INDIVIDUAL POLICY SUPPLEMENTAL APPLICATION

Mail this Supplemental Application Along with the Individual Uniform Application to:

Wisconsin Physicians Service Insurance Corporation

P.O. Box 7898

Madison, Wisconsin 53707

Greater Insurance Service Corp.

Instructions: Please complete the entire supplemental application. Please print using **black** ink. WPS ("the Insurer") does NOT guarantee approval of this application for any person, or issuance of a policy. If you do not understand any questions on this supplemental application, please contact your agent or WPS Individual Sales Representative.

1. Information About You (Primary Applicant)

Last Name	*First Name*	*MI*	*Social Security Number*

2. Information on Eligibility

A. Are any of your dependents applying for coverage your grandchildren? ❑ Yes ❑ No
If yes, please list their names: _____

B. Are you, your spouse, and every named dependent a citizen of the United States or a resident legal alien? ❑ Yes ❑ No

C. Do you and your spouse reside in Wisconsin for at least six months per year? ❑ Yes ❑ No

You are not eligible for the coverage and benefit plan you are requesting if:

- You answered "No" to questions B. and/or C. above
- You currently have other individual or group coverage which you are not cancelling
- You are eligible for Medicare.

If you are not eligible, do not proceed further and do not submit this application to WPS.

D. If any of your dependents are eligible for Medicare, those dependents are not eligible for coverage. WPS won't approve these persons for coverage. Dependents eligible for Medicare should not be included in your application.

3. Coverage Selection and Effective Date

If this supplemental application is approved by WPS, the policy effective date is determined only by WPS.

Requested Effective Date: ____ ____/01/____ ____ ____ ____ (mm/01/year)

Choose Coverage Type: ❑ Applicant ❑ Applicant & Spouse ❑ Applicant & Child(ren) ❑ Applicant, Spouse & Children

Choose Your Preferred Provider Network: _____

4. Health Benefit Plan Selection

❑ **INDIVIDUAL PREFERRED PLAN**

Deductible (choose one):

❑ $750 ❑ $1,250 ❑ $2,000

Coinsurance (choose one):

❑ 100%/70% of the next $5,000 ❑ 80%/60% of the next $5,000

❑ **HSA-QUALIFIED HIGH DEDUCTIBLE PLAN**

Deductible (choose one):

❑ $1,750 Single, $3,500 Family ❑ $3,250 Single, $6,500 Family

❑ $2,500 Single, $5,000 Family ❑ $5,950 Single, $11,900 Family

5. Your Premium Payment Options (Business checks and/or accounts cannot be used for premium payment)

Please check the mode of payment you're requesting in either A., B., or C. below:

A. ❑ **AUTOMATIC MONTHLY WITHDRAWAL.** We electronically transfer your premium directly from your bank account on the date of the month you request. (If you select this option, please complete the Automatic Withdrawal Payment Authorization Form.)

With this option, your first premium payment must be paid with a check or credit card.

B. ❑ **DIRECT BILL.** We send a premium notice directly to your home at the frequency you request. You return payment to GIS by the premium due date.
❑ Monthly (with a $5.00 billing fee) ❑ Quarterly (with no billing fee)
❑ Semiannually (with no billing fee) ❑ Annually (with no billing fee)

C. ❑ **CREDIT/DEBIT CARD.** (4% service fee) If you select this option, please complete Credit/Debit Card Authorization Payment Form.
❑ Initial Premium Deposit ❑ Monthly

With this option, your first premium payment can be charged to your credit card.

