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APPLICANT INFORMATION: Complete all sections, sign at bottom and read information on reverse side.

Check one: <input type="checkbox"/> New Application <input type="checkbox"/> Add Dependent <input type="checkbox"/> Change Ind. Plan Choice (select new choice below)			Eff. Date (mm/dd/yy)
<input type="checkbox"/> Other (Name change, address change, etc.) Indicate change _____			/ /
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married (Civil Union) <input type="checkbox"/> Legally Separated <input type="checkbox"/> Separated		Email Address	
<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership (include "Statement of Domestic Partnership")			
First Name	Middle Name	Last Name	
Street Address			Home Telephone Number
City	State	ZIP Code	Work Telephone Number
P.O. Box/Billing Address (if different from street address) City		State	ZIP Code

ConnectiCare, Inc. = HMO Benefit Plans and ConnectiCare Insurance Company, Inc. = POS Benefit Plans **A Plans** – Waive the In-Network Upfront Plan Deductible on Limited Preventive Care Services **B Plans** – All services – including Preventive Care – apply to the Plan Deductible

<p>POS Benefit Plans (Select one) (In-Network Deductible=Individ./Family):</p> <p><input type="checkbox"/> POS Hospital Deductible \$2,500/\$5,000 <input type="checkbox"/> POS Hospital Deductible \$5,000/\$10,000</p> <p><input type="checkbox"/> POS Upfront Deductible \$500/\$1,000 – A <input type="checkbox"/> POS Upfront Deductible \$750/\$1,500 – B</p> <p><input type="checkbox"/> POS Upfront Deductible \$1,500/\$3,000 – 20% – B <input type="checkbox"/> POS Upfront Deductible \$2,000/\$4,000 – A</p> <p><input type="checkbox"/> POS Upfront Deductible \$2,500/\$5,000 – B <input type="checkbox"/> POS Upfront Deductible \$2,500/\$5,000 – 20% – B</p> <p><input type="checkbox"/> POS Upfront Deductible \$10,000 Combined – B</p> <p>Pharmacy Co-Pay (Select one):</p> <p><input type="checkbox"/> \$10 / 50% / 50% \$1,000 Benefit Maximum <input type="checkbox"/> No RX</p> <p><input type="checkbox"/> \$10 / 50% / 50% \$5,000 Benefit Maximum</p>	OR	<p>HSA Compatible Plans (Select one HMO plan or POS plan) (Deductible=Individual/Family):</p> <p>HMO HDHP</p> <p><input type="checkbox"/> \$5,000/\$10,000 Deductible – A</p> <p>POS HDHP</p> <p><input type="checkbox"/> \$1,500/\$3,000 Deductible – 30/45 – B</p> <p><input type="checkbox"/> \$2,000/\$4,000 Deductible – 20% – A</p> <p><input type="checkbox"/> \$3,000/\$6,000 Deductible – 30/45 – A</p> <p><input type="checkbox"/> \$3,000/\$6,000 Deductible – 30/45 – B</p> <p><input type="checkbox"/> \$5,000/\$10,000 Deductible – A</p> <p><input type="checkbox"/> \$5,000/\$10,000 Deductible – B</p>
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MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Social Security Number or Current Member Identification Number	Sex	Date of Birth (mm/dd/yy)	Primary Care Physician	Provider ID Number (6 or 8 digits)	Existing Patient
Applicant			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse/Civil Union/Domestic Partner			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 1			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 2			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent 3			_____	<input type="checkbox"/> M <input type="checkbox"/> F	/ /		_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Race/Ethnicity (optional): This information is designed for the purpose of data collection and will not be used to determine eligibility, rating or claim payment.

Employee:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Spouse/Civil Union/Domestic Partner:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Dependent 1:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Dependent 2:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Dependent 3:
 White Black/African American Hispanic/Latino Asian Amer. Indian/Alaska Native Native Hawaiian/Pacific Islander Other Unknown

Tell us about your other insurance: Do you have any other health insurance policy or certificate in force? Yes No

Name of other insurance company	Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Last date of coverage
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Do you intend to replace your current medical or health policy with this policy? Yes No

AGENT SECTION:	
Agency Name Creative Health Insurance	Phone Number 860-647-7353
Robin Dubord	Agent Signature

FOR BUSINESS USE ONLY:	
Effective Date	
Account #	Other

Important: [The applicant, spouse/partner and all dependents aged 18 and over must sign this form]. By [selecting I (we) agree] signing here I acknowledge and agree that I have read and understand the information on the front **and back** of this form and Part 2: Health Statement. I also agree that the Member Consent below is valid as long as I am enrolled in a ConnectiCare health plan. I certify that I have personally completed this application on behalf of myself and on behalf of my dependents listed on the application who are under the age of 18. I represent that the answers and statements made herein and in Part 2 Health Statement are true, complete and correctly recorded to the best of my knowledge and belief. I understand that I have an obligation to notify ConnectiCare of any new conditions or changes in health condition that may occur after this application is signed and before any approval of my application. I acknowledge that I have received a copy of the Outline of Coverage for the Plan I have selected above. I acknowledge and agree that with respect to any dependents under age 18 that I am authorized to make these statements on their behalf. I further understand and agree that: (1) ConnectiCare may decline my application and that this application and the initial premium do not give me immediate coverage; (2) the broker has no authority to promise coverage or to modify ConnectiCare’s underwriting policy and is only authorized to submit this application and the initial premium payment; (3) if I have provided incorrect or incomplete information on this application and/or Health Statement that ConnectiCare may rescind any policy issued. This means that ConnectiCare will cancel coverage as if the policy never existed; and (4) I have personally read and completed this application and Health Statement and that if I am accepted that this application/Health Statement will become part of the contract between ConnectiCare and me and I agree to abide by the terms of that contract.

This plan is issued on an individual basis and is regulated as an individual health insurance plan.

▶ Applicant Signature	Date	▶	▶
Print name of parent/guardian (if applicable)	Date	Dependent Signature (age 18 years-over)	Date
▶ Spouse/Partner Signature (if applicable)	Date	▶ Dependent Signature (age 18 years-over)	Date

STATEMENT OF ACCOUNTABILITY

To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Application/Health Statement for the applicant named below because: Applicant does not read English Applicant does not speak English Applicant does not write English
 Other (explain): _____

I am qualified to translate the contents of this form and translated this information to: _____ .
 To the best of my knowledge I obtained and listed all the requested personal and medical history disclosed by this applicant. I also translated and fully explained the statements above.

▶ Signature of Translator (required)	Today's Date
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IMPORTANT: MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Inc., (CCI) or a CCI affiliate, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I understand that CCI’s privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CCI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CCI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents’ coverage under the Plan. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CCI as long as CCI or others have not taken action relying on this authorization. I acknowledge that I have retained a copy of this authorization.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment and restitution depending on applicable laws.

Any new conditions or changes occurring after the application is submitted but prior to approval, must be reported to ConnectiCare.