FOR OFFICE USE ONLY

ILLINOIS

CELTIC®

Celtic Health Plans

UNDERWRITTEN BY CELTIC INSURANCE COMPANY, CHICAGO, IL

Mail this application to: Celtic Insurance Company, P.O. Box 33640, Indianapolis, IN 46203-0640

PLEASE PRINT IN INK

Primary Applicant's Name:

FIRST MIDDLE LAST

Requested Effective Date: Requesting an effective date DOES NOT GUARANTEE underwriting to be completed before the date requested. _____/_____/_____
MO. DAY YR.
NOTE: the 29, 30 and 31 of the month are not eligible as effective dates. Application is valid within 60 days from the signature date.

Initial Payment Method:
One month/quarter premium:
☐ Credit card (including Check/Debit cards)
☐ Check
☐ Bill me later - online application only

Subsequent Payment Schedule:
☐ Monthly Automatic Pay - One month premium required
☐ Monthly Billing* - One month premium required (Not available for Celtic Basic)
☐ Quarterly Billing* - Three months premium required
*Billing fee applies

Total Payment Submitted: (Application fee waived for online application, www.celtic-net.com)
$ _____ /Monthly + $25.00 One-time, non refundable Application Fee = $ _____ Total Payment submitted
$ _____ /Quarterly + $25.00 One-time, non refundable Application Fee = $ _____ Total Payment submitted

Have you and/or any dependent to be covered previously applied for insurance with Celtic Insurance Company? ☐ Yes ☐ No

Is the Primary Applicant to be insured a U.S. citizen or a permanent legal resident of the U.S.? ☐ Yes ☐ No
(If "No," coverage cannot be granted.)

PRODUCT OPTIONS: (Choose one of the three plans): *The Term Life Insurance Option is not available in Ohio.

☐ **Celtic Basic:**

Coinsurance: **80/20 of the next $10,000** **70/30 of the next $10,000**
Deductible Options: ☐$1,500 ☐$2,500 ☐$5,000 ☐$1,500 ☐$3,500 ☐$5,000 ☐$7,500
Benefit Options: ☐ Prescription Drug Card

☐ **CeltiCare Preferred Options:** (Select one) ☐ Select PPO ☐ "AnyDoc" PPO ☐ Managed Indemnity

Coinsurance/Deductible Options: (Select one)
80/20 of the next $10,000
☐$500 ☐$1,000 ☐$1,500 ☐$2,500 ☐$5,000
100%
☐$2,500 ☐$5,000

Benefit Options: ☐ Prescription Drug ☐ Supplemental Accident ☐ Term Life Insurance*
Term Life Beneficiary Name: _____ Relationship to You: _____

☐ **CelticSaver HSA Options:** (Select one) ☐ PPO ☐ Managed Indemnity

Coinsurance/Deductible Options: (Select one)

Individual (Applicant Only)	**Family**
☐ 80/20 of the next $18,000- $1,500 deductible	☐ 80/20 of the next $36,000- $3,000 deductible
☐ 80/20 of the next $12,000- $2,600 deductible	☐ 80/20 of the next $24,000- $5,150 deductible
☐ 100%- $1,500 deductible	☐ 100%- $3,000 deductible
☐ 100%- $2,600 deductible	☐ 100%- $5,150 deductible
☐ 100%- $5,000 deductible	☐ 100%- $10,000 deductible

OCCUPATION/AVOCATION QUESTION:

Do you or any dependents to be insured participate in or work in any of the following occupations/avocations? ☐ YES ☐ NO

Bartending, Crop dusting, Hazardous materials, Inter-state trucking, Mining, Modeling, Motorized vehicle racing, Musician, Off-shore drilling, Police, Professional fire fighting, Professional sports or athletics, Roofing

If "Yes," please provide the name(s) of each person and their occupation/avocation.