6. Understanding/Notice

UNDERSTANDING: I understand: that: (1) no agent has the authority to waive an answer to any question, pass on insurability, make or alter any contract, or waive or alter any of the Insurer's other rights or requirements; (2) any misrepresentation contained herein may be used to reduce or deny a claim, or to rescind and void coverage and the policy within the contestable period, if such misrepresentation materially affects the Insurer's acceptance of the risk, including approving any person for coverage; (3) the Insurer has no liability for anything the agent said or failed to say before, during or after the application process, that's not subsequently confirmed in writing by an authorized officer of the Insurer, including, but not limited to, answers given by the agent in response to questions asked by myself, my spouse or my dependent(s); and (4) the Insurer is not liable for any statement, representation, or other information provided to myself, my spouse or my dependent(s) that isn't expressly contained in a written document provided to them and signed by an authorized officer of the Insurer.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE
IF YOU ARE REPLACING OTHER INDIVIDUAL OR GROUP HEALTH COVERAGE, PLEASE READ THIS SECTION.

According to your application or the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by WPS. For your own information and protection, certain facts shown below should be pointed out to you. If WPS approves your application for coverage and issues a policy, you should consider these facts before you lapse or terminate your present policy.

- Your new policy provides a time limit within which you may decide, without cost to you, whether you desire to keep the policy. The time limit is 10 days from the date of receipt of this policy.
- Health conditions which you presently may have might not be covered under the new policy. This change in coverage could result in a claim for benefits being denied under the new policy even though they are payable under your present policy.
- Although some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
- Questions in the application for the new policy must be answered truthfully and completely; if not, the validity of the policy and the payment of any benefits thereunder may be rescinded and voided.

7. Agent Statement/Information

Did an agent or sales representative assist you in the selection of this plan? ❑ Yes ❑ No If yes, agent must complete the following:

I asked the applicant, spouse and all child(ren) over age 18 all questions contained in this application and recorded their answers exactly as given to me. I also represent that no other person provided any of their answers, or influenced any of their answers; if any of their answers were influenced by another person, I have attached a written explanation thereof to this application.

Writing Agent's Name (Print) _____ Agent's Phone _____ Agent's Fax _____

Writing Agent's License# _____ Agency's 9 Digit ID# _____

Agency Name: _____

Agent's Signature _____ Date Signed by Agent _____

8. Authorization to Permit Use and Disclosure of Health Information

This shaded area to be completed by WPS.

Customer Name: _____ Date of Birth: _____

Customer Number _____

Person/Organizations authorized to *provide* the information: _____

I hereby authorize the following use or disclosure of my individually identifiable health information:

- Specific description of information to be used or disclosed: Medical records and office visit notes
- Specific purpose of the use or disclosure: Underwriting and for the purpose of creating an insurance policy
- Person/organizations authorized to *receive* the information: Health Underwriting
  WPS Health Insurance
  P.O. Box 7898,
  Madison, WI 53707-7898

I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to the Insurer or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulation promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA Privacy Regulation"), but excluding psychotherapy notes, if any) in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by the Insurer to determine eligibility for coverage under this policy and that my failure to authorize the release of said information might result in a refusal to issue or provide coverage. I agree that the Insurer may release said information to MIB or to the Insurer reinsuring companies, representative(s) or other person(s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand that I may revoke this authorization by providing advance written notice of termination to the Insurer, and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. In such case, the Insurer, its directors, officers, employees and agents shall not be held responsible or liable for such release.

I understand this authorization will remain valid for 30 months from the date I execute this authorization unless revoked by me in writing prior to the end of that 30-month period.

I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA Privacy Regulation and could be redisclosed by the person or entity that receives it.

To the best of my knowlege and belief, I represent that all statements and answers I made in this application, and on the attached sheet (if any) are complete and true. I have read and understand this application, including Section 6. Understanding/Notice and Section 8. Authorization to Permit Use and Disclosure of Health Information.

