

Individual Application for Health Insurance _____ Cox Health Systems Insurance Company

Section A: Reason for Application

New Applicant Add a Dependent to Policy #

Section B: Coverage Options

Requested Effective Date Month: _____ Day: _____ Year: _____

Plan:	Deductible:	Design Option:
<input type="checkbox"/> Economy	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$1500 <input type="checkbox"/> \$2000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000	Coinsurance: <input type="checkbox"/> 100% <input type="checkbox"/> 80%
<input type="checkbox"/> Kids First	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000	Parent/Legal Guardian Name: _____
<input type="checkbox"/> Traditional	<input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000	Coinsurance: <input type="checkbox"/> 90% <input type="checkbox"/> 70%
<input type="checkbox"/> Value First	<input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000 <input type="checkbox"/> \$10,000	\$30 Office Visit Copay: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HDHP	<input type="checkbox"/> \$2500 <input type="checkbox"/> \$3500 <input type="checkbox"/> \$5000 ¹	Coinsurance: <input type="checkbox"/> 100% <input type="checkbox"/> 80%
<input type="checkbox"/> Other: _____		

¹ \$5000 deductible available with 100% coinsurance option only.

Optional Riders: By selecting any of these riders, you are agreeing to adjusted premiums as applicable.

Maternity Waiver Rider (Removes all maternity benefits) Speech and Hearing Rider Autism Rider Other

Section C: Applicant Information

Legal Name (Last, First, MI): _____

Social Security #:	Birth Date:	Age:	Gender: M F	Height:	Weight:	Use Tobacco: Y N
Residential Address:						
City:	County:	State:	Zip:			
Mailing Address (if different than above):						
City:	County:	State:	Zip:			
Home Phone:	Work Phone:	Cell Phone:				
Fax:	E-Mail Address:					
Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Occupation:	Household Income:					
Do you and your spouse read, write, speak and understand the English language?						<input type="checkbox"/> Yes <input type="checkbox"/> No
Do all enrolling dependents live in Missouri?						<input type="checkbox"/> Yes <input type="checkbox"/> No* *If NO, please explain:
Do you have an adoption pending?						<input type="checkbox"/> Yes* <input type="checkbox"/> No *If YES, please explain:

Section D: Dependent Information

Please complete for all dependents applying for coverage. If your dependent(s) is 26 years of age or older and handicapped, please provide documentation of this status.

Legal Name (Last, First, MI)	Relationship	Social Security #	Gender	Birth Date (mm/dd/yy)	Age	Height	Weight	Use Tobacco
			M F					Y N
			M F					Y N
			M F					Y N
			M F					Y N

Section E: Other Coverage

(Must be completed or application will be returned)

Does any person listed on this application have other health insurance? Yes No

Will this plan replace existing Insurance? If yes, please list below and provide termination date. Yes No

In the **past two years**; list all health insurance carriers by which you have had coverage. Include coverage dates.

Name of Insurance Company	Type of Plan	Policy #	Eff Date	Term Date



Section F: Referral Information

How did you hear about Cox Health Systems Insurance Company's Individual Health Plan?

- Brochure Direct Mailing Internet Television – Station _____
 Insurance Agent Word of Mouth/Referral Other _____ Radio – Station _____
 _____ _____ _____ Advertisement – Publication _____

Section G: Health Statement

IMPORTANT! PLEASE GIVE COMPLETE DETAILS IN SECTION H ON 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:

