

INTERNAL USE ONLY
EFFECTIVE DATE: ____/____/____
GROUP NO.: _____

HSA COMPATIBLE HEALTH APPLICATION/CHANGE FORM – MICHIGAN

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	Email Address		City
County	State	Zip Code	Area Code and Phone Number

Reason for Application: Applying for New Coverage Applying for Dependent Only Coverage Applying for a Change to Current Coverage

LIST BELOW ALL INDIVIDUALS TO BE COVERED

	First Name, MI (and Last Name if different)	SS Number	Birth Date	Sex	Height	Weight	Smoker (circle)	Physician	Student
Self			/ /		' "		Y N		
Spouse			/ /		' "		Y N		
1			/ /		' "		Y N		Y N
2			/ /		' "		Y N		Y N
3			/ /		' "		Y N		Y N

SECTION II: PRODUCT

HEALTH INSURANCE

Note: Health Insurance products are medically underwritten.

Desired effective date (when coverage is to begin): ____/____/____

- \$1,200/\$2,400 HSA Compatible
- \$2,000/\$4,000 HSA Compatible
- \$2,500/\$5,000 HSA Compatible
- \$3,000/\$6,000 HSA Compatible
- \$4,000/\$8,000 HSA Compatible
- \$5,000/\$10,000 HSA Compatible

OPTIONAL COVERAGE:

- Dental¹
- Vision¹

TRAVEL NETWORK:

- First Health
- Private Healthcare Systems (PHCS)

¹ Can be purchased as a stand alone product. If purchased as stand alone product, one year of premium is due with payment of first bill.

SECTION III: OTHER COVERAGE INFORMATION

1. 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? Yes No If yes, please complete the following:

Name of Company	Name of Family Member with or applying for coverage
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2. If you were covered by another health plan within the last 63 days you may be eligible for credit of pre-existing condition limitation, except for Consumers Life Insurance Company Short Term. To qualify for credit, please complete the following.

Name of Insurance Company	Date of Coverage
	From _____ To _____
Policy # (If Medical Mutual)	

SECTION IV: MEDICAL ELIGIBILITY

1. Are YOU, your SPOUSE, or any listed DEPENDENT currently pregnant or an expected parent? Yes No
If yes, indicate in question No. 7 who and expected due date.
2. Are YOU, your SPOUSE, or any listed DEPENDENT currently taking any prescription medications? Yes No
If yes, indicate medication, reason for taking and dosage per day in question No. 7.
3. Has any insurance company refused or restricted any health coverage on any person listed on this Application within the past five years? Yes No If yes, indicate in question No. 7 for what condition.
4. Do YOU, your SPOUSE, or any listed DEPENDENT have a condition covered by Workers' Compensation? Yes No
If yes, please list name of family member, Workers' Comp. number, and condition when responding to question No. 7.
5. In the past three years, have YOU, your SPOUSE, or any listed DEPENDENT engaged in sports or hobbies such as scuba diving, automobile or motorcycle racing, skydiving or aerosports on a regular/routine basis? Yes No

Name	Specific Activity
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6. Have YOU, your SPOUSE, or any listed DEPENDENT within the past five years been treated for, diagnosed as having, has been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advise for any conditions? Each condition must be checked (✓) Yes or No