(Please sign in **black** ink)

SIGN HERE ➡

Applicant Signature *Date*

Spouse Signature *Date*

Child over Age 18 Signature *Date*

Credit/Debit Card Payment Authorization Form

A. Applicant Information

Last Name _____ First Name _____

Social Security Number _____ - _____ - _____

B. Billing Information, if Different Than Applicant

Name as it Appears on Credit/Debit Card _____

Mailing Address _____

City _____ State _____ Zip _____

Country _____

C. Premium Payment Mode

Select One: ❑ Initial Premium Deposit Only

❑ Initial Premium and Recurring
(Please select 10th, 15th, or 20th of the month for payment pull) _____

Note: Recurring premium payments will be charged to your credit/debit card on the day of the calendar month immediately preceding the premium due date, based on your selection. If you do not make a selection, premium payment will be charged on the 20th of the month. We will continue to charge premiums until the policyholder notifies us to discontinue charging premiums in accordance with the WPS policy.

D. Credit/Debit Card Authorization

Select One: ❑ Visa ❑ MasterCard ❑ Discover Card

Credit/Debit Card Number _____ Card Expiration Date _____ / _____

Must be from a personal account

I hereby authorize Greater Insurance Service (GIS) or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated above for payment of premiums charged for the WPS insurance policy for which I'm applying. If that WPS individual policy is issued to me by WPS, I understand and agree that by executing this authorization, that action doesn't affect, waive, or change any of the policy's terms, conditions, and provisions, including that policy's premium payment and grace period provisions. I am attesting the credit/debit card listed above is a personal account; I understand the premium may not be paid from a business account.

SIGN HERE ➡ _____

Applicant Signature *Date*

Automatic Withdrawal Payment Authorization

By my signature below, I authorize Greater Insurance Service (GIS) to instruct my financial institution to deduct my premium payments from the account designated below. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify GIS in writing of its termination. My notification must afford GIS and my financial institution reasonable opportunity to act on it.

A. ACCOUNT HOLDER INFORMATION

Name _____

WPS Customer Number (if available)_____

Address _____ State_____ Zip _____

Social Security Number _____ - _____ - _____

Payment Mode: Monthly

B. FINANCIAL INSTITUTION INFORMATION

Institution Name _____

Branch/Location _____

Address _____

City _____ State _____ Zip_____

Select One: ❑ Checking Account* ❑ Savings Account

Please indicate the 10th, 15th, or 20th day of the month in which you wish to have your premium payment withdrawn from your account: _____
(If you do not indicate a date of withdrawal, the withdrawal date shall be the 15th of each month.)

Transit Number_____ Account Number _____

*IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK WITH "VOID" WRITTEN ACROSS IT.

SIGN HERE ➡ _____
Applicant Signature *Date*

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INDIVIDUAL UNIFORM APPLICATION FOR INDIVIDUAL MAJOR MEDICAL HEALTH INSURANCE FORM

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov

Ref: Section Ins 3.33, Wis. Adm. Code, and s. 601.41 (10), Wis. Stat.

This form is designed for an individual's initial application for coverage. Please contact the insurer with questions regarding this form.

Instructions: Please complete the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application, please attach, sign and date each page.

I. INFORMATION

Primary Applicant/Insured Information:

First, Middle and Last Name				
Social Security No.*	Place of Birth	Birth Date	Gender	Height _____ Weight _____
Residential Address				
City	County	State	Zip Code	
Mailing Address, if different from residential address				
City	County	State	Zip Code	
Home Phone	Alternative Phone		Email (Optional)	
*If you have a Social Security Number.				
The Primary Applicant is: [ ] Single [ ] Married [ ] Under the age of 18** **If primary applicant is under the age of 18, please complete sections – II. C. and V.				
Employment Information: Primary job duties: Self-Employed: [ ] Yes [ ] No				

II. ADDITIONAL APPLICANTS

A. Please complete ONLY if your spouse and/or children under the age of 27 are applying for coverage. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

Spouse Name (First; M.I.; Last)	Gender	Social Security Number*/ Place of Birth	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

Child Name (First; M.I.; Last)	Gender	Social Security Number*	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

B. Does the child(ren) named within this application live with you at the address shown above?

[ ] Yes [ ] No If "No," please list the child(ren)'s name and mailing address(es):

Mailing Address Named Applicant			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child.			