Name: _____ Occupation/Avocation: _____

Name: _____ Occupation/Avocation: _____

Name: _____ Occupation/Avocation: _____

INITIAL PAYMENT: CREDIT CARD OR CHECK, **PRODUCER PAYMENTS ARE NOT ACCEPTED**

THE PLAN APPLIED FOR IS NOT AN EMPLOYER SPONSORED GROUP HEALTH PLAN.

1. For Initial Payment Only: I authorize Celtic Insurance Company to bill my account for the initial payment and I agree to pay the initial payment billed in accordance to my payment selection on this application by checking the following credit card box:

   ☐ VISA® (including Check/Debit cards*) ☐ Mastercard® (including Check/Debit cards*) ☐ Discover®

   * Debit cards must have a Visa or Mastercard logo on the front of the Debit Card.

   Card No.: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiration Date (MO/YR): ☐☐/☐☐

   Cardholder's Name: _____

2. Or, attach your check below for total payment submitted.

MONTHLY AUTOMATIC PAY PLAN

Note: If your withdrawal is not honored by your bank, you will be removed from the Monthly Automatic Pay Plan and sent a paper bill.

Payor Name or Depositor if different: (Please print)

FIRST MIDDLE LAST

Relationship to Applicant: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other _____

Signature of Primary Payor: **Date:**

Name of Financial Institution:

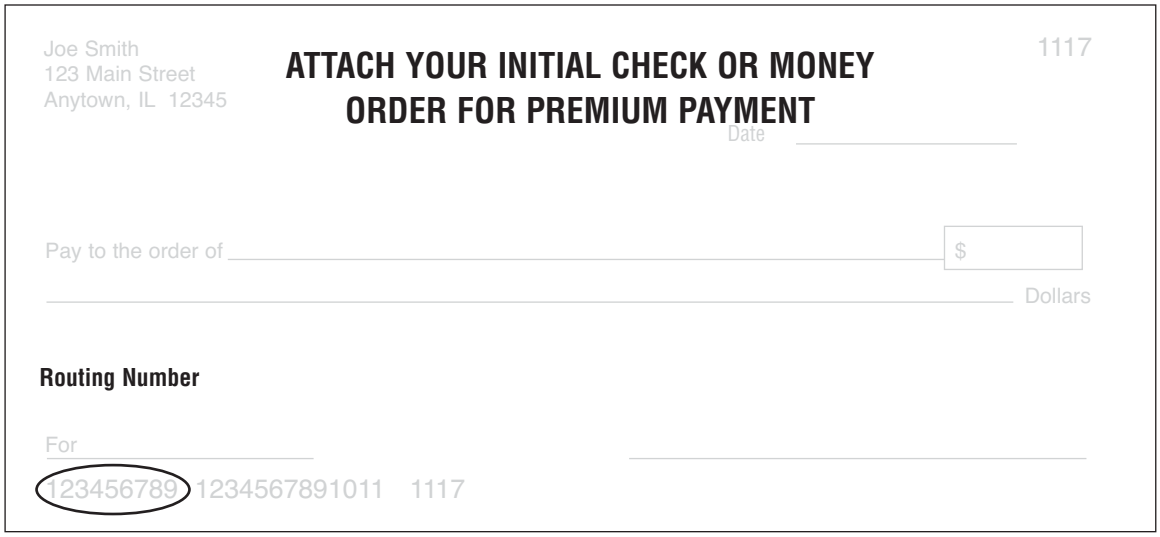
Specify type of account: ☐ Checking or ☐ Savings | **Checking/Savings Account Number:**

ABA 9 Digit Routing Number: (See below or please call your Financial Institution for assistance)

Celtic Insurance Company is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month, until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Health Plan is not issued.

I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by Celtic Insurance Company, and I agree that the bank named shall be fully protected in honoring any such payments. The bank'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 bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Celtic Insurance Company in writing.

DO NOT STAPLE CHECKS TO FORM



PRODUCER NOTICE: You must be currently licensed and appointed with Celtic in the state where the application was completed.

NOTE: If you have written business with Celtic <u>in this state</u> during this calendar year, just complete your name, Social Security number and sign below. There is no need to submit a copy of your license with every case.

