INDEPENDENCE AMERICAN INSURANCE COMPANY
APPLICATION FOR BASIC AND STANDARD HEALTH INSURANCE

ATTENTION: Where do you want the Policy mailed? (Check one) Producer _______ Insured _______

GENERAL INFORMATION

Applicant Information (Please print in blue or black ink)

Applicant's Name Last First Initial				Social Security Number		
Applicant's Home Address Street City State Zip Code						
Billing Address Street City State Zip Code				E-MAIL ADDRESS		
Home Telephone Number	Work Telephone Number		Fax Number	Best Time and Place to Call ☐ Home ☐ Work Time: ____________		
Occupation (Title & Industry)	Smoker: ❐ Yes ❐ No	Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married	Birthdate / /	Age	Height Ft In	Weight Lbs

Dependent Information (Complete only for dependents to be covered under this plan)

Spouse's Name Last First Initial				Social Security Number	
Spouse's Occupation (Title & Industry)	Smoker: ❐ Yes ❐ No	Height Ft In	Weight Lbs	Birthdate	Age

Dependent(s) Name (First and Last)	Relationship	Sex	Birthdate	Height	Weight	Full-time Student? Yes or No

Requested Effective Date (check one):

❐ I request the Company assign my effective date to be the 1st of the month.
❐ I request an effective date of ___________________ (must be the 1st or 15th of the month).
❐ Other Day ________________ (Available only to Federally Eligible Individuals)

Mode of Payment: ❐ Direct Bill: Select ❐ Monthly ❐ Quarterly or ❐ Semi-annually. Submit check for first premium payment with this application.
❐ Credit Card* ❐ Bank Draft*
*Drawn monthly only. Complete the Monthly Automatic Payment Plan page.

PLAN SELECTION (Check One)

❒ Basic Plan	$1,000 calendar year deductible; 50% coinsurance; $50,000 calendar year maximum
❒Standard Plan	$750 calendar year deductible; 70% coinsurance; $1,000,000 lifetime maximum

If you are a **Federally Eligible Individual,** complete this section and provide a copy of your Certificate(s) of Creditable Coverage.

INSTRUCTIONS: This section must be completed for each Federally Eligible Individual applying for coverage under O.S. 3923.581. If additional space is required, please include a separate page with the requested information and sign and date.				
Who is applying as a federally eligible individual? What will the effective date of coverage be? / /		❒ Applicant	❒ Spouse	❒Child(ren)
Has anyone applying as a federally eligible individual been continuously covered by health insurance (the last of which is a group health plan) for a minimum of eighteen months?		❒Yes ❒ No	❒Yes ❒No	❒Yes ❒No
What was the reason the coverage terminated under the most recent health insurance plan?	Was it for non-payment of premium? Was it for fraud?	❒Yes ❒No ❒Yes ❒No	❒Yes ❒No ❒Yes ❒No	❒Yes ❒No ❒Yes ❒No
Was there a break in health insurance coverage in excess of 63 days during the past 18 months?		❒Yes ❒No	❒Yes ❒No	❒Yes ❒No
Is any applicant eligible for or currently have group health insurance through an employer, spouse's employer or is a dependent on any person's plan?		❒Yes ❒No	❒Yes ❒No	❒Yes ❒No
Is any applicant eligible for coverage under any of the following: COBRA, State Continuation, Federal Employee's Continuation, MEDICARE or MEDICAID?		❒Yes ❒No	❒Yes ❒No	❒Yes ❒No
Was the most recent coverage under COBRA or any State or Federal Continuation plan? a. If "yes," when did coverage begin________ and when will coverage be exhausted under such plan ________?		❒Yes ❒No	❒Yes ❒No	❒Yes ❒No
Was the current coverage a conversion plan elected through a previous carrier?		❒Yes ❒No	❒Yes ❒No	❒Yes ❒No

To be eligible for this coverage as a Federally Eligible Individual a person must meet all the following criteria: have 18 months of continuous creditable coverage; whose most recent coverage was a group, governmental or church plan; must not be eligible for group coverage, Medicare or Medicaid; cannot have other health insurance coverage; must have elected and exhausted any COBRA or state continuation coverage; and whose most recent coverage did not terminate due to premium lapse or fraud.

