



*Temporarily Uninsured?
Here's a Temporary Solution...*

TempPlan



IF YOU ARE

- A recent graduate without coverage
- Between jobs or laid off
- Working a part-time or seasonal job
- A new employee temporarily without coverage
- A student in need of coverage for the summer
- Recently retired and not yet eligible for Medicare

LOOK INTO TEMP PLAN

TempPlan is a short-term major medical policy, providing up to \$1,000,000 of benefits per person.

TempPlan offers temporary protection against catastrophic events — severe and unexpected accidents, illnesses and disease — which could seriously affect your savings and financial resources.

With TempPlan, you can easily fit a plan to your needs. Simply choose:

1. **How long you want to be covered (policy term);**
2. **Your deductible (the amount you pay before benefits begin); and**
3. **Your coinsurance (the amount of expenses you want to share).**

TempPlan is also a single premium policy — you pay the premium only once for the entire term of the policy.



www.bluecrosswisconsin.com

HOW TEMP PLAN WORKS:

Choose How Long You Want Coverage:

- 30 days to 180 days

Choose Who Will Be Covered:

- Individual male (M)
- Individual female (F)
- Husband & wife without children (H&W)
- Family (M, F, or H&W and children)

Choose Your Deductible:

- \$100
- \$250
- \$500
- \$1,000

H&W must satisfy 2 deductibles.

Family must satisfy a maximum of 3 deductibles.

You Pay The Deductible

if you need medical care.

Then, TempPlan Pays 80%

- 80% of the next \$4,000 of covered services per person or \$8,000 per family;

OR

- 80% of the next \$10,000 of covered services per person or \$20,000 per family;

You Pay 20%

Then, TempPlan Pays 100%

of covered charges up to the maximum of \$1,000,000 per person lifetime maximum.

HOW TO APPLY

- Complete and sign an application and Authorization Form. The Authorization Form must be completed by all applicants over age 18, including dependent children. Parents or legal guardians must complete the Authorization Form for children under age 18.
- Calculate your premium, as explained in this brochure.
- Enclose a check made out to Blue Cross Blue Shield of Wisconsin, or include your charge card information.
- Mail the application and payment in the envelope provided, or send to:

Blue Cross Blue Shield of Wisconsin
P.O. Box 3047
Milwaukee, WI 53201

- Your policy and identification card will be sent to you.

ELIGIBILITY

You are eligible for TempPlan if you are a permanent resident of the United States, living in Wisconsin for the policy term and between the ages of 18 and 65, provided that TempPlan does not overlap Medicare. You are not eligible: (1) if you are a foreign citizen; (2) if you work in a job we consider hazardous or of poor risk; (3) if you have been turned down for an individually underwritten policy because of a health condition(s); (4) if you are covered by Medicare; or (5) if any member of your family is now pregnant or an expectant parent (application may be made after the pregnancy).

EFFECTIVE DATE

Your coverage effective date is the later of: (1) the date you request on your application; or (2) the day after the postmark date; if your payment is received and your correctly completed application is approved.

POLICY TERM & TERMINATION

*This policy is issued for the number of days you select: from 30 days up to 180 days. We may terminate this policy only if you have furnished fraudulent information, if you misuse your identification card, or if you begin employment at an occupation we consider hazardous or of poor risk. If we terminate this policy, we will give you 10 days written notice; **we will not refund any part of your premium.***

This policy may not be renewed, but you may apply for one additional policy. The second policy will not be a continuation of the first policy: any condition which may have been covered by the first policy will be considered a pre-existing condition and will not be covered by the second policy.

COVERED SERVICES

TempPlan pays usual, customary and reasonable charges for a wide variety of medically necessary care and services, subject to the terms of the policy. TempPlan is primarily intended as temporary protection against major medical expenses. Major benefits are listed below*:

- Inpatient hospital care, semi-private room;
- Inpatient hospital intensive or coronary care units;
- Inpatient hospital services and supplies (medications, tests, etc.);
- Surgery and anesthesia;
- Diagnostic x-rays and lab tests (not dental x-rays);
- Hospital outpatient services;
- Outpatient surgery;
- Emergency care by a physician for accidental injury;
- Physician's services for immediate treatment of medical emergency;
- Private duty nursing care by RN when recommended by your doctor;
- Complications arising from pregnancy;
- \$30,000 kidney disease care;
- 40 home care visits;
- Doctors' and chiropractors' services;
- Home & office calls (except for routine physical exams);
- 30 days skilled nursing facility care;
- External prosthesis and orthotic appliances, such as artificial limbs, eyes and braces;
- Purchase or rental (at our option) of durable medical equipment (e.g. crutches, walkers);
- Prescription drugs;
- Local ambulance service.

