

AFFIRMATION

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. **By signing this form, you certify the following:**

1. I have read this entire application or it has been read to me.
2. **All of the answers provided within this application are, to the best of my knowledge and belief, true and complete.**
3. No independent producer, agent or employee of the insurer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
4. I understand that if I intentionally omit or give false information I may lose my coverage, in which case I may have to pay for services paid under that coverage. I understand that, in addition to losing my coverage, I may incur additional legal liability.

STATEMENT OF UNDERSTANDING

I understand and agree that:

- The information I have provided in this application will be used by the insurer in making its determination to extend coverage and in establishing the premium rate for such coverage.
- No coverage shall be in force until approved by the insurer. If approved, coverage will be in force as of the effective date determined by the insurer.
- This application will become part of the contract between the insurer and me.
- A twenty-four month waiting period for coverage of preexisting conditions may apply.
- I am entitled to a copy of this application and the Authorization to Use and Disclose Protected Health Information that is a part of this application upon request. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original.
- I authorize the insurer to transmit the information contained herein electronically.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, claim or benefit records, lab results, mental health records, as well as information regarding the use of drug, alcohol, HIV/AIDS, sexually transmitted disease and reproductive health services. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes.

II. Purpose of this Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage, to determine eligibility for enrollment or benefits under a health plan or to allow the insurer to conduct utilization review and quality improvement activities (“Purpose”).

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize the following insurers, their reinsurers, and their legal representatives (“Insurers”) to receive, use, and disclose my protected health information for the Purpose listed above:

Insurer: _____ **Insurer:** _____ **Insurer:** _____

Insurer: _____ **Insurer:** _____ **Insurer:** _____

I authorize the Insurers to disclose my protected health information: between themselves, to reinsuring companies, and to insurance intermediaries or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or person that has any record or knowledge of my health to disclose such information to the extent permitted by law to Insurers for the Purpose above.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

IV. Term of Authorization

I agree this Authorization shall be valid for two and one half (2 ½) years from the latest signature date below.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to Insurers. Revocation of this authorization form will not affect actions Insurers and others took in reliance on this form prior to the written notice of revocation.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM.

Primary Applicant Signature Date _____

Spouse Signature (ONLY if to be insured) Date _____

Dependent Signature (ONLY if 18 or over and ONLY if to be insured) Date _____

Dependent Signature (ONLY if 18 or over and ONLY if to be insured) Date _____

Dependent Signature (ONLY if 18 or over and ONLY if to be insured) Date _____

Dependent Signature (ONLY if 18 or over and ONLY if to be insured) Date _____

Dependent Signature (ONLY if 18 or over and ONLY if to be insured) Date _____