

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – Pricing is based on a per day rate. Be sure to remit your check for the entire premium with your application. You may also choose to pay by credit card. See attached for the per day rate.

Step 3

PLEASE CONTACT OUR OFFICE FOR DELIVERY OPTIONS OR MAIL THE COMPLETED APPLICATION TO THE FOLLOWING ADDRESS:

**ASSURANT HEALTH
P.O. BOX 3088
MILWAUKEE, WI 53201**

Please make your check payable to: Assurant Health

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...



ASSURANT
Health



UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

A. APPLICANT INFORMATION

Name (Last) _____ (First) _____ (MI) _____

Marital Status Legally Married Single Divorced Widowed Domestic Partner

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Street Address _____ Apt. _____ City _____ State _____ Zip _____

Home (or other) Phone (_____) _____ Business Phone (_____) _____

Driver's License Number: _____ Email Address: _____

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? Yes No If yes, % of time _____

Please check one of the following boxes: New Application Dependent Addition Re-apply

B. APPLICANT AND DEPENDENT INFORMATION (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under coverage.

	Social Security # (for internal use only)	Name (Last, First, MI)	Date of Birth	Age	M/F	Weight	Height
Self						lbs.	
Spouse						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. (Financial dependency is not required for court-ordered dependent coverage.) Any dependent not listed will not be considered for coverage.

C. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage was in effect within the past 24 months, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the carrier can determine whose coverage is primary.

Enrolling Individual's Name (Non-Medicare)	Insurance Carrier (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check all that apply) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
		From	To		
Self				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

If you were previously insured on a group plan, have you exhausted your COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

Have you ever been or are you currently insured through HIPUtah? Yes No If "Yes" Date Started _____ Date Ended _____

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

D. EMPLOYMENT INFORMATION

Employer _____ Group Insurer _____ Job Title _____ Hrs/Week _____

Spouse's Employer _____ Spouse's Group Insurer _____ Spouse's Job Title _____ Hrs/Week _____

1. Is any employer reimbursing or paying for any portion of this coverage? Yes No

2. Are you self-employed? Yes No If self employed, do you have any full or part-time employees? Yes No

E. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS G. & H. ON THE FOLLOWING PAGE.

The federal Genetic Information Nondiscrimination Act prohibits health issuers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

Respond to the following questions:			YES	NO	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):			YES	NO
1	Pregnancy/Adoption: Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?				21	Female Reproductive Conditions/Disorders: Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease or any other disorder of the reproductive system?			
2	Pregnancy/Fertility Related Treatment: Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy (including premature births)?				22	Digestive Conditions/Disorders: Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?			
3	Last Menstrual Period: Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.				23	Nervous, Mental and Behavioral: Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?			
Within the past 12 MONTHS has any applicant:			YES	NO	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:			YES	NO
4	Prescriptions/Medications/Immunizations: Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?				24	Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?			
5	Conditions Requiring Follow Up Medical Consult/Treatment: Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?				25	Musculoskeletal Conditions/Disorders: Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis or other musculoskeletal disorder?			
6	Medical Consult/Treatment: Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?				26	Digestive Conditions/Disorders: Crohn's disease. Colitis, colostomy, or ileostomy or other digestive disorder?			
7	Conditions Requiring Initial Medical Consult/Treatment: Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has <u>not</u> been sought ?				27	Alcohol or Drug Use/Abuse: been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?			
Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:			YES	NO	28	Eating Disorders/Obesity Treatment: including bulimia, anorexia, or obesity and any surgical services for obesity.			
8	Urinary, bladder, incontinence, kidney or liver conditions or disorders? Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?				29	Respiratory Conditions/Disorders: RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, emphysema?			
9	Neurological Disorders: Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions or other neurological disorder?				30	Tobacco use (chewing or smoking)? Quit Date: _____			
10	Metabolic and Endocrine Conditions/Disorders: Lupus, thyroid disorder, goiter, or any other lymph system disorder?				Has any applicant EVER been diagnosed with or treated for any of the following:			YES	NO
11	Eyes, ears, nose, sinus, or throat conditions/disorders or any other respiratory system disorder including allergies or hay fever?				31	Birth Defects/Congenital Abnormalities: premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?			
12	Skin Conditions/Disorders: Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?				32	Nervous, Mental and Behavioral: Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?			
13	Breast Conditions/Disorders: Breast lumps, breast augmentation, or breast reduction?				33	Transplant or Implanted Device: Any organ or tissue transplant, pacemaker or other implanted device?			
14	Heart Conditions/Disorders: Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?				34	Immune System Conditions/Disorders: Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?			
15	Back, neck, bone, joint or spinal disorder: bone or joint disorders (including foot, knee, jaw, fracture, dislocation or joint replacement)?				35	Brain/Nervous System Conditions/Disorders: Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?			
16	Blood Conditions/Disorders: Hemophilia, anemia, blood or bleeding disorder?				36	Diabetes (type I or II), insulin resistance?			
17	Male Reproductive Conditions/Disorders: Impotence, prostate or testicular disorder, or abnormal PSA or other reproductive disorder?				37	Heart and Circulatory Conditions/Disorders: Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, or coronary artery disease, or congestive heart failure?			
18	Circulatory System Conditions/Disorders: Varicose veins, or any other circulatory disorder?				38	Cancer/Tumors: (including skin cancer or melanoma) or tumors?			
19	Hospitalization/Surgery: Have you, your spouse or any dependent family member been hospitalized or had surgery?				39	Urinary/Liver Conditions/Disorders: Cirrhosis, hepatitis, or renal failure?			
20	Sexually transmitted diseases?				OTHER MEDICAL INFORMATION			YES	NO
					40	Any medical condition or treatment that you are unsure of where it fits in above? _____			

I. ACKNOWLEDGMENT & SIGNATURE

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, carrier and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved; that no benefits will be provided for any services which begin before the coverage is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT. I understand that no producer or carrier representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the carrier changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of health care providers whose services will be covered may be restricted by the policy, and I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied. I understand the coverage for which I am applying may limit or exclude certain conditions, regardless of whether or not they are pre-existing. I also understand that the coverage may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the date I apply for coverage, according to the pre-existing conditions limitation provisions of the policy.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE. According to information furnished, you may intend to lapse or otherwise terminate existing accident and health insurance and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the carrier to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on pages three and four of this application, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. **If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to the carrier.**

I understand there may not be participating providers in all specialty fields.

I understand that credit for prior coverage will be based upon the information contained in this application. If any information provided is false, the insurer may without advance notice declare the contract null and void and cancel the coverage retroactive to its original effective date or impose the pre-existing condition waiting period and deny claims that are pre-existing.

I further certify that all information completed on this form is true, correct and complete and acknowledge my coverage is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

Any matter in dispute between myself and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both myself and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed the Authorization to Disclose Protected Health Information form that accompanies this application.

Applicant Signature _____ Date _____

Spouse's Signature _____ Date _____
(Required if applying for coverage)

Requested Effective Date _____

Coverage is not in force until the carrier approves your application and determines the effective date.

J. PRODUCER AGREEMENT AND COMPENSATION DISCLOSURE (If applicable)

I understand and agree that in acting as the producer for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah that authorizes me to sell and service health insurance contracts;
3. I have no authority to: a) make, alter, interpret, or discharge an application or contract in the name of a carrier; or b) waive any of the terms or conditions of the policy.
4. I have no authority to assign effective dates or to effect member changes.

Producer Name _____ Agency _____ Phone (____) _____

Producer Signature _____ Date Signed _____

Producer Compensation Disclosure:

I have received written disclosure that the producer will receive compensation from the insurer or a third party administrator for the placement of insurance, including the amount or type of compensation.

Applicant Signature _____ Date _____