* Please read your policy for a complete listing of covered and excluded services.

HOW TO DETERMINE YOUR RATE

(See rate chart on page 7)

First, find your coinsurance level and deductible, then;

FIRST 30 DAYS

1. 30-day rate for adults (M, F, or H&W). _____
2. 30-day rate for child(ren) _____
3. ADD LINES 1 AND 2 _____

ADDITIONAL DAYS *(skip to line 10 if not applicable)*

4. Enter daily rate for adults (M, F, or H&W). _____
5. Enter daily rate for child(ren). _____
6. ADD LINES 4 AND 5 _____
7. MULTIPLY LINE 6 times additional number of days. X _____ = _____
8. ADD LINES 3 AND 7 _____
9. Multiply line 8 by Area Factor
(Skip this step if you live in Milwaukee, Ozaukee, Washington, Waukesha, Racine or Kenosha Counties). X _____ .9
10. TOTAL PREMIUM = _____

EXAMPLE

For a:

• Single male • Age 22 • Dane County

That wants this plan:

- 65 days of coverage
- Coinsurance of 80/20% to \$4,000
- \$250 deductible

Rate for First 30 Days of Coverage . . . = \$57.21

Rate for 35 Additional Days of Coverage = \$50.05

SUBTOTAL
(add 30 day rate and additional days rate) \$107.26

Multiply subtotal by area factor X _____ .9

The result is the TOTAL PREMIUM . . . = \$96.53

RATES

Your premium depends upon your age, the type of contract you want, the number of days you want, the deductible or coinsurance you select, and the area in which you live. You calculate your premium based on these factors, using the rate charts. Full payment is required with your application.

REFUNDS

Once you have been accepted into TempPlan, your premium will not be refunded for any reason.

PRE-EXISTING CONDITIONS

Benefits are not paid for care related to a condition which manifested itself before your TempPlan coverage started, whether or not you saw a doctor about the condition.

LIMITATIONS

If you have other health or dental insurance, this policy will not duplicate benefits payable by that policy. In that case, TempPlan will pay the lesser of: (1) the part of any charge which is more than the policy's benefits; or (2) the benefit TempPlan would pay if you had no other coverage.

EXCLUSIONS

Services not covered include*:

- pre-existing conditions;
- services that are not medically necessary or which are experimental/investigational;
- organ transplants, except for kidney transplants;
- care for temporomandibular (TMJ) dysfunction/disease, except as stated by the policy;
- pregnancy and childbirth (related complications are covered);
- in-vitro fertilization;
- artificial insemination;
- contraceptives;
- treatment or removal of tonsils or adenoids;
- care for alcohol or drug dependency, or for nervous and mental disorders;
- custodial care;
- care due you under any regulation, including workers' compensation and employer liability laws;
- care received outside the U.S.;
- care due to war or service in any armed force;
- therapy services including physical, occupational and speech;
- care from other than a physician, unless stated.

* Please read your policy for a complete listing of covered and excluded services.

EXTENSION OF BENEFITS

If you are hospitalized for a covered condition when this policy ends, you may be eligible for an extension of benefits. This extension applies only to the condition for which you are hospitalized. Benefits are extended until the earlier of: (1) the date you reach any applicable benefit maximum; (2) the date following your discharge from the hospital; or (3) the date you reach the maximum length of your benefit extension.

DEPENDENTS

Under a Family Plan, TempPlan also protects your legal spouse and your dependent children until the earlier of: (1) the end of the month in which they marry; or (2) the end of the calendar year in which they reach age 19 (age 25 if a full-time student).