C. If the primary applicant is under the age of 18, provide the name and mailing address of the legal guardian or custodial parent:

Mailing Address Legal Guardian or Custodial Parent			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child			

III. CURRENT AND PREVIOUS COVERAGE

Please provide information about you or your dependent's individual or group health insurance coverage or other health coverage (either prior or current). It will help us determine whether you will have any waiting periods for preexisting conditions for the health insurance you are applying for. By providing this information you are not reducing your health insurance.

Does anyone applying for coverage have current health coverage?
[ ] Yes [ ] No If "Yes," please indicate insurer and applicant _____.

Has any applicant had health insurance coverage within the last 18 months?
[ ] Yes [ ] No If "Yes," please indicate insurer and applicant_____.

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted?
[ ] Yes [ ] No

Is any applicant enrolled in Medicare?
[ ] Yes [ ] No If "Yes," name of applicant _____. For this applicant, please stop here – this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid or other governmental health programs (i.e. BadgerCare, TRICARE, Veterans services)?
[ ] Yes [ ] No If "Yes," name of applicant _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

IV. MEDICAL INFORMATION

NOTICE TO APPLICANT:

The insurance company does not use or collect genetic information for any Underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the insurance company in any manner. For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.

You are required to disclose information regarding any disease or condition for which:

- Any applicant has been diagnosed or treated by any healthcare provider.
- Any applicant has had testing with abnormal results.
- Any applicant is awaiting test results.
- Any applicant has been recommended or scheduled for diagnostic testing, consultation, treatment, follow-up, or surgery.
- Any applicant has taken or has been advised to take any prescription medication.
- Any change in health status for which any applicant has not sought medical care or treatment.

Within the last FIVE (5) YEARS has anyone, including you or any family member requesting coverage, received counseling, care or treatment, medication, medical advice or been told a diagnosis for any of the conditions or illnesses listed below? (Please check all conditions that apply.)

Please mark "Yes" or "No" for each item, for you and any family members requesting coverage. Provide additional information for each question you answer "Yes" to on the Additional Medical Details page that follows the health questions.

Answers to the medical questions should be complete, true and correct to the best of your knowledge. You are required to promptly notify us if there is a change in your or your family's health prior to the effective date of coverage and provide updated information. If at any time during the underwriting process prior to the effective date of coverage, you or your health history changes, please notify us immediately as this may impact your coverage.

WITHIN THE LAST FIVE (5) YEARS:

1. Infectious and Parasitic Diseases

a. AIDS (acquired immunodeficiency syndrome), ARC (AIDS-related complex), HIV positive [The reporting of HIV test results is limited to FDA-licensed tests, and you need not report results of tests conducted at an anonymous counseling and testing site or through the use of a home test kit.] ..... [ ] Yes [ ] No

b. Lyme's Disease	[ ] Yes [ ] No
c. Sexually transmitted disease(s)	[ ] Yes [ ] No

2. Blood, Gland, Endocrine, Metabolic and Immune Disorders (other than HIV, ARC, AIDS)

a. Anemia/blood disorder	[ ] Yes [ ] No
b. Thyroid disease	[ ] Yes [ ] No
c. Diabetes/high or low blood sugar. (If "Yes," record last HGA1C reading and date on the Additional Medical Details page.)	[ ] Yes [ ] No
d. Adrenal disorder	[ ] Yes [ ] No
e. Enlargement of lymph nodes	[ ] Yes [ ] No
f. Endocrine/gland/hormone system	[ ] Yes [ ] No

3. Cancer, Cyst and Tumors

c. Cancer. (If "Yes," include the stage, type and location of the tumor on the Additional Medical Details page.)	[ ] Yes [ ] No
b. Tumors, cyst, lump, polyp	[ ] Yes [ ] No

