Application for Health Insurance

Underwritten by: American Republic Insurance Company, 601 6th Avenue, Des Moines, Iowa 50334

Application Instruction—This application may be completed by the agent or the applicant.
The applicant is responsible for providing accurate and complete responses to all questions and for all details provided for "Yes" responses on this application. By signing the application, applicants are indicating that all questions and detail responses were provided by the applicant. We rely on the information provided for each family member listed on the application in our underwriting review. **Health conditions listed on this application with complete details will be covered, according to contract provisions, unless excluded by coverage.**

PART A PERSONAL DATA—PRINT CLEARLY USING BLACK OR BLUE INK.

Name of Applicants to be Insured (Print First Name, Middle Initial, Last Name)		Birthdate Mo/Day/Year	Age	Height Ft.	Height In.	Weight Lbs.	Sex	Social Security Number
Proposed Principal Insured								
Spouse								
Children to be insured	Full-time Student? (Yes/No)							

Residence Address: Street City State ZIP Code	
Proposed Principal Insured: Driver's License Number: State Issued:	**Spouse:** Driver's License Number: State Issued:
Telephone number: Home Work Cell phone number	Telephone number: Home Work Cell phone number
Best time to call Home Work	Best time to call Home Work
E-mail address (optional)	E-mail address (optional)

1. Present occupation (Principal Insured) ____________ Duties ____________
   a. If employed part time or unemployed are you currently seeking full-time employment? Yes No
2. Present occupation (Spouse, if applying) ____________ Duties ____________
   a. If employed part time or unemployed are you currently seeking full-time employment? Yes No
3. Do all applicants reside in the same household? If no, please explain Yes No
   ____
4. Are all applicants U.S. citizens, or has permanent resident status been established, with all applicants having been in the U.S. for a minimum of two years? Yes No
5. Are any applicants planning to live, work, or attend school outside the U.S. for more than 60 consecutive days? Yes No

PART B MEDICAL HISTORY

1. Is any applicant now pregnant, or an expectant father, or in the process of adopting a child? Yes No
2. Is any applicant eligible for Medicare due to a disability? Yes No
3. Has any applicant been diagnosed as having or tested positive for AIDS/HIV? Yes No

Has any applicant been treated for, been diagnosed as having, or had symptoms of any of the following medical conditions? (Please indicate "Yes" or "No" for each condition).

Yes	No		Yes	No	
		4. **Heart Conditions—**Heart Attack or Angina (within the past 2 years) or Congestive Heart Failure			13. **Major Organ Transplant—**Heart, lung, kidney, liver
		5. **Endocrine Conditions—**Addison's Disease, Cushing's Syndrome, Pheochromocytoma			14. **Severe lung conditions—**COPD (chronic obstructive pulmonary disorder) or emphysema on oxygen, Cystic Fibrosis
		6. **Diabetes**			15. **Psychotic Conditions—**Schizophrenia, Psychoses
		7. **Inflammatory Bowel Disease within the past 5 years—**Ulcerative Colitis or Crohn's Disease			16. **Cancer within the past 5 years—**Including but not limited to cancer of any organ, melanoma, sarcoma, leukemia, Hodgkins or other lymphoma, but excluding basal or squamous cell skin cancers
		8. **Alzheimer's Disease/Dementias**			17. **Lupus (Systemic)**
		9. **Parkinson's Disease**			18. **Kidney Failure/Dialysis**
		10. **Amyotrophic Lateral Sclerosis (ALS)**			19. **Stroke/TIA**
		11. **Multiple Sclerosis (MS)**			20. **Liver Failure**
		12. **Muscular Dystrophy (MD)**			

Any applicant who must answer "yes" to any of the questions in PART B will not qualify for coverage.