- | | | |
|---|------------------------------|-----------------------------|
| 1. The lungs or respiratory system, including but not limited to: hay fever, allergies, sinus infections, asthma, bronchitis, tuberculosis, pneumonia, emphysema or sleep apnea? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. 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 |
| 3. The digestive system including but not limited to: ulcer, gastritis, heartburn, intestinal disorder, recurrent diarrhea or recurrent vomiting, unexplained weight loss, 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 |
| 4. 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 |
| 5. The genitourinary system including but not limited to any kidney disorder, kidney stones, cystitis, prostatitis, or bladder infections? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. 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 |
| 7. Injuries on the job, workers' compensation, work related injury, disability or athletic injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Congenital disorders, birth defects or developmental delays including but not limited to: Down's Syndrome, autism, cleft palate, club foot, congenital heart defects or heart murmurs? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Diabetes, high or low blood sugar, disorder of the thyroid, breast or other glands? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Blood or lymph disorders, tested positive for HIV? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Cancer, leukemia, tumor, cyst, skin condition, or growth of any kind? Provide location and treatment received. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. 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 |
| 13. 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, fibroids, heavy menstrual bleeding, infertility, ever had an abnormal pap smear, herpes, HPV (Human Papilloma Virus) or sexually transmitted disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. To the best of your knowledge are you, your spouse, or any dependent now pregnant? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Complications of pregnancy including but not limited to caesarean section, delivery or miscarriage? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Does any person have any fixation devices/eye or limb prosthesis present and including but not limited to plates, screws, pins, implants (including breast implants), shunts, pacemakers, or valve replacement? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Mental disease or nervous disorder including but not limited to any emotional disorder, mental handicap, anxiety, depression, attention deficit, hyperactivity, eating disorder, or psychiatric treatment or counseling? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Alcohol or drug dependency, problem or abuse? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Used marijuana, cocaine, methamphetamine, hallucinogenic, narcotic drugs, or received treatment for drug abuse or chemical dependency? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Any surgery, diagnostic testing, treatment, medical evaluation or outstanding medical appointment that has been recommended but not completed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Been hospitalized or treated in an emergency room? If yes, give name of hospital and reason for seeking treatment. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. Referral to a specialist not already disclosed, abnormal test or physical results, treatment, or surgery discussed/advised or pending test results? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. To the best of your knowledge, does any applicant listed have any mental or physical impairment, conditions, disease or deformity not disclosed from the previous questions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. Is there any behavior, symptom, or condition that you would anticipate seeking an evaluation or treatment within the next six months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

IMPORTANT! FOR EACH YES ANSWER ABOVE, PROVIDE COMPLETE DETAILS IN SECTION H.



Section K: Agent Certification

(To be completed by agent representing applicant(s)).

Agent Use Only

I hereby certify that I hold a valid health 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 herein. I certify that each question has been read by each adult applicant or the parent/legal guardian of a child applicant.

I understand that this application and any other required parts shall not be binding until approved by Cox Health Systems Insurance Company. I as well understand that any false statement or misrepresentation, if material to the risk, may result in loss of this insurance coverage, and requires the applicants 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.**

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.

Signature of Writing Producer	Printed Name	Date Signed
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Section L: Authorization

Please complete, sign and date.

I acknowledge that I have personally completed this application. I represent the information to be complete and accurate to the best of my knowledge 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.

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, consumer reporting agency, insurance or reinsurance company having information about me or my minor children to provide all such information as may be requested by 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 or any other proposed applicant, including but not limited to, information regarding diagnosis, testing, treatment, and prognosis of physical or mental conditions 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 EKGs. Although federal regulations require that CHSIC informs 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.

I understand that failure to disclose known medical information on the Application shall be deemed to be intentional misrepresentation of material fact. If this occurs, subject to the provisions of PPACA, CHSIC may deny any future claims, rescind the policy (upon proper notice) and refund your premium as though your policy had never been in force. After the Application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I acknowledge that I have read the terms and conditions of this application, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand that they are being relied on by CHSIC in acceptance of this application.

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 insured by Cox Health Systems Insurance Company.

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:

MUST BE SIGNED AND DATED BY EACH APPLICANT 18 YEARS AND OLDER.

**A parent or legal guardian must submit this document. If you are a personal representative or legal guardian of the applicant, you must attach documentary evidence of your authorization to act in this capacity for this application to be valid.*