4. Mental/Nervous/Behavioral Disorders

a. Alcohol/chemical/drug abuse/dependency	[ ] Yes [ ] No
b. Has any applicant used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs?	[ ] Yes [ ] No
c. Eating disorders such as, but not limited to, anorexia or bulimia	[ ] Yes [ ] No
d. Mental/emotional condition/depression	[ ] Yes [ ] No
e. Autism	[ ] Yes [ ] No
f. Suicide attempt	[ ] Yes [ ] No
g. Alcohol, chemical, drug abuse therapy, treatment or counseling within last 5 years (if "Yes," record date of last session in on the Additional Medical Details page)	[ ] Yes [ ] No

5. Brain and Nervous System

a. Brain disease or injury/concussion	[ ] Yes [ ] No
b. Convulsion/seizures/epilepsy	[ ] Yes [ ] No
c. Chronic headaches/migraines	[ ] Yes [ ] No
d. Neurological condition/disease/injury	[ ] Yes [ ] No
e. Sleep apnea/chronic sleep disorder	[ ] Yes [ ] No
f. Stroke	[ ] Yes [ ] No
g. Multiple Sclerosis	[ ] Yes [ ] No
h. Paralysis	[ ] Yes [ ] No

6. Skin Disorders

a. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer	[ ] Yes [ ] No

7. Eyes, Ears, Nose

a. Chronic ear/nose condition/disease	[ ] Yes [ ] No

b. Chronic eye condition/disease	[ ] Yes [ ] No
c. Cataracts/glaucoma	[ ] Yes [ ] No

8. Mouth, Throat or Jaw

a. Chronic throat/tonsil/adenoid/disease/disorder	[ ] Yes [ ] No
b. TMJ/jaw joint	[ ] Yes [ ] No

9. Heart or Circulatory System

a. Blood/circulatory disorder	[ ] Yes [ ] No
b. Heart attack/chest pain/murmur/angina	[ ] Yes [ ] No
c. Elevated/High cholesterol (if "Yes," record last reading and the date on the Additional Medical Details page)	[ ] Yes [ ] No
d. Elevated/High or low blood pressure (if "Yes," record last 3 readings and dates in past 12 months on the Additional Medical Details page)	[ ] Yes [ ] No
e. Phlebitis/blood clot	[ ] Yes [ ] No
f. Heart disease/disorder	[ ] Yes [ ] No

10. Respiratory System

a. Asthma	[ ] Yes [ ] No
b. Emphysema/Chronic obstructive pulmonary disease (COPD)	[ ] Yes [ ] No
c. Chronic respiratory/lung condition	[ ] Yes [ ] No
d. Pneumonia/bronchitis	[ ] Yes [ ] No

11. Digestive System

a. Appendicitis/chronic abdominal pain	[ ] Yes [ ] No
b. Blood in stool	[ ] Yes [ ] No
c. Colon/rectum/intestine/bowel/Crohn's disease	[ ] Yes [ ] No
d. Ulcer/esophageal reflux	[ ] Yes [ ] No
e. Gallbladder	[ ] Yes [ ] No
f. Liver condition/hepatitis/pancreas	[ ] Yes [ ] No

12. Urinary System

a. Bladder/urinary tract	[ ] Yes [ ] No
b. Kidney/kidney stones	[ ] Yes [ ] No

13. Male or Female Reproductive Systems

a. Breast (lumps or masses)	[ ] Yes [ ] No
b. Prostate/elevated PSA/prostatitis	[ ] Yes [ ] No
c. Reproductive system disorder/infertility/dysfunction	[ ] Yes [ ] No
d. Abnormal pap smear or mammography	[ ] Yes [ ] No

14. Pregnancy, Birth or Congenital Abnormalities

a. Birth defect/congenital deformities	[ ] Yes [ ] No
b. Pregnancy complications	[ ] Yes [ ] No

c. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date _____.)	[ ] Yes [ ] No

15. Muscular or Skeletal System

a. Back/neck/spine disorder	[ ] Yes [ ] No
b. Bone/orthopedic disorder	[ ] Yes [ ] No
c. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia	[ ] Yes [ ] No
d. Osteoarthritis/osteoporosis/osteopenia	[ ] Yes [ ] No
e. Rheumatoid arthritis	[ ] Yes [ ] No
f. Knee/shoulder/hip/joint surgery/disorder	[ ] Yes [ ] No
g. Hernia	[ ] Yes [ ] No