If you are a **Non-Federally Eligible Individual,** complete this section:

INSTRUCTIONS: This section must be completed for each Non Federally Eligible Individual applying for coverage under O.S. 3923.58.			
Who is applying as a non-federally eligible individual? What will the effective date of coverage be? _____/_____/_____	❐ Applicant	❐ Spouse	❐Child(ren)
Are you applying for coverage as an employee, member of an association or member of any other group?	❐Yes ❐ No	❐Yes ❐No	❐Yes ❐No
Are you able to be covered under any private or public health benefit plan including the following: Medicare or Medicare Supplement Policy; Medicaid; any COBRA or state continuation coverage plan; or any other health benefit arrangement?	❐Yes ❐No	❐Yes ❐No	❐Yes ❐No
Are you currently confined to a health care facility due to chronic illness or permanent injury?	❐Yes ❐No	❐Yes ❐No	❐Yes ❐No

To be eligible for this coverage as a Non-Federally Eligible Individual a person must meet all of the following conditions: must not be applying for coverage as an employee of an employer, member of an association or member of any other group; must not have any other health coverage and are not eligible to be covered under any private or public health benefit plans including Medicare or Medicare supplement policy, Medicaid, any COBRA or state continuation coverage plan, or other health benefit arrangement.

STATEMENT OF PRIOR COVERAGE

If any applicant has had previous qualifying major medical coverage which has been in effect within the past 63 days, please provide the following information.

NAME OF PRIOR INSURANCE COMPANY	INSURANCE COMPANY'S PHONE NUMBER ( )	PRIOR COMPANY'S POLICY OR CERTIFICATE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE
TYPE OF COVERAGE ❐Individual ❐Employer Group ❐COBRA ❐Medicare/Medicaid ❐Short Term Major Medical ❐Other:_________________			
EFFECTIVE DATE OF PREVIOUS COVERAGE ______/________/______________ Month Day Year		TERMINATION DATE OF PREVIOUS COVERAGE ______/________/_____________ Month Day Year	
REASON COVERAGE WAS TERMINATED OR INELIGIBILITY OCCURRED?			

AGREEMENT & SIGNATURE

INSTRUCTIONS: Read the following information and signify your agreement with the terms of this agreement for insurance by signing and dating the application as indicated below.

Premium Payment: I agree that (1) I am responsible for making the proper monthly premium payments; (2) a grace period of 31 days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the 31 days grace period, coverage for all insured persons shall lapse as of the premium due date; (3) any negotiable premium checks received in an envelope postmarked after the thirty-one day grace period will be refunded less any amounts due (if any) from previous months; (4) negotiation of any check from or on behalf of the insured shall not constitute acceptance of premium as premium is only accepted when acknowledged and applied by insurer. There is a one-time non-refundable application fee.

Pre-certification and Signature: I agree that failure to pre-certify treatment results in reduced benefits pursuant to the terms of the policy.

U.S. Resident: I understand that the coverage under this plan is available to United States residents only, benefits are not payable for medical expenses outside of the United States except when traveling, and if I stay outside the United States for more than 90 days I will be deemed to be residing outside of the United States and not traveling.

Application for Insurance: I understand that I am applying as an individual for insurance to which I am now or may become eligible for under the provisions of the Policy issued by Independence American Insurance Company. I understand that this coverage is not an employer health plan and I certify that (a) premiums are being paid by me as a personal expense and, neither my employer nor the employer of my dependents is now or in the future will be paying any part of the premium either directly or through wage adjustments or otherwise and (b) to the best of my knowledge and belief my employer has not and will not maintain, endorse or represent this health plan as an employer health insurance plan for any purpose, including a tax deduction, individuals not meeting this certification above are not eligible for this plan. I further understand that acceptance of the check submitted with this application does not constitute approval or guarantee of coverage.

My answers are true, complete and correct: I have personally reviewed all of my answers to the questions on this application and any attachments to it and certify that all of the information I have provided is true, complete and correct, I agree that it is my responsibility to provide truthful, complete and correct information. I certify I fully understand the questions asked. I agree that any misstatements or failure to report information may be used as the basis of rescission or reformation of coverage for me or my dependents, if any. I agree that under no circumstances is any agent allowed to: (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any question; or (c) instruct me not to disclose any particular medical condition on the application. I agree that no agent is authorized or has the authority to alter the terms of the Policy.

Pre-existing condition limitation for non-federally eligible individuals: I understand that if application is being made as a non-federally eligible individual, coverage may be limited for pre-existing existing conditions for the first 12 months; however, time will be credited while you were covered under previous creditable coverage to a date not more than 63 days prior to the effective date of this coverage.