Illinois Standard Health Application for Individual & Family Health Insurance Coverage

For assistance in completing this application, please contact your insurance agent or the insurance company directly. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

INSTRUCTIONS:

1. Any information you provide in this application is confidential.
2. The answers you provide in this application must be true and complete, to the best of your knowledge and belief. Do not leave any question unmarked.
3. An intentional misrepresentation may result in your policy being modified or terminated, or in claims being reduced or denied.
4. [For online version only] You should have the following information available, for each person requesting coverage:
   - Social Security Number, date of birth, and height/weight;
   - Information about any current or prior insurance coverage in effect within the last 12 months; and
   - Personal health information. If you do not have enough information to respond to a question, you should obtain any required information from your current or former health care provider(s).
5. For purposes of this application, the term "dependent" refers to any child up to age 26 (or age 30 for military veterans) for whom you are requesting coverage, regardless of whether the child may be considered a dependent for tax or other purposes. For information about Illinois' Young Adult Dependent Coverage law, which allows parents to cover children up to age 26, and up to age 30 for military veterans, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

A Primary Applicant Information

Name (Last)	(First)	(MI)
Residential Street Address:		Apt #:
City:	State:	Zip:
Mailing Address (if different):		Apt #:
City:	State:	Zip:
Primary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Secondary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Email Address (optional):		
Please check one of the following boxes: ☐ New Application ☐ Dependent Addition ☐ Plan Change ☐ Reinstatement		
Requested Effective Date: _____ (Coverage not in force until the insurance carrier approves your application and determines the effective date.)		

B Employment Information

Occupation:	Job Title:
Spouse/Domestic Partner's Occupation:	Job Title:
Currently employed? (optional) Self: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No	

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PRIMARY APPLICANT NAME ________________________________ DATE ____________________

C Persons Requesting Coverage

List all family members you wish to include under the policy. Insurance companies may have different rules about who may qualify as an eligible dependent. For more information regarding the available coverage, please check with your insurance agent or insurance carrier.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Self Name (Last) ____________________ (First) ______________________ (MI) ______

Social Security Number (for internal use only):	Date of Birth: / /
State of Birth (country if born outside the U.S.):	Gender: ☐ Male ☐ Female
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Spouse/Domestic Partner Name (Last) ________________ (First) ________________ (MI) ____

Social Security Number (for internal use only):	Date of Birth: / /
State of Birth (country if born outside the U.S.):	Gender: ☐ Male ☐ Female
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Dependent Name (Last) ____________________ (First) ____________________ (MI) ______

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Dependent Name (Last) ____________________ (First) ____________________ (MI) ______

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

Dependent Name (Last) ____________________ (First) ____________________ (MI) ______

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

PRIMARY APPLICANT NAME _____ DATE _____

Dependent Name (Last) _____ (First) _____ (MI) _____

Relationship to Applicant:	Date of Birth: / /
Social Security Number (for internal use only):	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No	
Percentage of time annually spent outside of Illinois for residence, work, or school:	

D Current/Prior Coverage Information

For EACH person listed on this application, please indicate any public health insurance coverage (for example, Medicare, HFS Medical Card, All Kids, Family Care, or other federal and state programs) or private health insurance in effect within the **last 12 months**. Each person applying for insurance must be listed below. If health insurance coverage was not in effect within the **last 12 months**, please indicate **NONE.**

Self Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

Dependent Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

PRIMARY APPLICANT NAME ______________________________ DATE ____________________

Dependent Name (Last) __________________ (First) __________________ (MI) ______

▶ Current/Most Recent Coverage:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________________)
▶ Dates of Coverage: From: ______/______/______ To: ______/______/______
▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ Prior Coverage (if any):
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________ ____________________)
▶ Dates of Coverage: From: ______/______/______ To: ______/______/______

Dependent Name (Last) __________________ (First) __________________ (MI) ______

▶ Current/Most Recent Coverage:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________________)
▶ Dates of Coverage: From: ______/______/______ To: ______/______/______
▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ Prior Coverage (if any):
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________ ____________________)
▶ Dates of Coverage: From: ______/______/______ To: ______/______/______

