







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

<b>AGENT USE ONLY</b>	<p>I hereby certify that I hold a valid insurance license issued by the state of Missouri and that all of the information contained herein is correct to the best of my knowledge, and that I know nothing unfavorable about any individual applying for coverage, unless fully described.</p> <p>I certify that 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 believe, and understand that this application and any 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.</p> <p>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. <b>I understand Cox Health Systems Insurance Company will diligently review submitted medical claims and filled prescriptions to enforce this provision.</b></p>		
	<p>PRODUCER AGREES THAT ANY AGENT OF RECORD CHANGE IS SUBJECT TO APPROVAL BY CHSIC AND THAT ANY COMMISSIONS PAYABLE ARE SUBJECT TO CHANGE AT THE DISCRETION OF THE COMPANY. COMMISSIONS ARE PAID TO AGENT OR AGENCY AS DIRECTED IN AGENT/BROKER AGREEMENT.</p>		
	SIGNATURE OF WRITING PRODUCER:	PRINTED NAME:	DATE SIGNED:

**SECTION L: AUTHORIZATION** *Please complete, sign, and date.*

<p>I have personally completed this application. I represent the information to be complete and accurate to the best of my knowledge and believe, and understand that this application and other required parts shall not be binding until approved by Cox Health Systems Insurance Company (CHSIC). The undersigned Applicant(s) certify that each person proposed for insurance has read the completed application.</p> <p>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 CHSIC for claims paid due to these false statements or misrepresentations. I understand CHSIC will diligently review submitted medical claims and filled prescriptions to enforce this provision.</p> <p>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 CHSIC, its legal representative or any medical records retrieval service CHSIC may engage.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	
SIGNATURE OF APPLICANT OR PERSONAL REPRESENTATIVE*:	SIGNATURE OF SPOUSE APPLYING FOR COVERAGE (Required):
PRINTED NAME OF APPLICANT OR PERSONAL REPRESENTATIVE*:	PRINTED NAME OF SPOUSE APPLYING FOR COVERAGE (Required):
RELATIONSHIP OF PERSONAL REPRESENTATIVE TO APPLICANT (IF APPLICABLE):	SIGNATURE OF DEPENDENT AGE 18 OR OLDER APPLYING FOR COVERAGE:
DATE SIGNED:	PRINTED NAME OF DEPENDENT AGE 18 OR OLDER APPLYING FOR COVERAGE:
<p><i>* 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 individual's representative for this authorization to be valid.</i></p>	