WISCONSIN TEMPPLAN APPLICATION

OFFICE	BASE GROUP #	_____
USE	GROUP SECTION	_____
ONLY	PACKAGE CODE	_____

A

SELECT YOUR PLAN

TERM (DAYS)	DEDUCTIBLE AMOUNT	REQUESTED EFFECTIVE DATE	PREMIUM CALCULATION
(30 – 180 days)	<input type="checkbox"/> \$100 <input type="checkbox"/> \$500 <input type="checkbox"/> \$250 <input type="checkbox"/> \$1,000	_____ / _____ / _____ <input type="checkbox"/> New Applicant <input type="checkbox"/> Re-enrollment	FIRST 30 DAYS: FIRST, FIND YOUR COINSURANCE LEVEL AND DEDUCTIBLE THEN: 1. 30 day rate for adults (M, F, or H&W*) _____ 2. 30 day rate for child(ren) + _____ 3. SUBTOTAL (lines 1 & 2) subtotal = <input type="text"/>
COINSURANCE AMOUNT	<input type="checkbox"/> 80%/20% \$4,000 (Ind)/\$8,000 (Fam) <input type="checkbox"/> 80%/20% \$10,000 (Ind)/\$20,000 (Fam)		ADDITIONAL DAYS 4. Enter daily rate for adults (M, F, or H&W*) _____ 5. Enter daily rate for child(ren) + _____ 6. SUBTOTAL (lines 4 & 5) subtotal = _____ 7. MULTIPLY LINE 6 times additional number of days x _____ = <input type="text"/>
TYPE OF MEMBERSHIP WANTED (Check one)	<input type="checkbox"/> Applicant Only <input type="checkbox"/> Applicant & Spouse* <input type="checkbox"/> Applicant & _____ Child(ren) <input type="checkbox"/> Applicant, Spouse & _____ Child(ren)*		8. SUBTOTAL (lines 6 & 7) subtotal = _____ 9. ADD LINES 3 AND 8 _____ 10. Multiply Line 9 by Area Factor (Skip this step if you live in Milwaukee, Ozaukee, Washington, Waukesha, Racine or Kenosha Counties) x _____ .9 11. TOTAL PREMIUM = _____
PAYMENT METHOD	<input type="checkbox"/> Check <input type="checkbox"/> VISA <input type="checkbox"/> Master Card <input type="checkbox"/> Discover NOTE: Payment or Credit Card information must accompany your application. Credit Card Account No: _____ Credit Card Expiration Date _____ / _____ / _____ (Month/Day/Year) Premium Amount Enclosed: \$ _____	<div style="border: 1px solid black; padding: 2px; width: fit-content;"> OFFICE USE ONLY Authorization Number _____ </div>	*For husband & wife contract, use the older individual as the applicant. *For husband & wife contract, use the older individual as the applicant.

B

TELL US ABOUT YOURSELF (PLEASE PRINT)

Applicant's Last Name	First Name	M.I.	Sex	Date of Birth Mo./Day/Year	Soc. Security No.
				_____ / _____ / _____	_____ - _____ - _____
Street Address, City, State, Zip Code				Telephone Nos. Daytime () _____ - _____ Evening () _____ - _____	Best Time to Call: _____ a.m. _____ p.m.

C

TELL US ABOUT FAMILY MEMBERS APPLYING FOR COVERAGE

	Last Name (If Different Than Applicant's)	First Name	M.I.	Sex	Date of Birth Mo./Day/Year	Soc. Security No.
Spouse						
Dependents						Student? Check Yes or No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

D

PLEASE ANSWER THESE ELIGIBILITY QUESTIONS

IF YOU ANSWER YES TO ANY OF THE FOLLOWING QUESTIONS, THE POLICY CANNOT BE ISSUED.

- Are you or anyone else who will be insured by this policy covered by any or all of the following: hospital, major medical, group health or medical insurance coverage that will not terminate prior to the effective date of this coverage? Yes No
- Are you, your spouse, or any dependent now pregnant or expect to be a parent in the next nine months? (even if not applying for coverage) Yes No
- Have you or anyone else who will be insured by this policy been turned down for insurance due to health reasons? Yes No
- Have you or anyone else who will be insured by this policy been a resident and citizen of the United States for less than one year? Yes No
- Do you or anyone else who will be insured by this policy plan to reside outside of Wisconsin for the duration of coverage? Yes No
- Do you or anyone else who will be insured by this policy engage in any of these activities: farming, racing a motor vehicle, boat or snowmobile; sky diving; hang gliding; mountain climbing; stunt flying; crop dusting or flying ultralight aircraft? Yes No

I understand that benefits are not payable for any pre-existing condition.