Dependent Name (Last) __________________ (First) __________________ (MI) ______

▶ Current/Most Recent Coverage:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________________)
▶ Dates of Coverage: From: ______/______/______ To: ______/______/______
▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ Prior Coverage (if any):
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ____________ ____________________)
▶ Dates of Coverage: From: ______/______/______ To: ______/______/______

✶ If answering **"YES"** please carefully read the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT & HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by the insurance carrier. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurance carrier to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you do not terminate your present contract until you are certain that your application for the new contract has been approved by the insurance carrier.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

E Health Statement

The federal **Genetic Information Nondiscrimination Act** prohibits health insurers from asking for and using **"genetic information"** when deciding whether to offer coverage and how much to charge for coverage. For more information on the Genetic Information Nondiscrimination Act, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Instructions:

1. Each medical question below applies to each person requesting coverage.
2. Answer the questions below by checking Yes or No. If you answer Yes to any question, you must provide additional information in Section F below.
3. Do not leave any question unmarked.

Limited Privacy Available: Persons age 18 or older may submit a signed and dated separate health statement. The information provided in such separate health statement(s) will likely be disclosed to the primary applicant.

1 For any of the following conditions, **within the past FIVE (5) years**, has anyone applying for coverage:

- Been diagnosed with;
- Had treatment or testing recommended;
- Received treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition listed below?

If answering "YES," check all that apply.

A. **Heart/Circulatory Conditions/Disorders:** ☐ Yes ☐ No

▶ **Heart:** ☐ Heart attack ☐ Chest pain ☐ Heart murmur ☐ Irregular heartbeat
☐ High/elevated blood pressure* ☐ High/elevated cholesterol*
✶ If applicable, please provide last known blood pressure or cholesterol reading in Section F.

▶ **Circulatory:** ☐ Anemia ☐ Bleeding/clotting disorder ☐ Varicose/spider veins ☐ Phlebitis

B. **Lymphatic Conditions/Disorders:** ☐ Yes ☐ No

☐ Lymphadenopathy ☐ Enlarged lymph nodes ☐ Disease of the spleen

C. **Cancer/Tumors/Growths:** ☐ Yes ☐ No

☐ Cancer ☐ Tumors ☐ Cysts ☐ Polyps ☐ Lumps ☐ Other abnormal growths

D. **Respiratory Conditions/Disorders:** ☐ Yes ☐ No

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Sleep apnea ☐ Pneumonia ☐ Tuberculosis
☐ Chronic obstructive pulmonary disease (COPD)

E. **Intestinal/Digestive Conditions/Disorders:** ☐ Yes ☐ No

☐ Acid reflux ☐ Ulcers ☐ Hernia *(indicate type)* ☐ Colitis ☐ Hemorrhoids ☐ Rectal bleeding ☐ Gallstones
☐ Irritable bowel syndrome ☐ Chronic diarrhea ☐ Hepatitis *(indicate type)* ☐ Elevated liver function test
☐ Jaundice ☐ Cirrhosis ☐ Gallbladder infection or inflammation ☐ Pancreatitis ☐ Crohn's disease

F. **Urinary Conditions/Disorders:** ☐ Yes ☐ No

☐ Kidney infection ☐ Kidney stones ☐ Bladder infection ☐ Cystitis ☐ Urinary reflux ☐ Urinary tract infection

G. **Metabolic/Endocrine Conditions/Disorders:** ☐ Yes ☐ No

☐ Diabetes ☐ Thyroid disorder ☐ High/low blood sugar ☐ Adrenal, pituitary, or other glandular disorder
☐ Chronic fatigue syndrome ☐ Obesity/weight loss surgery

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

H. **Brain/Nervous System Conditions/Disorders:** ☐ Yes ☐ No

☐ Seizures ☐ Migraine headaches/Chronic severe headaches ☐ Head injury ☐ Paralysis ☐ Epilepsy ☐ Tremor
☐ Stroke or TIA ☐ Multiple sclerosis ☐ Parkinson's ☐ Restless leg syndrome ☐ Lou Gehrig's disease (ALS)