Application for Health Insurance

PART C COMPREHENSIVE MEDICAL HISTORY— Has any applicant been treated for, diagnosed with, or had symptoms of any of the following? (Please indicate “Yes” or “No” for each condition)

Yes	No	Condition	Yes	No	Condition
		1. **Head/Brain Condition—**Including but not limited to seizures, epilepsy, convulsions, paralysis			17. **Reproductive System Conditions—**Including but not limited to prostate disorder, impotence, abnormal PSA, abnormal PAP smear, menstrual disorders (amenorrhea, painful or excessive bleeding,), uterine fibroids, ovarian disorders, infertility, sexually transmitted diseases, complications of pregnancy, cesarean section delivery
		2. **Headaches/Migraines**			18. **Breast Conditions—**Including but not limited to cysts, gynecomastia, mastitis
		3. **Eye Conditions—**Including but not limited to cataracts, double vision, glaucoma/increased eye pressure, loss of vision, neuritis, retinal detachment, macular degeneration			19. **Neuromuscular Conditions—**Including but not limited to dizziness/syncope, cerebral palsy, neuropathy, muscular weakness, carpal tunnel syndrome
		4. **Ear Conditions—**Including but not limited to infections/otitis, hearing loss, Meniere’s Disease, ear tubes, otosclerosis, cochlear implant			20. **Arthritis—**Including but not limited to osteoarthritis, degenerative joint disease, rheumatoid arthritis, gout, joint replacements
		5. **Mouth/Nose/Throat Conditions—**Including but not limited to sleep apnea, rhinitis, sinusitis, enlarged tonsils/adenoids, tonsillitis, speech impairment			21. **Fibromyalgia**
		6. **Allergies**			22. **Osteoporosis/Osteopenia**
		7. **Respiratory Conditions—**Including but not limited to asthma, emphysema, COPD (chronic obstructive pulmonary disorder), reactive airway disease, bronchitis, pneumonia, chronic cough, chronic lung disease, tuberculosis			23. **Back/Spine Conditions—**Including but not limited to back pain, scoliosis, sciatica, curvature, subluxation, or herniated, bulging or degenerative discs
		8. **Thyroid Conditions—**Including but not limited to goiter, hyperthyroid, hypothyroid			24. **Dermatologic/Skin Conditions—**Including but not limited to acne, rosacea, eczema, psoriasis, shingles, herpes, or basal or squamous cell skin cancer
		9. **Heart Conditions—**Including but not limited to chest pain, angina, heart murmurs, irregular heart beat, heart valve disorders, heart attack, heart surgery (angioplasty/stent placement, coronary artery bypass, valve), coronary artery disease			25. **Cancer/Tumor—**Including but not limited to cancer of any organ, melanoma, sarcoma, adenoma, leukemia, Hodgkins or other lymphoma
		10. **High Blood Pressure/Hypertension**			26. **Congenital Disorders—**Including but not limited to Down’s Syndrome, mental retardation, autism, club foot, cleft lip/palate, pectus excavatum
		11. **High Cholesterol, Lipids, Triglycerides**			
		12. **Blood Conditions—**Including but not limited to anemia, bleeding disorders, hemophilia, leukemia, thrombocytopenia			27. **Mental/Nervous Conditions—**Including but not limited to emotional disorder, anxiety, depression, Attention Deficit Disorder, eating disorder, psychiatric treatment or counseling
		13. **Circulatory Conditions—**Including but not limited to peripheral vascular disease, varicose veins, phlebitis, thrombophlebitis, claudication, edema, aneurysm			28. **Substance Abuse—**Including but not limited to alcohol, marijuana, heroin, cocaine, methamphetamines, pain pills or any other drugs not prescribed by a physician
		14. **Digestive Conditions—**Including but not limited to esophagitis, gastric reflux, GERD, hernia, ulcers, gastritis, recurrent indigestion, irritable bowel, ulcerative colitis, Crohn’s Disease, hemorrhoids, diverticulosis, chronic diarrhea, rectal bleeding			29. **Prosthetic Devices—**Including but not limited to plates, pins, screws, breast implants, shunts, pacemakers, valve or joint replacements, artificial limbs
		15. **Liver/Gallbladder/Pancreas Conditions—**Including but not limited to cirrhosis, hepatitis, fatty liver, gallstones, pancreatitis, disorders of spleen/pancreas			30. **Medications—**any currently taken prescription or non-prescription medication
		16. **Urologic/Kidney/Bladder Conditions—**including but not limited to bladder infections, incontinence, overactive bladder, kidney stones, interstitial cystitis, pyelonephritis, nephritis			31. **Other Conditions—**Any other conditions for which any applicant has received treatment, or been suggested to have treatment from a physician, chiropractor or other practitioner in the past 10 years

