

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
Self			/ /		' "		Y N	
Spouse			/ /		' "		Y N	
1			/ /		' "		Y N	
2			/ /		' "		Y N	
3			/ /		' "		Y N	

SECTION II: PRODUCT

HEALTH INSURANCE

Note: Health Insurance products are medically underwritten.

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

- | | |
|--|---|
| <input type="checkbox"/> \$500/\$1,000 Deductible | Value Plans |
| <input type="checkbox"/> \$1,000/\$2,000 Deductible | <input type="checkbox"/> \$500/\$1,000 Deductible |
| <input type="checkbox"/> \$1,500/\$3,000 Deductible | <input type="checkbox"/> \$1,000/\$2,000 Deductible |
| <input type="checkbox"/> \$2,500/\$5,000 Deductible | <input type="checkbox"/> \$1,500/\$3,000 Deductible |
| <input type="checkbox"/> \$5,000/\$10,000 Deductible | |
| <input type="checkbox"/> \$500/\$1,000 Deductible (Short-Term) | |

OPTIONAL RIDERS: (Can only be purchased along with health insurance)

- \$15/\$30/\$45 Prescription Drug Copay
 Maternity care without a maximum

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 Personal Health Care Short Term. To qualify for credit, please complete the following.

Name of Insurance Company	Date of Coverage
Policy # (If Consumers Life)	From _____ To _____

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 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