I. **Immune System Conditions/Disorders:** ☐ Yes ☐ No

☐ HIV positive ☐ AIDS ☐ Diseases associated with AIDS

J. **Musculoskeletal Conditions/Disorders:** ☐ Yes ☐ No

☐ Arthritis ☐ Gout ☐ Lupus ☐ Herniated disc ☐ Temporomandibular joint disorder (TMJ)
☐ Carpal tunnel syndrome ☐ Disease/disorder of the back or spine ☐ Other bone or joint disorder

K. **Mental/Behavioral/Emotional Conditions/Disorders:** ☐ Yes ☐ No

☐ Depression ☐ Anxiety disorder ☐ Attention deficit disorder ☐ Chemical imbalance ☐ Bi-polar disorder
☐ Obsessive compulsive disorder ☐ Eating disorder

L. **Allergies:** ☐ Yes ☐ No

☐ Allergies in any form ☐ Hay fever ☐ Hives ☐ Anaphylaxis

M. **Eye Conditions/Disorders:** ☐ Yes ☐ No

☐ Glaucoma ☐ Cataracts ☐ Strabismus (crossed eyes) ☐ Detached retina

N. **Ear Conditions/Disorders:** ☐ Yes ☐ No

☐ Hearing disorder ☐ Ear infection ☐ Loss of hearing

O. **Nasal Conditions/Disorders:** ☐ Yes ☐ No

☐ Deviated septum ☐ Adenoiditis ☐ Sinusitis

P. **Throat Conditions/Disorders:** ☐ Yes ☐ No

☐ Tonsillitis ☐ Strep throat

Q. **Skin Conditions/Disorders:** ☐ Yes ☐ No

☐ Acne ☐ Psoriasis ☐ Eczema ☐ Keratosis ☐ Pre-cancerous lesions ☐ Herpes ☐ Melanoma

R. **Congenital Abnormalities/Developmental Disorders:** ☐ Yes ☐ No

- **Congenital Abnormality:** ☐ Cleft palate/lip ☐ Club foot ☐ Heart/lung/kidney defect or malformation
- **Developmental Disorder:** ☐ Pervasive development disorder ☐ Down's syndrome ☐ Autism spectrum disorder ☐ Learning disability

S. **Reproductive System Conditions/Disorders:** ☐ Yes ☐ No

- **Female:** ☐ Infertility ☐ Abnormal menstrual bleeding ☐ Abnormal PAP smear ☐ Endometriosis ☐ Ovarian cyst ☐ Sexually transmitted disease ☐ Human papillomavirus (HPV) ☐ Pregnancy complications ☐ Uterine fibroid ☐ Breast infection or inflammation
- Is any female applicant currently pregnant, an expectant parent, or in the process of adopting? ☐ Yes ☐ No
- **Male:** ☐ Infertility ☐ Erectile dysfunction ☐ Sexually transmitted disease ☐ Prostate disorder ☐ Gynecomastia
- Is any male applicant an expectant parent or in the process of adopting? ☐ Yes ☐ No

T. **Other Conditions:** ☐ Yes ☐ No

Within the **past 5 years**, has anyone applying for coverage been diagnosed with, had treatment or testing recommended, received treatment, including prescription medications, or been hospitalized for **any illness, injury, or health condition not indicated elsewhere in this application?**

Note: You must include any illness, injury, or health condition related to one of the categories above, even if your specific illness, injury, or condition is not listed above.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

Within the past FIVE (5) YEARS:		
2 Has anyone applying for coverage received treatment or had treatment recommended for drug or alcohol abuse, or been convicted of a drug or alcohol related offense (including a DUI)?	☐ Yes	☐ No
3 **Other than indicated elsewhere on this application**, has anyone applying for coverage had an implant (e.g., breast, chin, or penile implant), internal fixation (e.g., pins, plates, rods, screws), prosthesis, pacemaker, heart valve replacement, shunt, or monitoring device?	☐ Yes	☐ No
4 Has anyone applying for coverage had testing performed and are currently **waiting for results**, or been advised to have treatment, testing, counseling, therapy, or surgery which has **not yet been performed**?	☐ Yes	☐ No

Within the past TWELVE (12) MONTHS:		
5 Has anyone applying for coverage experienced unexpected weight gain or loss of more than 20 pounds?	☐ Yes	☐ No
6 Has anyone applying for coverage used any tobacco product (such as cigarettes, snuff, chewing tobacco, or any nicotine substitution product)? ▶ If yes, indicate who: ☐ Primary Applicant ☐ Spouse/Domestic Partner ☐ Dependent Children	☐ Yes	☐ No
7 Has anyone applying for coverage participated in any dangerous or extreme sport activities, including, but not limited to: organized automobile/motorcycle/powerboat racing, skydiving, bungee jumping, ultralight flying, scuba diving, hang gliding, or outdoor rock/mountain climbing?	☐ Yes	☐ No

If yes, indicate:

Who & Which Activity	When/How Often	Do you plan continued participation?
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No

8 **Other than indicated elsewhere on this application**, has any person applying for coverage **EVER** been treated, hospitalized, or had surgery for:

- bypass? ☐ Yes ☐ No
- angioplasty? ☐ Yes ☐ No
- stent? ☐ Yes ☐ No
- aneurysm? ☐ Yes ☐ No
- valve replacement? ☐ Yes ☐ No
- cancer? ☐ Yes ☐ No
- stroke? ☐ Yes ☐ No
- congenital abnormality? ☐ Yes ☐ No
- organ or bone marrow transplant? ☐ Yes ☐ No

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

9 For **EACH** person applying for coverage, complete the following information regarding his/her **last physical exam** (including checkups):

Self Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Spouse/Domestic Partner's Name: _____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

10 For **EACH** person applying for coverage, provide the following <u>current</u> information regarding his/her **height and weight**:

Self Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Spouse/Domestic Partner's Name: _____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

F Additional Information

If you answered "YES" to any of the questions in Section E, you must provide additional information below. For an example of how to fill out this section, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Attach a separate sheet for additional information if necessary.

Question Number: _____ Name of Individual: _____

Condition/Diagnosis: _____

Treatment Received: _____

_____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: _____

Additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? ☐ Yes ☐ No

Physician Name _____

Phone # (_____)_____ City & State _____

PRIMARY APPLICANT NAME ______________________________ DATE ____________________

DEPENDENT NAME (If submitted separately) ____

Question Number: _______ **Name of Individual:** ______________________________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________________________

Additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ______________________________

______________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (__________)____________________ City & State ______________________________

Question Number: _______ **Name of Individual:** ______________________________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________________________

Additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ______________________________

______________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (__________)____________________ City & State ______________________________

Question Number: _______ **Name of Individual:** ______________________________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________________________

Additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ______________________________

______________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (__________)____________________ City & State ______________________________

Question Number: _______ **Name of Individual:** ______________________________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________________________

Additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ______________________________

______________________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (__________)____________________ City & State ______________________________

PRIMARY APPLICANT NAME ______________________ DATE ______________

DEPENDENT NAME (If submitted separately) ____________________________

G Prescription Information within the Last Twelve (12) Months

Within the past 12 months, has anyone applying for coverage been prescribed medication (other than for the common cold or flu) that is **not indicated elsewhere in this application**? ☐ Yes ☐ No

Attach a separate sheet for additional information if necessary.

Name of Individual: ____________________

Name of Medication: ____________________

Reason for Taking: ____________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____________________

Phone # (______)______________ City & State ______________

Name of Individual: ____________________

Name of Medication: ____________________

Reason for Taking: ____________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____________________

Phone # (______)______________ City & State ______________

Name of Individual: ____________________

Name of Medication: ____________________

Reason for Taking: ____________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____________________

Phone # (______)______________ City & State ______________

Name of Individual: ____________________

Name of Medication: ____________________

Reason for Taking: ____________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____________________

Phone # (______)______________ City & State ______________

Name of Individual: ____________________

Name of Medication: ____________________

Reason for Taking: ____________________

First & Last Treatment Date: ______________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ____________________

Phone # (______)______________ City & State ______________

PRIMARY APPLICANT NAME _____ DATE _____

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. 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.
3. I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
4. **All of the answers provided within this application are, to the best of my knowledge and belief, true and complete.** For more information, please visit the Illinois Department of Insurance's website at www.insurance.illinois.gov.

STATEMENT OF UNDERSTANDING

I understand and agree that:

- The information I have provided in this application will be used by the insurer to determine whether to extend coverage and the premium amount 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.
- Except for a dependent up to the age of 19, coverage for preexisting medical conditions may be excluded or be subject to a waiting period of up to 24 months.
- 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 effect 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:

(Please list below the names of all the insurers to whom you are submitting this application).

Insurer: _____ Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____ Insurer: _____

PRIMARY APPLICANT NAME _____ DATE _____

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.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____Date _____
Primary Applicant (or Authorized Legal Representative) Signature

_____Date _____
Spouse / Domestic Partner 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)

✪ For assistance in completing this application, please contact your insurance agent or the insurance company directly. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance, toll free at (877) 527-9431.

PRIMARY APPLICANT NAME _____ DATE _____

TO BE COMPLETED BY AGENT
I. Agent/Producer Information

I certify that:
1. All answers provided in this application were completed by or provided by the applicant.
2. I have reviewed this enrollment form to ensure that all required items have been completed.
3. I am not aware of any information not disclosed on this enrollment form relating to the health, habits, or reputation of any person listed on this enrollment form, which might have a bearing on the risk.

1. Producer/Writing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	
Producer Signature: Date Signed: (A faxed signature shall be valid as an original signature.)	

2. Agent/Managing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	
Agent Signature: Date Signed: (A faxed signature shall be valid as an original signature.)	

PLEASE KEEP THE FOLLOWING SECTIONS FOR YOUR RECORDS

NOTICE OF INFORMATION PRACTICES:

In order to properly underwrite and administer your insurance coverage, we must collect personal information concerning your insurability. You are our most important source of information, but we may also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see (and copy if you wish) items of personal information about you which appear in our files, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment, or deletion of information you believe to be inaccurate.

If you have questions or desire additional information about the items disclosed above, please write to us at Celtic Insurance Company, Underwriting Department, 233 South Wacker Drive, Suite 700, Chicago, IL 60606.

Requests for medical information will only be disclosed to your attending physician.

CONDITIONAL RECEIPT FOR HEALTHPLAN:

ALWAYS COLLECT THE INITIAL PREMIUM AND GIVE THE APPLICANT THIS CONDITIONAL RECEIPT.

No insurance will become effective prior to the approval of your application by Celtic. No producer or broker is authorized to alter or waive any of the following provisions of the receipt:

Applicant's Name: _____

Social Security Number: _____

Amount Received: _____

Date: _____

Coverage will become effective on the "Effective Date" (as defined below) if all of the following conditions are met: (1) On the Date of Application, the applicant and all proposed insureds must be a risk acceptable to Celtic. (2) If Celtic cannot determine the acceptability of the applicant(s) as defined in (1) above, due to the nonreceipt (within 60 days of the date of application) of medical or other material information that Celtic has requested from the applicant or other sources; then this condition has not been fulfilled and no coverage will be provided under the terms of this Conditional Receipt. (3) The initial premium, equal to one month/quarter of the first yearly premium has been paid, and the check, credit card or bank draft is honored on the first presentation for payment.

"Effective Date" as used herein means 12:01 a.m. on the later of: (A) the Requested Effective Date; (B) the day following the postmarked date on the application envelope addressed to Celtic; the day following the fax date to Celtic; or the date after the electronic submission of the application to Celtic.