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
1. Abnormal Pap Smears	<input type="checkbox"/>	<input type="checkbox"/>	32. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	58. Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
2. AIDS, ARC, or HIV	<input type="checkbox"/>	<input type="checkbox"/>	Last 3 Blood Sugars & Dates:			59. Mental Health Disorders within past five years	<input type="checkbox"/>	<input type="checkbox"/>
3. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	1) _____			60. Migraines	<input type="checkbox"/>	<input type="checkbox"/>
4. Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	2) _____			61. Motor/Sensory Aphasia	<input type="checkbox"/>	<input type="checkbox"/>
5. Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	3) _____			62. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
6. Angina	<input type="checkbox"/>	<input type="checkbox"/>	33. Diverticulitis/Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	63. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
7. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	34. Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	64. Open Heart Surgery Candidate	<input type="checkbox"/>	<input type="checkbox"/>
8. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	35. Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	65. Otitis Media (ear infections)	<input type="checkbox"/>	<input type="checkbox"/>
9. Ataxia	<input type="checkbox"/>	<input type="checkbox"/>	36. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	66. Ovarian Cyst	<input type="checkbox"/>	<input type="checkbox"/>
10. Back Strains	<input type="checkbox"/>	<input type="checkbox"/>	37. Fibrocystic Breast Disease	<input type="checkbox"/>	<input type="checkbox"/>	67. Pacemaker Implantation	<input type="checkbox"/>	<input type="checkbox"/>
11. Bronchitis, Chronic	<input type="checkbox"/>	<input type="checkbox"/>	38. Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	68. Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
12. Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	39. Gallbladder Disease within past 5 years	<input type="checkbox"/>	<input type="checkbox"/>	69. Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
13. Cancer (Date Last Treated: _____)	<input type="checkbox"/>	<input type="checkbox"/>	40. Gastric Reflux	<input type="checkbox"/>	<input type="checkbox"/>	70. Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
14. Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>	41. Gout	<input type="checkbox"/>	<input type="checkbox"/>	71. Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
15. Carotid Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	42. Graves Disease	<input type="checkbox"/>	<input type="checkbox"/>	72. Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>
16. Carpel Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	43. Guillian Barr Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	73. Polycystic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
17. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	44. Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	74. Prostate Disorders within past 5 years	<input type="checkbox"/>	<input type="checkbox"/>
18. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	45. Heart Bypass (Date: _____)	<input type="checkbox"/>	<input type="checkbox"/>	75. Quadriplegia	<input type="checkbox"/>	<input type="checkbox"/>
19. Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	46. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	76. Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
20. Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	47. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	77. Scleroderma	<input type="checkbox"/>	<input type="checkbox"/>
21. Chronic Obstructive Pulmonary Disease	<input type="checkbox"/>	<input type="checkbox"/>	48. Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	78. Spina Bifida Cystica	<input type="checkbox"/>	<input type="checkbox"/>
22. Crohns Disease	<input type="checkbox"/>	<input type="checkbox"/>	49. High Blood Pressure Last 3 Pressures & Dates:			79. Spinal Disorders with past 5 years	<input type="checkbox"/>	<input type="checkbox"/>
23. Cirrhosis of the Liver	<input type="checkbox"/>	<input type="checkbox"/>	1) _____			80. Stroke (Date: _____)	<input type="checkbox"/>	<input type="checkbox"/>
24. Colitis	<input type="checkbox"/>	<input type="checkbox"/>	2) _____			81. Systemic Lupus	<input type="checkbox"/>	<input type="checkbox"/>
25. Congenital Disorders within past 5 years	<input type="checkbox"/>	<input type="checkbox"/>	3) _____			82. Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
26. Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	50. Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	83. Thyroid Disorder with past 5 years	<input type="checkbox"/>	<input type="checkbox"/>
27. Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	51. Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	84. TMJ	<input type="checkbox"/>	<input type="checkbox"/>
28. Coronary Insufficiency	<input type="checkbox"/>	<input type="checkbox"/>	52. Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	85. Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
29. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	53. Ileostomy	<input type="checkbox"/>	<input type="checkbox"/>	86. Transient Ischemic Attacks	<input type="checkbox"/>	<input type="checkbox"/>
30. Cystitis	<input type="checkbox"/>	<input type="checkbox"/>	54. Kidney Failure	<input type="checkbox"/>	<input type="checkbox"/>	87. Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
31. Depression	<input type="checkbox"/>	<input type="checkbox"/>	55. Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	88. Other Condition(s)	<input type="checkbox"/>	<input type="checkbox"/>
			56. Lou Gehrig's Disease	<input type="checkbox"/>	<input type="checkbox"/>			
			57. Major Organ Transplant/Failure	<input type="checkbox"/>	<input type="checkbox"/>			

7. If any questions or conditions from No. 6 are checked "YES", please explain below, (use additional paper, if necessary). Please indicate all details of the injury, ailment or condition. Include items such as specific location of condition (example: right knee), diagnosis, type of treatment and hospitalization. Also list any prescribed medications, any insurance company refusals or restrictions or workers' compensation number and condition.

Condition No.	Patient's Name	Details of Injury Ailment or Condition	Start and End Date(s) of Treatment(s)	Physician

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 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 Code	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

Card Holder 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	Area Code and 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 Code

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 ID
Royal Advantage Broker	Commission Indicator 96.15

SECTION VI: TERMS AND CONDITIONS

I hereby apply under Consumers Life Insurance Company for the coverage indicated on this application. I agree to be bound by 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 Consumers Life Insurance Company (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.
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.
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 (if applicable) in full reliance and in consideration of the information, answers, and statements contained herein. I understand that this policy will be medically underwritten.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care 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 six (6) 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.

Signature	Date	Spouse's Signature	Date
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SECTION VII: HOW DID YOU HEAR ABOUT PERSONAL HEALTH PLAN?

Please check how you heard about Personal Health Plan

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

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 is guilty of insurance fraud.