TempPlan is an individual policy.

I have read this page and the preceding answers and statements and declare that they are true and complete to the best of my knowledge and belief. I understand and agree that no agent has the authority to waive any questions or to determine insurability. I believe that the TempPlan benefits are suited to my needs.

I understand and agree that the policy will not take effect unless and until this application is approved and Blue Cross Blue Shield of Wisconsin notifies me of my effective date. Any premium payment made will be returned to me should this application be declined.

1. Any of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if any information is false or incomplete and that Blue Cross Blue Shield of Wisconsin may revoke coverage if it discovers that any information on this application is incomplete or false.
2. The Applicant and/or Co-Applicant or Parent/Guardian on behalf of himself/herself and the dependents, if any, named herein, shall provide the Insurer with information needed to process this Application form. This may include signing an authorization form for the release of personal health information by a hospital, doctor or other health care provider to the Insurer or its legal representative.
3. The Applicant and/or Co-Applicant or Parent/Guardian acknowledges receiving the Fair Credit Reporting Act Notice and authorizes the Insurer to obtain an investigative or other consumer report as described on the Fair Credit Notice.
4. The Application, when approved, and any endorsement, amendment or rider hereto will be made part of the contract applied for. The Applicant or Parent/Guardian has the right to receive a copy of their authorization for release of medical information.
5. I understand that Blue Cross Blue Shield of Wisconsin may use any information prior to the effective date of coverage in considering my application, including medical conditions that occur after the signature and before the original effective date.

FAIR CREDIT REPORTING ACT NOTICE

As part of the Insurer's regular underwriting procedures, an investigative or other consumer report may be obtained through personal interviews with the Applicant's neighbors, friends or other persons with whom the Applicant is acquainted. This inquiry will include information as to the Applicant's character, general reputation, personal characteristics and modes of living. As part of his/her application for insurance, the Applicant or Custodial Parent/Guardian has authorized the Insurer or its legal representatives to obtain such a report, as he/she understands that he/she has the right to make written request within a reasonable period of time to the Insurer's Underwriting Department to receive additional detailed information about the nature and scope of this investigation. The Applicant or Custodial Parent/Guardian also understands that, upon written request, he/she will be informed whether such a report has actually been ordered, and if it has, the Applicant will be furnished the name and address of the consumer reporting agency to whom the request was made. The Applicant or Custodial Parent/Guardian may contact this consumer reporting agency and request a copy of any such report.

FOR APPLICANTS AGES 18 OR OLDER:

X	X	
SIGNATURE OF APPLICANT	SIGNATURE OF CO-APPLICANT	DATE

AGENT'S NAME: _____ AGENT'S NUMBER _____

WISCONSIN TEMPPLAN RATE TABLE

(See "How to Determine Your Rate" on page 4.)

