



INTERNAL USE ONLY
EFFECTIVE DATE: ____ / ____ / ____
GROUP NUMBER: _____

HEALTH APPLICATION/CHANGE FORM — GEORGIA

INSTRUCTIONS: All questions must be answered. Incomplete applications will be returned.

Section I: CONTRACT HOLDER INFORMATION

Last Name		MI	First Name		SS Number	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed					Marriage Date: / /	Divorce Date: / /
Permanent Residence			City		E-mail Address	
County	State	Zip Code	Phone Number ()		Occupation	
Reason for Application: <input type="checkbox"/> Applying for new coverage <input type="checkbox"/> Applying for dependent only coverage <input type="checkbox"/> Applying for change to current coverage						

LIST BELOW ALL INDIVIDUALS TO BE COVERED

	First Name, MI (and Last Name, if different)	Social Security Number	Birth Date	Sex	Height	Weight	Tobacco User	Physician	Student (circle)
Self							Y N		Y N
Spouse							Y N		Y N
1							Y N		Y N
2							Y N		Y N
3							Y N		Y N

Section II: PRODUCTS

Desired Effective Date ____ / ____ / ____ (when coverage is to begin)

<p>Standard Plans – 80% Coinsurance</p> <p><input type="checkbox"/> 500/1500 Deductible – \$30 Copay</p> <p><input type="checkbox"/> 750/2250 Deductible – \$30 Copay</p> <p><input type="checkbox"/> 1000/3000 Deductible – \$30 Copay</p> <p><input type="checkbox"/> 1500/4500 Deductible – \$30 Copay</p> <p><input type="checkbox"/> 500/1500 Deductible – \$40 Copay</p> <p><input type="checkbox"/> 750/2250 Deductible – \$40 Copay</p> <p><input type="checkbox"/> 1000/3000 Deductible – \$40 Copay</p> <p><input type="checkbox"/> 1500/4500 Deductible – \$40 Copay</p> <p>Optional Riders: (Can only be purchased with the 80% Coinsurance plans.)</p> <p><input type="checkbox"/> Maternity Services</p> <p>Standard Plans – 70% Coinsurance</p> <p><input type="checkbox"/> 1000/3000 Deductible – \$40 Copay</p> <p><input type="checkbox"/> 2000/6000 Deductible – \$40 Copay</p> <p><input type="checkbox"/> 3500/10500 Deductible – \$40 Copay</p> <p><input type="checkbox"/> 5000/15000 Deductible – \$40 Copay</p> <p><input type="checkbox"/> 10000/30000 Deductible – \$40 Copay</p> <p>Optional Riders: (Can only be purchased with the 70% Coinsurance plans.)</p> <p><input type="checkbox"/> Mental Health</p>	<p>HSA Compatible:</p> <p><input type="checkbox"/> 1200/2400 Deductible HSA Compatible</p> <p><input type="checkbox"/> 2200/4400 Deductible HSA Compatible</p> <p><input type="checkbox"/> 2500/5000 Deductible HSA Compatible</p> <p><input type="checkbox"/> 3000/6000 Deductible HSA Compatible</p> <p><input type="checkbox"/> 4000/8000 Deductible HSA Compatible</p> <p><input type="checkbox"/> 5000/10000 Deductible HSA Compatible</p> <p><input type="checkbox"/> I hereby certify that this health plan will be maintained in connection with a health plan savings account established in accordance with the application provisions of the Internal Revenue Code.</p>	
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Optional Coverage:

Dental Vision

Section III: OTHER COVERAGE INFORMATION

1. Yes No Do **YOU**, your **SPOUSE**, or any **listed DEPENDENT** have any other type of (Accident, Medicare, Medicaid, etc.) or are you currently applying for any other health insurance? If yes, please complete the following:

NAME	TYPE	NAME OF INSURANCE COMPANY

2. Yes No Were **YOU**, your **SPOUSE**, or any **listed DEPENDENT COVERED** by another health plan within the last 90 days? If yes, please complete the following:

NAME	NAME OF INSURANCE COMPANY	DATES OF COVERAGE	
		From:	To:
		From:	To:
		From:	To:
		From:	To:
		From:	To:

Section IV: MEDICAL ELIGIBILITY

A. Yes No Are **YOU**, your **SPOUSE** or any **DEPENDENT** currently pregnant, an expectant parent?

Name	Due Date
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B. Yes No Are **YOU**, your **SPOUSE** or any listed **DEPENDENT** currently taking any prescription medication?

NAME	MEDICATION AND DOSAGE	MEDICAL CONDITION

C. Yes No Has any insurance company refused, restricted or charged more for health coverage on any person listed on this application?

NAME	REFUSAL OR RESTRICTION	MEDICAL CONDITION

D. Yes No DO **YOU**, your **SPOUSE** or any listed **DEPENDENT** have a condition covered by Workers' Compensation?

NAME	WORKERS' COMPENSATION NUMBER	MEDICAL CONDITION

E. Yes No In the past five years, have **YOU**, your **SPOUSE** or any listed **DEPENDENT** engaged in sports or hobbies such as scuba diving, automobile or motorcycle racing, skydiving or aero sports on a regular/routine basis? If YES, please complete the following"

NAME	SPECIFIC ACTIVITY

F. When was the last time **YOU**, your **SPOUSE** or any listed **DEPENDENT** saw a physician? Please complete the following:

NAME	DATE	REASON	RESULTS

Section V: BILLING INFORMATION

CHOOSE ONE:

- HOME** — Receive monthly premium billings
- FINANCIAL INSTITUTION** — Have monthly automatic premium withdrawals

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Consumers Life Insurance Company® to initiate premium deductions from my account. The authorization will remain in effect until Consumers Life Insurance Company and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from: Checking Savings
(Please note: Not all Financial Institutions allow deductions from a savings account. Please verify this information with your financial institution.)