PART C continued…ADDITIONAL HISTORY

Yes	No	Has any applicant… (please indicate yes or no response for each question)
		32. Used Tobacco in the past 2 years—Including but not limited to cigarettes, cigars, pipes, oral tobacco, nicotine replacement treatments? **Provide details for "Yes" response.** Name ____________________ Amount used daily ______ # of years used ______ Date of last use (if quit) ________
		33. Participated in hazardous activities in the past 2 years—Including but not limited to piloting, crop dusting, ultralight flying, parachuting, hang-gliding, aerobatics, scuba diving, rodeoing, mountain or rock climbing, boxing, stunts, motor vehicle racing? **Provide details for "Yes" response.** Name ____________________ Activity ________________________________ How often__________________
		34. Been convicted of any driving violations in the past 2 years—Including but not limited to DUI, DWI, license suspension or revocation, recurrent speeding? **Provide details for "Yes" response.** Name ____________________ Details/Date of Conviction ________________________________
		35. Been declined for health insurance or had coverage rated or issued with waivers or ratings within the past 5 years? Provide details for "Yes" response. Name ____________________ Company_____________ Action (decline, rated, modified, cancelled, renewal refused) ____ Reason ____ Date________________________

MEDICAL HISTORY & HISTORY DETAILS

Give details for all PART B and C Medical questions answered "Yes" for any applicant. If additional space is needed please insert an additional sheet of paper.

Question # ______ Applicant Name ____________________ Medical Condition ______________________________

Date of onset ______________ Date(s) of Treatment ______________________________

Treatment (Prescription drugs, herbal or over the counter medications, or surgery) ______________________________

Treating Physician Name and Address ______________________________

Question # ______ Applicant Name ____________________ Medical Condition ______________________________

Date of onset ______________ Date(s) of Treatment ______________________________

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Treating Physician Name and Address ______________________________

Question # ______ Applicant Name ____________________ Medical Condition ______________________________

Date of onset ______________ Date(s) of Treatment ______________________________

Treatment (Prescription drugs, herbal or over the counter medications, or surgery) ______________________________

Treating Physician Name and Address ______________________________

Physician Information—if not previously provided for all applicants, provide physician name, address and phone.

Applicant Name ________________________________ Date last seen ______________

Primary Physician ______________________________
Name Address Phone

Applicant Name ________________________________ Date last seen ______________

Primary Physician ______________________________
Name Address Phone

Applicant Name ________________________________ Date last seen ______________

Primary Physician ______________________________
Name Address Phone

PART D—EXISTING COVERAGE

1. Does any applicant intend to replace any other health coverage now in force? .... ☐ Yes ☐ No
An applicant may be eligible for guaranteed issue of health coverage if the applicant qualifies under the rules of the Health Insurance Portability and Accountability Act (HIPAA). The information provided in this section will help determine if an applicant qualifies for this coverage.
2. List all health insurance or health benefit plans under which an applicant was covered within the last 18 months and provide complete details for each plan.

Applicant Name	Insurance Company	Insurance Company Phone	Type of Coverage*	Policy or ID#	Dates of Coverage Mo/Day/Yr to Mo/Day/Yr	Replacing Yes or No

* For type of coverage, indicate (I) individual, (G) group, (C) COBRA, (M) Medicare/Medicaid, or (O) other.

3. Was there any period of 63 days or more during the past 18 months, when any applicant was not continuously covered by group or individual health insurance, Medicare, Medicaid, or any other health benefit? .... ☐ Yes ☐ No
4. Is any applicant eligible for Medicaid or presently covered under any other health coverage? .... ☐ Yes ☐ No
5. Was any applicant offered coverage under COBRA or a similar state program and refused coverage or did not complete the allowable period of coverage, or is any applicant presently eligible for such coverage? .... ☐ Yes ☐ No
6. Is any applicant presently eligible for, or will be eligible for, health coverage provided by an employer? .... ☐ Yes ☐ No
7. Was any applicant's most recent coverage terminated for non-payment, misrepresentation or fraud? .... ☐ Yes ☐ No

If an applicant has answered "yes" to any question 3-7, or have other health insurance in force, the applicant does not qualify as an Eligible Individual. If an applicant has answered "no" to all of the above questions, does not have other coverage, and the most recent coverage was group coverage, the applicant is an Eligible Individual.

List below the name of any applicant who qualifies for guaranteed issue as an Eligible Individual under HIPAA but who wants to be underwritten and considered for coverage on the plan being applied for. Any applicant must qualify medically for the underwritten plan. I understand that if they are issued and accept coverage, these family members are waiving any rights as an Eligible Individual.

Name
Name

I represent that all of the information on this application is complete and truthful to the best of my knowledge. I understand the Company is relying on this information to qualify each applicant named in the application for this insurance coverage, and that any false statement or misrepresentation may result in loss of coverage under this policy/certificate. I understand this coverage will cover accidents that occur, and sicknesses, the symptoms of which first manifest themselves after the date the policy/certificate is issued. I understand that health conditions which are present before this application is signed will be covered according to contract provisions only if listed on this application and if the Company does not exclude them from coverage. I understand that I will be informed whether or not my application has been accepted within 90 days or be given the reason for further delay.

WARNING: Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive may be guilty of a crime and may be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

I UNDERSTAND THAT COVERAGE WILL NOT BE EFFECTIVE UNTIL A POLICY/CERTIFICATE HAS BEEN ISSUED AND THE FIRST PREMIUM HAS BEEN PAID.

Signed at ______________________ this __________ day of __________, ______
(City/State) (Date) (Month) (Year)

X ______________________
Signature of Proposed Principal Insured

X ______________________
Signature of Spouse, if to be insured

X ______________________
Signature of Owner (if other than proposed principal insured)

X ______________________
Signature of children (over age 18), if to be insured

I CERTIFY that the answers given to the foregoing questions in this application were provided by the applicant. I have no information to add to the application that could affect the acceptance or rejection of the risk and that the Special Notice Federal Fair Credit Reporting Act was given to the applicant.

Signed at ______________________ this __________ day of __________, ______
(City/State) (Date) (Month) (Year)

X ______________________ ______________________ ______________________
Signature of Licensed Agent Agent Number (Date)

MEDICAL HISTORY & HISTORY DETAILS

Question 1

Treatment Details ___

Question 2

Treatment Details ___

Question 3

Treatment Details ___

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Treating Physician Name and Address ___

Treatment Details ___

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Physician Information—if not previously provided for all applicants, provide physician name, address and phone.

Applicant Name ______________________ Date last seen ______________

Primary Physician ______________________________________

Applicant Name ______________________ Date last seen ______________

Primary Physician ______________________________________

PART D—EXISTING COVERAGE

Applicant Name	Insurance Company	Insurance Company Phone	Type of Coverage*	Policy or ID#	Dates of Coverage Mo/Day/Yr to Mo/Day/Yr	Replacing Yes or No

* For type of coverage, indicate (I) individual, (G) group, (C) COBRA, (M) Medicare/Medicaid, or (O) other.