Rates effective January 1, 2006

80/20 to \$4,000	\$100 Deductible		\$250 Deductible		\$500 Deductible		\$1,000 Deductible	
	30 Day Rate	Additional Daily Rate	30 Day Rate	Additional Daily Rate	30 Day Rate	Additional Daily Rate	30 Day Rate	Additional Daily Rate
M 18 - 24	\$90.46	\$2.26	\$72.37	\$1.81	\$57.90	\$1.45	\$43.42	\$1.09
M 25 - 29	90.46	2.26	72.37	1.81	57.90	1.45	43.42	1.09
M 30 - 34	95.04	2.26	76.03	1.81	60.82	1.45	45.62	1.09
M 35 - 39	118.80	3.10	95.04	2.48	76.03	1.98	57.02	1.49
M 40 - 44	146.23	3.93	116.98	3.14	93.58	2.51	70.19	1.88
M 45 - 49	180.94	5.05	144.75	4.04	115.80	3.23	86.85	2.42
M 50 - 54	228.48	7.13	182.78	5.70	146.22	4.56	109.67	3.42
M 55 - 59	296.99	8.69	237.59	6.95	190.07	5.56	142.55	4.17
M 60 - 64	412.60	10.24	330.08	8.19	264.06	6.55	198.05	4.91
F 18 - 24	103.28	2.65	82.62	2.12	66.10	1.70	49.57	1.27
F 25 - 29	108.76	2.65	87.01	2.12	69.61	1.70	52.21	1.27
F 30 - 34	123.36	2.90	98.69	2.32	78.95	1.86	59.21	1.39
F 35 - 39	148.04	3.56	118.43	2.85	94.74	2.28	71.06	1.71
F 40 - 44	173.63	4.24	138.90	3.39	111.12	2.71	83.34	2.03
F 45 - 49	199.24	5.10	159.39	4.08	127.51	3.26	95.63	2.45
F 50 - 54	231.15	7.25	184.92	5.80	147.94	4.64	110.95	3.48
F 55 - 59	258.53	8.43	206.82	6.74	165.46	5.39	124.09	4.04
F 60 - 64	284.98	9.50	227.98	7.60	182.38	6.08	136.79	4.56
H&W 18 - 24	193.75	4.89	155.00	3.91	124.00	3.13	93.00	2.35
H&W 25 - 29	199.24	4.89	159.39	3.91	127.51	3.13	95.63	2.35
H&W 30 - 34	218.40	5.18	174.72	4.14	139.78	3.31	104.83	2.48
H&W 35 - 39	266.84	6.65	213.47	5.32	170.78	4.26	128.08	3.19
H&W 40 - 44	319.85	8.15	255.88	6.52	204.70	5.22	153.53	3.91
H&W 45 - 49	380.18	10.15	304.14	8.12	243.31	6.50	182.48	4.87
H&W 50 - 54	459.61	14.38	367.69	11.50	294.15	9.20	220.61	6.90
H&W 55 - 59	555.51	17.11	444.41	13.69	355.53	10.95	266.65	8.21
H&W 60 - 64	697.59	19.74	558.07	15.79	446.46	12.63	334.84	9.47
1 Child	54.71	1.80	43.77	1.44	35.02	1.15	26.26	0.86
2 Children	107.31	3.54	85.85	2.83	68.68	2.26	51.51	1.70
3 Children	155.70	5.06	124.56	4.05	99.65	3.24	74.74	2.43

80/20 to \$10,000	\$100 Deductible		\$250 Deductible		\$500 Deductible		\$1,000 Deductible	
	30 Day Rate	Additional Daily Rate	30 Day Rate	Additional Daily Rate	30 Day Rate	Additional Daily Rate	30 Day Rate	Additional Daily Rate
M 18 - 24	\$85.94	\$2.15	\$68.75	\$1.72	\$55.00	\$1.38	\$41.25	\$1.03
M 25 - 29	85.94	2.15	68.75	1.72	55.00	1.38	41.25	1.03
M 30 - 34	90.29	2.15	72.23	1.72	57.78	1.38	43.34	1.03
M 35 - 39	112.86	2.95	90.29	2.36	72.23	1.88	54.17	1.41
M 40 - 44	138.91	3.73	111.13	2.98	88.90	2.39	66.68	1.79
M 45 - 49	171.89	4.80	137.51	3.84	110.01	3.07	82.51	2.30
M 50 - 54	217.05	6.77	173.64	5.42	138.91	4.33	104.18	3.25
M 55 - 59	282.14	8.25	225.71	6.60	180.57	5.28	135.43	3.96
M 60 - 64	391.97	9.73	313.58	7.78	250.86	6.22	188.15	4.67
F 18 - 24	98.11	2.52	78.49	2.01	62.79	1.61	47.09	1.21
F 25 - 29	103.32	2.52	82.66	2.01	66.13	1.61	49.60	1.21
F 30 - 34	117.19	2.76	93.76	2.20	75.00	1.76	56.25	1.32
F 35 - 39	140.64	3.38	112.51	2.71	90.01	2.17	67.51	1.62
F 40 - 44	164.94	4.03	131.96	3.22	105.56	2.58	79.17	1.93
F 45 - 49	189.28	4.85	151.42	3.88	121.14	3.10	90.85	2.33
F 50 - 54	219.59	6.89	175.67	5.51	140.54	4.41	105.40	3.31
F 55 - 59	245.60	8.00	196.48	6.40	157.18	5.12	117.89	3.84
F 60 - 64	270.73	9.03	216.58	7.22	173.26	5.78	129.95	4.33
H&W 18 - 24	184.06	4.64	147.25	3.71	117.80	2.97	88.35	2.23
H&W 25 - 29	189.28	4.64	151.42	3.71	121.14	2.97	90.85	2.23
H&W 30 - 34	207.48	4.92	165.98	3.93	132.79	3.15	99.59	2.36
H&W 35 - 39	253.50	6.32	202.80	5.05	162.24	4.04	121.68	3.03
H&W 40 - 44	303.86	7.74	243.09	6.19	194.47	4.96	145.85	3.72
H&W 45 - 49	361.17	9.64	288.93	7.71	231.15	6.17	173.36	4.63
H&W 50 - 54	436.63	13.66	349.31	10.93	279.44	8.74	209.58	6.56
H&W 55 - 59	527.74	16.26	422.19	13.01	337.75	10.40	253.31	7.80
H&W 60 - 64	662.71	18.75	530.17	15.00	424.13	12.00	318.10	9.00
1 Child	51.98	1.71	41.58	1.37	33.27	1.09	24.95	0.82
2 Children	101.95	3.36	81.56	2.69	65.25	2.15	48.93	1.61
3 Children	147.92	4.81	118.33	3.85	94.67	3.08	71.00	2.31

