

**COX HEALTH SYSTEMS INSURANCE COMPANY  
INDIVIDUAL APPLICATION FOR HEALTH INSURANCE**

**SECTION I: REASON FOR APPLICATION**

New Applicant       Add a Dependent       Dependent to Policyholder       Lower Deductible

**SECTION II: COVERAGE OPTIONS**

**A** In the last 12 months, has anyone applying for coverage smoked cigarettes, pipes, cigars, or used any form of tobacco?       YES       NO

**B** REQUESTED EFFECTIVE DATE:

<b>C</b>	PLAN: Check one.	COINSURANCE	OOP Max	Office Visit - Select one	Deductible - Select one		
	<input type="checkbox"/> Traditional:	90/60	\$2500/\$5000	<input type="checkbox"/> \$30 COPAY <input type="checkbox"/> COINSURANCE	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000		
	<input type="checkbox"/> ValueFirst:	80/50	\$3000/\$6000	<input type="checkbox"/> \$30 COPAY <input type="checkbox"/> COINSURANCE	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000 <input type="checkbox"/> \$10000		
<input type="checkbox"/> Other:							

**D** OPTIONAL RIDERS: By selecting any of these riders, you are agreeing to adjusted premiums as applicable.

SPEECH AND HEARING RIDER       MATERNITY WAIVER RIDER - Removes all maternity benefits  
 KIDS FIRST PLAN - Minor Dependent Only       PHASE II CANCER RIDER - Provides limited coverage for  
Rider. Please print name of parent/legal      Phase II Cancer Trials.

PARENT/LEGAL GUARDIAN:

**SECTION III: APPLICANT INFORMATION** Please print in ink.

**A** LEGAL NAME (Last, First, MI)

SOCIAL SECURITY #:	BIRTHDATE:	AGE	GENDER: M F	HEIGHT:	WEIGHT:
RESIDENTIAL ADDRESS:		CITY:	STATE:	ZIP:	
MAILING ADDRESS (If different from above):		CITY:	STATE:	ZIP:	
HOME PHONE:	WORK PHONE:	CELL PHONE:	FAX:	EMAIL:	

**B** MARITAL STATUS:       SINGLE       MARRIED       DIVORCED       WIDOWED

**C** OCCUPATION: Please print

EMPLOYER NAME:

YEARLY HOUSEHOLD INCOME: \$

Do you and your spouse read, write, speak and understand the English language?       YES       NO

**SECTION IV: DEPENDENT INFORMATION - Please print. If your dependent(s) is 19 years of age or older and handicapped or is a full time student in an accredited institution, please provide documentation of this status.**

Dep 1	LEGAL NAME (Last, First, MI)	RELATIONSHIP				
	SOCIAL SECURITY #:	BIRTHDATE:	AGE	GENDER: M F	HEIGHT:	WEIGHT:
Dep 2	LEGAL NAME (Last, First, MI)	RELATIONSHIP				
	SOCIAL SECURITY #:	BIRTHDATE:	AGE	GENDER: M F	HEIGHT:	WEIGHT:
Dep 3	LEGAL NAME (Last, First, MI)	RELATIONSHIP				
	SOCIAL SECURITY #:	BIRTHDATE:	AGE	GENDER: M F	HEIGHT:	WEIGHT:
Dep 4	LEGAL NAME (Last, First, MI)	RELATIONSHIP				
	SOCIAL SECURITY #:	BIRTHDATE:	AGE	GENDER: M F	HEIGHT:	WEIGHT:
Dep 5	LEGAL NAME (Last, First, MI)	RELATIONSHIP				
	SOCIAL SECURITY #:	BIRTHDATE:	AGE	GENDER: M F	HEIGHT:	WEIGHT:

**Other** Do all dependents reside with applicant?       YES       NO       N/A      If 'NO' please explain below.

Do you have an adoption pending?       YES       NO       N/A      If 'YES' please explain below.