16. Miscellaneous

a. Cosmetic surgery/implants	[ ] Yes [ ] No
b. Use of prosthetic devices/limbs	[ ] Yes [ ] No
c. Had chronic fatigue	[ ] Yes [ ] No
d. Is any person to be insured now disabled, on disability, or unable to perform normal work or age-related activities	[ ] Yes [ ] No
e. Any fluctuations in weight (+/- 20lbs) in the past 12 months	[ ] Yes [ ] No
f. Implantable devices/stents/shunts/pace maker	[ ] Yes [ ] No
g. Allergies	[ ] Yes [ ] No
h. Transplants	[ ] Yes [ ] No

17. Other Injury, Illness, Treatment or Condition

a. Within the last 5 years, has any applicant had any other injury, illness, treatment, or condition not already listed; been hospitalized or scheduled to be hospitalized; had surgery or had surgery scheduled; had a test or a test scheduled; been recommended to have a test or surgery that was not performed for any reason not already mentioned; been prescribed medication for a condition or injury not already mentioned? (We are NOT seeking the results of HIV Antibody test.)	[ ] Yes [ ] No

18. Tobacco Use

a. Has any applicant used tobacco products in any form within the last 12 months?	[ ] Yes [ ] No
If "Yes", provide the name of applicant(s), amount of tobacco used and frequency:	

19. Other Activities

a. Has any applicant been involved in or participated in organized motorized racing or other extreme activities?	[ ] Yes [ ] No
If "Yes", provide the name of applicant(s), activity and frequency of the activity:	

ONLY complete this section if you need assistance with completing the medical information portion of this Application. Please note that this may require additional time to process your application.

Please contact me at this phone number during business hours:

I am unavailable during business hours, please contact me at this number during evenings or weekends:

Additional Medical Details Page

For any "Yes" responses in the medical information questions, please provide complete details below. Not providing complete details will delay the application process. Within the last five years has anyone been prescribed medications that were recommended or received from a licensed health care professional? Use an additional sheet(s) of paper if necessary.

All additional pages must be signed and dated by the primary applicant.

Question # or additional information								
Applicant Name								
Specific Diagnosis & Type of Treatment								
Duration of Condition	**Began mm/yy**		**Began mm/yy**		**Began mm/yy**		**Began mm/yy**	
	End mm/yy		**End mm/yy**		**End mm/yy**		**End mm/yy**	
Name/ Dosage/ Frequency of medication & Dates of Medication Use	**Name of Rx**		**Name of Rx**		**Name of Rx**		**Name of Rx**	
	Dose		**Dose**		**Dose**		**Dose**	
	Began mm/yy	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**
Was surgery performed								
Description of surgery/ Procedures/ Tests/Result & Dates								
Current Status/ O-Ongoing/ R-Resolved								
Readings for Blood Pressure, Cholesterol & Diabetes	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**
Physician/ Hospital Name, City, State								

V. TERMS AND CONDITIONS

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified the person(s) who assisted me. I agree that the answers are, to the best of my knowledge and ability, complete and true.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company on the certificate or policy.

I understand that any intentional misrepresentation relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a family member made an intentional misrepresentation in the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application that is intended to mislead an insurer or conceal significant information about the applicant.

I understand that I may request a copy of this Application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original.

Signature (or e-signature) of Primary Applicant (If Primary Applicant is under the age of 18, Signature of legal guardian or custodial parent)	**Date Signed**
Signature (or e-signature) of Spouse	**Date Signed**

Signature (or e-signature) of each listed child who has attained the age of 18

Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**Date Signed**

Complete this section if someone assisted you in the completion of this Application

The following person assisted me in completing the Application:
Please explain the assistant's relationship to you and your family: