

Applicant Information

(Please keep a copy of this application for your records)

Office Use Only	Group: 50006	
	Class:	Sub Group:

Applicant's Last Name	First Name	MI	Date of Birth	Social Security #	Requested Effective Date <small>Month / Day / Year</small>
Street Address		City	State	Zip Code	Home Phone #
<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Work Phone #	Cell Phone #
Applicant's Primary Physician's Name and Phone Number:					

Dependent Information (If you have additional dependents attach a separate sheet)

Full Name (Last, First, MI)	Relationship	DOB	Sex M/F	Social Security #	Primary Physician's Name and Phone Number	Benefit Selection: Deductible and Duration
						Contract Duration (check one) <input type="checkbox"/> 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days
						Deductible Amount (check one) <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000

Chemical Dependency Related Disorders (includes alcohol and drug disorders): I want to include at an additional cost, benefits for the diagnosis and treatment of chemical dependency related disorders including inpatient and outpatient services. I understand this election applies to all persons identified on this application. YES NO

Eligibility Questions:

	Yes	No
1. Have you or any family members included in this application been covered by short-term coverage by any health carrier within the past 555 days? If yes, how many days were you or your family members covered by short-term coverage? ____ days.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Will any person to be insured have other health insurance coverage in effect during the period for which coverage is requested?.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any person applying for coverage ever been declined for insurance by any health carrier?.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Does any person applying for coverage intend to reside outside of Minnesota for the duration of the coverage? ..	<input type="checkbox"/>	<input type="checkbox"/>
5. Is any person applying for coverage:		
a. now pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment? ...	<input type="checkbox"/>	<input type="checkbox"/>
b. currently confined to or in any health care facility?	<input type="checkbox"/>	<input type="checkbox"/>
c. less than 90 days of age or over 64 years 11 months of age at this time?.....	<input type="checkbox"/>	<input type="checkbox"/>
d. been a resident and citizen of the United States for less than two years?.....	<input type="checkbox"/>	<input type="checkbox"/>
e. seen a health care professional for any reason other than preventive care in the past 30 days?	<input type="checkbox"/>	<input type="checkbox"/>
6. Within the past 5 years, has any person applying for coverage ever had any diagnosis of, received treatment for, or consulted with a medical provider concerning any heart disorder, kidney disorder, liver disorder, lung disorder, AIDS or tested positive for HIV, stroke, cancer or tumor, diabetes, Crohn's disease, ulcerative colitis, alcoholism or abuse, or chemical dependency or abuse?	<input type="checkbox"/>	<input type="checkbox"/>

A contract cannot be issued if you answer "yes" to any question under questions 2 to 6.

Payment Information:

Step 1. Select a payment method (there is a \$20.00 non-refundable application fee):

- Check - total contract premium amount submitted with application. Check or money order made payable to PIC.
- ACH - total contract premium amount to be drafted upon approval, EPP must be completed. (complete step 2a)
- Credit Card - total contract premium amount to be debited upon approval. (complete step 2b)

Important reminder: There will be no refund of premium after the 10-day cancellation period described in the contract.

Step 2a. Authorize for payment via Electronic Payment Plan (EPP)

OR

Step 2b. Authorize for payment via Credit Card

Name on Bank Account:	Routing Number:	
Bank Account Number:	Bank Name:	Phone #:
City:	State:	Zip:

Name on Credit Card:
Credit Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard
Credit Card Number:
3 digit Card Verification #:
Expiration Month/Year:

I authorize PIC to initiate the withdrawal of the \$20.00 application fee and the total contract premium amount from my checking account, savings account or credit card account as indicated above.

PreferredOne Insurance Company or "PIC" complies with Minnesota Insurance Fair Information Reporting Act which requires notification to you that during the health underwriting process personal information about you may be collected from persons other than you. Information collected by PIC or the insurance broker may be disclosed for health underwriting purposes to third parties without your authorization, but only if permitted by applicable state and federal privacy laws. The applicant has a right to see personal information collected about the applicant in the health underwriting process, and there is a procedure for the applicant to correct inaccurate personal information collected. For information about these rights, contact PIC individual sales customer service area. On behalf of myself and family applicants, I/we authorize any physician, medical practitioner, hospital, clinic, veterans' administration facility, other medical facility, PIC and any entity affiliated with PIC, including but not limited to PreferredOne Community Health Plan and PreferredOne Administrative Services, Inc. (PAS), who has treated or has claim history (excluding claim history PAS obtained acting as a preferred provider organization (PPO)) or has medical information about me or my family applicants, to release to PIC information as to diagnosis, treatment, and prognosis with respect to any physical or mental conditions of me or my family applicants for insurance underwriting and plan administration purposes. On behalf of myself and family, I/we agree to authorize, execute and submit all authorizations and releases required by a physician, medical practitioner, hospital, clinic, veterans' administration facility, or other medical facility who has treated, has claim history or has medical information about me or my family to release to PIC information as to diagnosis, treatment and prognosis with respect to any physical or mental conditions of myself or my family for insurance underwriting purposes and/or plan administration purposes. These authorizations exclude release of HIV (AIDS virus) tests administered to: 1) a criminal offender or crime victim as a result of a crime reported to the police; 2) a patient who received services of emergency medical personnel at a hospital or medical facility; or 3) emergency medical personnel tested as a result of performing emergency medical services. This authorization excludes psychotherapy notes. This authorization remains valid while I am/we are continually covered by the medical plan I am/we are enrolling in with this form. Information released by this authorization is released to an entity subject to Health Insurance Portability and Accountability Act (HIPAA). This authorization may be revoked by submitting a written revocation to PreferredOne Customer Service. Such revocation will not effect actions taken prior to the revocation. Because this authorization is for underwriting, risk rating, and enrollment purposes, revocation of or failure to give this authorization may result in denial or termination of coverage.

To the best of my/our knowledge and belief, on behalf of myself and my family applicants, I/we represent that the answers to the questions and statements on this form are true and complete. I/we understand that coverage is only provided for the number of days as selected on the front of this application. I agree to notify PIC of any change and understand that I must update this form and resubmit it if anything changes to my or my family applicants health that affects the information on this form between submission of the form and effective date of coverage. **I/we understand and agree that PIC will act in reliance upon the information I/we have provided herein. I/we understand that providing false information or omission of relevant information on this form which materially affects the acceptance of risk or hazard assumed by PIC may result in denial of claims, retroactive cancellation of coverage, or an increase in premiums, and may be considered insurance fraud.**

I/we understand that, subject to the terms and conditions of the contract under which I am/we are enrolling for coverage, I/we are subject to a pre-existing condition exclusion that excludes coverage during the entire term of the contract for any condition for which you or your eligible dependent have: 1) had medical treatment, diagnosis of, or consultation at anytime prior to the effective date of this contract; or 2) had signs, symptoms or any manifestations of an injury, sickness, or condition at anytime prior to the effective date of this contract which should have caused an ordinary prudent person to seek diagnosis or treatment.

If it is determined during the first two years after your effective date of your coverage that: 1) relevant information was omitted or misstated (except for age) on this form, the omission or misstatement of information may result in denial of claims, cancellation of coverage or an increase in premiums; or 2) you misstated your age or the age of an enrolled dependent and if the right age had been provided, the individual would not have been eligible for coverage, then PIC will refund all premiums paid for that individual from their effective date of coverage within 90 days of the date of discovery of the misstatement and in all other cases PIC will adjust premium. PIC will seek reimbursement for claims paid from the individual's effective date of coverage. **I/we agree that a copy of this authorization shall be as valid as the original.**

Signatures:

Applicant's Signature _____ Date _____ Print Full Name _____

Spouse's Signature _____ Date _____ Print Full Name _____

Dependent Signature _____ Date _____ Print Full Name _____
(If over 18 years of age and applying)

Dependent Signature _____ Date _____ Print Full Name _____
(If over 18 years of age and applying)

Agent's Signature _____ Date _____ Print Full Name _____