Fraud Statement: Any person who with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Attachments: I understand that any attachments to this application become a part of it.

DO NOT CANCEL ANY EXISTING HEALTH INSURANCE UNTIL RECEIVING WRITTEN NOTICE OF APPROVAL.

Dated at ______________________________ on the _______ day of _________________, 20_________.
City State Month Year

____ ____
Name of Applicant or parent, if applicant is under age 18 (print) Name of Spouse if applying for coverage (print)

____ ____
Signature of Applicant (or parent, if applicant is under age 18) Date Signature of Spouse (if applying for coverage) Date

PRODUCER INFORMATION

Producer's Name _______________________________________

Company Name _______________________________________

Producer # ______________________________ Are you licensed in the state where the application was completed? ❒ Yes ❒ No

Are you currently appointed with Independence American Insurance Company in the state where the application was completed?
❒ Yes ❒ No (If not, please refer to the Producers Guide for contracting rules.)

Address ____
Street City State Zip

Business Phone (______)_______________________ Fax (______)______________________

E-Mail Address___________________________

PRODUCER'S STATEMENT: I certify that I have truly and accurately recorded all the information given to me by the applicant and I know of no other medical information about those persons applying for coverage other than that contained on this application. I understand that commissions cannot be paid unless appointed with Independence American Insurance Company.

____
Producer's Signature Date

PRODUCER'S FINAL CHECKLIST

- ✓ Are all the questions answered and boxes checked?
- ✓ Have you obtained a personal check from the applicant payable to IHC Health Solutions?
- ✓ Have you offered the applicant the option of the Monthly Automatic Payment Plan?
- ✓ Has the applicant enclosed a voided check for the Monthly Automatic Payment Plan, if applicable?

Submit to Independence American Insurance Company
c/o IPA
14497 N. DALE MABRY HWY SUITE 200, TAMPA, FL 33618
Fax No. (813) 983-2996

Authorization for Release of Health-Related Information.

I authorize the disclosure of health information regarding, or related to the following individuals for whom an application for insurance has been submitted:

Print Name(s): (Last) (First) (MI)	Date of Birth (Month/Day/Year)	Social Security Number
1.		
2.		
3.		
4.		
5.		
6.		

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group, Inc.), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Independence American Insurance Company ("IAIC"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit IAIC, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to make prospective and retrospective eligibility, underwriting and risk rating determinations, including whether the individual is subject to a pre-existing condition exclusion.

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that eligibility for the health plan is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to P.O. Box 37587, Phoenix, AZ 85069, Attention Privacy Officer.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

Signature of each Individual over the age of 18 or the Individual's Legal Representative: Date:

X______________________________ ______________

X______________________________ ______________

X______________________________ ______________

If signed by the individual's legal representative (e.g. a parent on behalf of a child), please describe the representative's authority to sign on behalf of the individual:

Name: ______________________ Authority: ______________________

MONTHLY AUTOMATIC PAYMENT PLAN – Complete All Applicable Areas	
To initiate the Automatic Payment Plan, **the following must accompany your application:** • This fully completed and signed form. • Credit Card information; **- OR -** • A voided check OR savings account deposit slip (business accounts not acceptable) *Coverage purchased by check is subject to clearance of the check, and coverage purchased by credit card is subject to acceptance of the credit card issuer.*	Independence American Insurance Company (IAIC), or its designated administrators, is hereby authorized to debit my bank account or credit card for the IAIC insurance premiums for the initial amount, and for each month thereafter until this Authorization is terminated. **I understand that the applicable initial premiums collected will be refunded to me if my health insurance policy is not issued**. I agree that the named institution shall be fully protected in honoring any such payments. The institution's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the institution shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. This Authorization will remain in effect until the bank is notified of termination by me in writing. To terminate insurance coverage, I will also notify IAIC or its administrators in writing. ❒ **Credit Card Payment** Choose one: ❒ MasterCard ❒ Visa Initial Amount collected upon receipt of application $____________________ Name (as it appears on card) ____________________ Card# ____________________________________ Exp. Date__________ Signature of Cardholder ___________________________ Date______________ ❒ **Monthly Bank Account Bank Draft** Initial Amount collected upon receipt of application $____________________ Name of Bank ___________________________ Address ________________________________ Routing No. ____________________________ Account No. ______________________________ Signature of Cardholder or Depositor ______________________________Date ______________ Name (please print) ____ Relationship to Proposed Insured _______________________________