Details:

**SECTION V: OTHER COVERAGE** (Must be completed or will be returned).

A	<input type="checkbox"/> YES <input type="checkbox"/> NO	Does any person listed on this application have other health, accident, or indemnity insurance?
B	<input type="checkbox"/> YES <input type="checkbox"/> NO	Will this plan replace existing insurance? If yes, please list below and provide termination date.
C	Please list below ALL health insurance carriers by which any person listed on this application has been insured in the last 5 years. Include all pertinent dates.	
	Name of Insurance Company	Policy #
	Type of Plan	Eff Date
	Term Date	

**SECTION VI: HIPAA ELIGIBILITY** (You must complete this section)

A	The Health Insurance Portability and Accountability Act (HIPAA) and related state laws require insurance carriers or state sponsored plans to offer coverage to eligible individuals. If you do not qualify for our standard issue plans, you may be eligible for a HIPAA guaranteed issue plan. The benefits of the HIPAA plans are the same as the benefits of the standard issue plans, except that there are only 2 deductible options available. Individuals who are eligible for a HIPAA plan are guaranteed acceptance and won't have any exclusions or waiting periods for coverage of existing medical conditions. The premium for the HIPAA plans are considerably higher than standard premiums. An eligible individual is a person who meets <u>ALL</u> of the following requirements:	
	1. On the date of application for coverage, has had 18 months or more of creditable coverage without a break in continuous coverage of more than 63 consecutive days; 2. The most recent prior creditable coverage was under a group health plan, governmental plan, or church plan; 3. Does not have other health insurance coverage; 4. Has no right to other insurance, such as another group health plan, Medicare or Medicaid, COBRA, or continuation coverage under a state plan. If the individual was offered COBRA or state continuation, they must have elected and exhausted that coverage; 5. With respect to the most recent creditable coverage; was not terminated for nonpayment of premium or fraud.	
B	<input type="checkbox"/> YES <input type="checkbox"/> NO	Can you answer 'Yes' to all the statements above? If 'Yes', you and your listed dependents are eligible for HIPAA plan coverage and you will need to submit a certification of coverage from your previous group carrier. If a certification is unavailable you will need to submit a copy of your previous carrier's ID card, a copy of your previous carrier's specification page or summary plan document, and a copy of your latest bill. These requirements are necessary for each applicant for HIPAA coverage. Your signature on this form attests that the answer above is correct to the best of your knowledge.

**SECTION VII: AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

As required by HIPAA of 1996, Cox Health Systems Insurance Company (CHSIC) may not use or disclose your personal health information (PHI) without your authorization. Use this section to authorize persons other than yourself to receive your PHI from CHSIC.

I authorize CHSIC to use or disclose information only as indicated below, that pertains to myself and minor dependents listed on this application. I understand that information disclosed pursuant to this authorization may be redisclosed to additional parties by the authorized recipient(s) listed below and no longer protected. I understand that I may revoke this authorization by submitting a request to revoke in writing to CHSIC. I further understand that any revocation does not apply to the extent that persons authorized to use or disclose my information have already acted in reliance on this authorization. (See Section XI for complete authorizations).

I understand that I am under no obligation to complete this section of the application.

Type of information:	For:
<input type="checkbox"/> Protected Health Information	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents
<input type="checkbox"/> Claim Status	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents
<input type="checkbox"/> Billing Information	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents
<input type="checkbox"/> Other: <input style="width: 150px;" type="text"/>	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents

Authorized Recipients:	Relationship to Applicant:

**SECTION VIII: HEALTH STATEMENT**

Please print

Please list below all medications any applicant listed is taking or have taken in the last 12 months. Include non-prescription or 'over the counter' medications. (Use additional paper if necessary, sign and date all pages.)

