS 15 DAYS OF AGE OR OLDER BUT UNDER 18 YEARS OF AGE IS APPLYING FOR CPIC *LIFE* SHORT-TERM HEALTH INSURANCE, WITH MY FULL KNOWLEDGE AND CONSENT, AND I REQUEST THAT YOU CONSIDER MY CHILD FOR SUCH COVERAGE.

SIGNATURE ______________________ PRINT NAME ______________________

SOCIAL SECURITY NO. ______________________ RELATIONSHIP ______________ DATE ______________

PLEASE COMPLETE THIS FORM IN FULL.
MAIL OR FAX TO CPIC *LIFE*.

Did you remember to include:

- ❑ 1. Applicant's signature (and spouse's, if applicable)?
- ❑ 2. The premium?
  - Check premium by using the rate table.
  - Be sure correct rates for region and age are used.
- ❑ 3. Applicant's Social Security Number? If not available, please explain.

  ____

  ____
- ❑ 4. Applicant's birthdate?
- ❑ 5. Dependents' birthdates?
- ❑ 6. Answers to eligibility questions?
- ❑ 7. AD&D beneficiary information? (Only available for primary applicant, 18 years of age or over.)
- ❑ 8. Information about previous health insurance carrier(s), if available?

AGENT INFORMATION

Agent's CPIC *Life* Producer Number or Tax ID Number	Date
Agent's Name (Printed)	
Agency Name & Complete Address ❑ (Please check if new address)	
Agent's Phone Number	
Agent's Fax Number	
Agent's Email	
Agent's Signature	