www.bluecrosswisconsin.com

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This form **must be signed by each adult person seeking coverage**, including all adult dependent children. Parents should sign for their minor children. If you need additional forms, please photocopy this form or download it by clicking "Literature & Forms" then "HIPAA Information and Forms" on our web site: www.bluecrosswisconsin.com.

Please note: Your application will not be processed without a signature for each person seeking coverage. We appreciate your cooperation in helping us protect the privacy rights provided you through federal privacy laws.

Purpose: This form is used for an individual's conditioned authorization to allow use and/or disclosure of protected health information for the individual's pre-enrollment underwriting or risk-rating or determination of the individual's eligibility for enrollment in or benefits under a health plan. This form may not be used to obtain authorization to use or disclose psychotherapy notes.

SECTION A: The individual authorizing the use or disclosure

Name (or parent name): _____

Child's name (if applicable): _____

Address: _____

Telephone: _____ Social Security Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Purpose of this Authorization: By signing this form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or risk-rating of health insurance coverage for you, or to determine your eligibility for enrollment or benefits under a health plan.

Effect of Declining this Authorization: This authorization is a condition of your enrollment in or eligibility for benefits under a health plan. If you decide not to sign this authorization, we will decline to enroll you in a health plan or to give you the benefits.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations that are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION B: The use and/or disclosure being authorized

Protected Health Information to Be Disclosed: The protected health information of which this authorization allows disclosure includes hospital records, physician records, lab results, and specifically includes mental health records (if any), and alcohol and/or drug abuse records (if any).

Entities Authorized to Disclose: We, as well as any hospital, medical provider, medical lab or mental health treatment provider, will be authorized to disclose the protected health information described above.

Entities Authorized to Receive and Use: Blue Cross Blue Shield of Wisconsin, including DentalBlue, or CompCare Health Services Insurance Corporation, are the organizations to which you give authorization to receive and use the protected health information described above.

SECTION C: Expiration and revocation

Expiration: This authorization will expire thirty (30) months from date signed.

Right to Revoke: You may revoke this authorization at any time by giving written notice of revocation to a Privacy Contact in our organization. You can only revoke your own authorization. If you are a parent with minor child(ren) applying for coverage, you can revoke authorization for your child(ren). Privacy Contact information is listed in our Privacy Practices Notice. Revocation of this authorization will not affect any action we took in reliance on this authorization before we received your written notice of revocation. Revocation of this authorization may also mean that we may disenroll you from our health plan or end your eligibility for benefits.

SECTION D: INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form. I understand that I may only revoke authorization for myself or my minor child(ren).

Adult Applicant Signature: _____ Date: _____

Adult Applicant Signature: _____ Date: _____

Adult Applicant Signature: _____ Date: _____

Signature of parent for child(ren): _____ Date: _____

If this authorization is signed by a personal representative on behalf of an individual, complete the following:

Personal Representative's Name: _____

- Relationship to Individual:
- Parent or legal representative of minor
 - Power of attorney
 - Legal representative of incompetent
 - Other (*please specify*): _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.



An independent licensee of the
Blue Cross and Blue Shield Association



An independent licensee of the
Blue Cross and Blue Shield Association



Blue Cross Blue Shield of Wisconsin
Compcare Health Services Insurance Corporation
Independent licensees of the Blue Cross and Blue Shield Association