Name and branch of bank/financial institution			Account Number
Address			Account Holder's Name
City	State	Zip	Transit Routing Number
Account Holder's Signature			Date

Please attach a voided check for checking account or a deposit slip for savings account in order for our office to verify the bank information.

- CREDIT CARD** — Have monthly premium billed to credit card

If you wish to be billed through your credit card, please complete the following authorization: Mastercard Visa

Cardholder Name	Card Number
Bank Name (if applicable)	Expiration Date
Account Holder's Signature	Date

- LIST BILLING THROUGH EMPLOYER** — is available only to employees of a common employer who has agreed to collect the premiums on a monthly basis through payroll deduction and where the employer is not paying any portion of the premium.

Name of Employer	Occupation	
Address	Phone Number	
City	State	Zip Code

- DIFFERENT BILLING ADDRESS** Have home billing sent to a different address

If your mailing address is different than your permanent address, complete the following:

Last Name (C/O)	First Name	MI
Address		
City	State	Zip

ATTACH VOIDED CHECK
OR DEPOSIT SLIP HERE

FOR OFFICE USE ONLY

Sold — Account Executive and Code
Service — Account Executive and Code

or

Agent of Record	Tax I.D.
Royal Advantage® Broker	Commission Indicator

Section VI: TERMS AND CONDITIONS

I hereby apply under Consumers Life Insurance Company (CLIC) for the coverage indicated on this application. I further agree to be bound to the relevant terms of the health insurance policy.

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, government agency or person to (CLIC) and/or any affiliates or division of CLIC: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities; (d) for credentialing purposes. I authorize the applicable carrier to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this application. I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information. Also, I understand that, if my personal health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
2. I agree that a medical examination of me may be required in connection with this Health Application. I further agree that I, as the Applicant, will be responsible to pay for the medical examination and/or the release of any and all records on behalf of myself, my spouse, and/or the listed dependents. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my personal health information have acted in reliance upon this authorization.
3. I represent that I have read this Health Application, and understand each of the questions and the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any intentional misrepresentation or concealment on this Application will void my policy at the discretion of CLIC. I further agree that if a policy is issued, it will be issued by CLIC in full reliance and in consideration of the information, answers, and statements contained herein. I understand that this policy will be medically underwritten, and that I must notify CLIC if there is a change in the health history of any applicant between the time I sign this application and the effective date of coverage, if approved.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the cost containment features of this health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction.
5. No issuance, waiver, modification or change of policy or any of CLIC rules or amendments shall be binding upon CLIC unless it is in writing and signed by an authorized officer of CLIC, as applicable.
6. Notice: Certain Pre-Existing Condition limitations will apply: A Pre-existing Condition is a Condition for which an ordinarily prudent person would seek medical advice, diagnosis, care or treatment; or for which you incurred medical expense, received medical treatment, used Prescription Drugs or were advised by a Physician or Other Professional Provider to receive treatment prior to your Enrollment Date. Your Enrollment Date is your Effective Date. If a Pre-existing Condition existed at any time during the twelve (12) month period immediately preceding your Enrollment Date, CLIC will provide benefits for the Pre-existing Condition for Covered Services incurred after twelve (12) months following your Enrollment Date.
7. I represent that neither I nor my spouse are receiving any form of reimbursement or compensation for this coverage from any employer.
8. I also understand that information submitted with this application may require further medical underwriting. If that underwriting discloses additional medical risk I understand that there may be a significant change in the rate charged for this coverage or in certain cases, the coverage may be rescinded. A permanent ID card will be issued following the final review and acceptance of the application.
9. I understand and agree that no agent or broker has the authority: (i) to bind CLIC by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information CLIC requests; (iii) approve coverage; (iv) make or alter any contract on behalf of CLIC; or (V) waive or alter any of CLIC's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of CLIC to be binding on CLIC.

I am signing this Health Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. Do not cancel any current health insurance coverage until you receive an approval letter and insurance policy from Consumers Life.

Contract Holder's or Guardian's Signature	Date	Guardian's Social Security Number (if child only policy)	
Spouse's Signature	Date	Dependent's Signature if 18 or older	Date
Dependent's Signature if 18 or older	Date	Dependent's Signature if 18 or older	Date

Section VIII: HOW DID YOU HEAR ABOUT PERSONAL HEALTH PLAN? (CHECK ONE)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> 1. Friend/Family Member | <input type="checkbox"/> 4. Advertisement in newspaper, magazine, etc. | <input type="checkbox"/> 7. Radio | <input type="checkbox"/> 10. Other _____ |
| <input type="checkbox"/> 2. Yellow Pages | <input type="checkbox"/> 5. Newspaper Article | <input type="checkbox"/> 8. Mail | _____ |
| <input type="checkbox"/> 3. Insurance Agent | <input type="checkbox"/> 6. Internet/Web site | <input type="checkbox"/> 9. Through current employer | |

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.