**MEDICATIONS**

Applicant's name	Diagnosis of Condition	Date medication started	Date medication stopped	Prescription name	Dosage	Frequency taken

**HEALTH HISTORY**

**IMPORTANT! PLEASE GIVE COMPLETE DETAILS ON PAGE 4 "ADDITIONAL MEDICAL DETAILS" OF EACH YES ANSWER BELOW.**

**WITHIN THE LAST 10 YEARS, HAS ANY APPLICANT LISTED BEEN ADVISED OF, DIAGNOSED, TREATED, HAD SYMPTOMS OF, TAKEN MEDICINE FOR, OR CONSULTED WITH A MEDICAL PROFESSIONAL FOR THE FOLLOWING CONDITIONS:**

<input type="checkbox"/> YES <input type="checkbox"/> NO	a) The lungs or respiratory system, including but not limited to: hayfever, allergies, sinus infections, asthma, bronchitis, tuberculosis, pneumonia, emphysema, or sleep apnea?
<input type="checkbox"/> YES <input type="checkbox"/> NO	b) The heart or circulatory system including but not limited to: high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis or elevated cholesterol?
<input type="checkbox"/> YES <input type="checkbox"/> NO	c) The digestive system including but not limited to: ulcer, gastritis, heartburn, intestinal disorder, colitis, irritable bowel, gallbladder, hemorrhoids, hernia, disorder of the pancreas, spleen, acid reflux, liver, hepatitis, jaundice or cirrhosis?
<input type="checkbox"/> YES <input type="checkbox"/> NO	d) The nervous system including but not limited to: epilepsy, seizures, unconsciousness, convulsions, dizziness, headaches, paralysis, multiple sclerosis, cerebral palsy, Parkinson's disease, stroke, mini - stroke, TIA or brain attack?
<input type="checkbox"/> YES <input type="checkbox"/> NO	e) The genitourinary system including but not limited to any kidney disorder, kidney stones, cystitis, prostatitis, bladder infections?
<input type="checkbox"/> YES <input type="checkbox"/> NO	f) The muscular, skeletal, connective tissue or joint disorder including but not limited to: broken bones, arthritis, lupus (SLE), back pain, neck pain, spine disorder or chiropractic therapy?
<input type="checkbox"/> YES <input type="checkbox"/> NO	g) Injuries on the job, workers compensation, work related injury, disability or athletic injury?
<input type="checkbox"/> YES <input type="checkbox"/> NO	h) Congenital disorder, birth defects or developmental disorders including but not limited to: Down Syndrome, mental retardation, autism, cleft palate, club foot, congenital heart defects or heart murmur?
<input type="checkbox"/> YES <input type="checkbox"/> NO	i) Diabetes, high or low blood sugar, disorder of the thyroid, breast, or other glands?
<input type="checkbox"/> YES <input type="checkbox"/> NO	j) Blood or lymph disorders, tested positive for HIV?
<input type="checkbox"/> YES <input type="checkbox"/> NO	k) Cancer, tumor, cyst, skin condition, or growth of any kind? Provide location, and treatment received.
<input type="checkbox"/> YES <input type="checkbox"/> NO	l) Any disorder of the eyes, ears, (including ear infections or ear tubes), nose, mouth, throat, tonsils, adenoids, any speech or hearing impairment?
<input type="checkbox"/> YES <input type="checkbox"/> NO	m) Any disorder of the reproductive organs, including but not limited to: disorders of the penis, testes, vagina, ovaries and cervix, uterus, diagnosed or treated for pelvic pain, endometriosis, ever had an abnormal pap smear, or sexually transmitted disease?
<input type="checkbox"/> YES <input type="checkbox"/> NO	n) To the best of your knowledge, are you, your spouse or any dependent now pregnant?
<input type="checkbox"/> YES <input type="checkbox"/> NO	o) Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage?
<input type="checkbox"/> YES <input type="checkbox"/> NO	p) Does any person have any fixation/prosthetic devices present including but not limited to plates, screws, pins, implants (including breast implants), shunts, pacemakers, or valve replacements?
<input type="checkbox"/> YES <input type="checkbox"/> NO	q) Any surgery, diagnostic testing, or treatment recommended that has not been completed?
<input type="checkbox"/> YES <input type="checkbox"/> NO	r) Been hospitalized or treated at an emergency room? If yes, give name of hospital, and reason for seeking treatment.
<input type="checkbox"/> YES <input type="checkbox"/> NO	s) Mental disease or nervous disorder including but not limited to any emotional disorder, anxiety, depression, attention deficit, hyperactivity, eating disorder, or psychiatric treatment or counseling?



**SECTION X: AGENT CERTIFICATION (To be completed by agent representing applicant(s).)**

<b>AGENT USE ONLY</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	Each question has been read by each proposed insured. I represent the information to be complete and accurate to the best of my knowledge and belief, and understand that this application and other required parts shall not be binding until approved by Cox Health Systems Insurance Company. I certify that each person proposed for insurance has read the completed application and that I have witnessed the signatures on the application.
	<input type="checkbox"/> YES <input type="checkbox"/> NO	The undersigned Agent realizes any false statement or misrepresentation, if material to the risk, may result in loss of this insurance coverage, and requires the applicant(s) to reimburse Cox Health Systems Insurance Company for claims paid and due to these false statements or misrepresentations. I understand Cox Health Systems Insurance Company will diligently review submitted medical claims and filled prescriptions to enforce this provision.
	NAME OF WRITING PRODUCER PRINTED: _____ SIGNATURE OF WRITING PRODUCER: _____ DATE SIGNED: _____	
	MISSOURI PRODUCER LICENSE #: _____	

**SECTION XI: AUTHORIZATION (This must be completed, signed, and dated).**

<b>APPLICANT MUST READ, COMPLETE, AND SIGN THIS SECTION.</b>	<input type="checkbox"/> YES <input type="checkbox"/> NO	I have personally completed this application. I represent the information to be complete and accurate to the best of my knowledge and belief, and understand that this application and other required parts shall not be binding until approved by Cox Health Systems Insurance Company. The undersigned Applicant(s) certify that each person proposed for insurance has read the completed application.
	<input type="checkbox"/> YES <input type="checkbox"/> NO	The undersigned Applicant(s) realize any false statement or misrepresentation, if material to the risk, may result in loss of this insurance coverage, and requires the applicant(s) to reimburse Cox Health Systems Insurance Company for claims paid due to these false statements or misrepresentations. I understand Cox Health Systems Insurance Company will diligently review submitted medical claims and filled prescriptions to enforce this provision.
	I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Cox Health Systems Insurance Company (CHSIC), its legal representative or any medical records retrieval service CHSIC may engage.	
	This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data and EKG's. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by CHSIC pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.	
	I understand that this authorization is required in order to enable CHSIC to make eligibility or enrollment determinations, and underwriting or risk rating determinations, relating to me and/or my minor children. If I refuse to sign or revoke this authorization, CHSIC may refuse to consider my application for enrollment.	
	I understand that I may revoke this authorization at any time by submitting an Authorization Revocation form, available upon request, to Cox Health Systems Insurance Company. Such revocation will not be valid if CHSIC has taken action in reliance on the authorization.	
	Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Cox Health Systems Insurance Company.	
	PRINTED NAME OF APPLICANT	PRINTED NAME OF SPOUSE APPLYING FOR COVERAGE (REQUIRED)
	SIGNATURE OF APPLICANT/OR PERSONAL REPRESENTATIVE	SIGNATURE OF SPOUSE APPLYING FOR COVERAGE (REQUIRED)
	DATE SIGNED:	DATE SIGNED
PRINTED NAME OF PERSONAL REPRESENTATIVE*	PRINTED NAME OF DEPENDENT AGE 18 OR OVER APPLYING FOR COVERAGE.	
RELATIONSHIP TO APPLICANT	SIGNATURE OF NAMED APPLICANT ABOVE / OR PERSONAL REPRESENTATIVE	
DATE SIGNED	DATE SIGNED	
*If you are the Personal Representative of the applicant and are not the parent or legal guardian, you must attach documentary evidence of your authority to act as the individuals' representative for this authorization to be valid.		

**SECTION XII: COMPANY APPROVAL**

This application has been approved for issuance by Cox Health Systems Insurance Company.		
SIGNATURE OF OFFICER OF COMPANY	COMPANY TITLE	DATE SIGNED