If no postmarked date, the effective date is the day after the confirmed receipt date of the application. **Note: Metered mail is not an acceptable postmark.**

ILLINOIS
HIPAA Notice OF Privacy Practices For Protected Health Information ("PHI")
For CELTIC Insurance Company ("Celtic")
EFFECTIVE NOVEMBER 1, 2003

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information.
Please Review It Carefully.

Celtic is committed to protecting the confidentiality and security of information it collects about you and does not share information about you with any other companies for their use in marketing products to you. **If the practices described in this Notice are acceptable to you, there is nothing you need to do.** If after reading this notice you still have questions, feel free to send them to Attn: HIPAA Privacy Officer, 233 South Wacker Drive, Suite 700, Chicago, IL 60606.

You have received this notice because of your proposed or actual health insurance coverage with Celtic Insurance Company. Celtic is required by federal law to maintain the privacy of your Protected Health Information ("PHI"), and to provide you with this notice of its legal duties and privacy practices regarding your PHI. Celtic is required to abide by the terms of this notice as currently in effect, and reserves the right to change the terms of this notice and to make new notice provisions effective for all PHI that it maintains. Notice of any such changes will be provided to you.

1. Protected Health Information ("PHI"):
This notice describes how Celtic may use and disclose your PHI if needed, to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, which is individually identifiable information that relates to your past, present or future health or condition and related health care services. Examples of PHI used by Celtic include, but are not limited to, your application for coverage and claims submitted by you or health care providers on your behalf.

2. Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations:
Your PHI may be used and disclosed by Celtic for purposes of payment or health care operations. Celtic may use or share your PHI with providers for payment purposes. Celtic may share your PHI with third party "business associates" that perform various functions for the Company. Celtic maintains written agreements with its business associates contractually binding them to protect the privacy of your PHI. Celtic may use or disclose, as needed, your PHI to support the Company's business activities related to providing health insurance benefits. These activities may include, but are not limited to, quality assessment, underwriting, premium rating, actuarial analysis, reinsurance, medical review, legal services, auditing, fraud and abuse detection, regulatory compliance, business planning and development, and general management and administration.

3. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object:
Celtic may use or disclose your PHI in certain circumstances without your consent or authorization. These situations may include, but are not limited to, the following:

Required by Law: Celtic may use or disclose your PHI to the extent state or federal law requires use or disclosure. Any use or disclosure will be compliant with applicable law, and will be limited to the requirements of such law. Celtic will notify you of the uses or disclosures if the law requires such notification.

Public Health: Celtic may disclose your PHI to a public health authority for public health activities and purposes if applicable law permits the authority to collect or receive the information. Celtic also may disclose your PHI, when directed by a public health authority, to a foreign government agency that is collaborating with such authority.

Health Oversight: Celtic may disclose PHI to a health oversight agency for activities authorized by state or federal law, such as audits and investigations.

Abuse or Neglect: Celtic may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. Furthermore, Celtic may disclose your PHI to the governmental entity authorized to receive such information, in accordance with state or federal law, if the Company reasonably believes that you have been a victim of abuse, neglect or domestic violence.

Legal Proceedings: Celtic may disclose PHI in the course of judicial or administrative proceedings, in response to a court order or administrative tribunal, to the extent such disclosure is expressly authorized, and in response to a subpoena, discovery request, or other lawful purpose.

Military Activity and National Security: Celtic may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that

foreign military. Celtic also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities.

4. Other Permitted or Required Uses and Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to Object:

Celtic may use or disclose your PHI in certain circumstances with your consent, authorization or if you have no objection. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of your PHI, then Celtic may determine, using professional judgment, whether such use or disclosure is in your best interest. If such circumstances arise, only the PHI that is necessary and relevant to the provision of your health insurance benefits will be disclosed.

EOBs Sent to Primary Insured: Unless you object and instruct otherwise, all explanations of benefits ("EOBs"), including your spouse, will be sent to the primary insured person.

5. Uses and Disclosures of PHI Based Upon Your Written Authorization:

Celtic may engage in other uses and disclosures of your PHI upon receiving your written authorization. You may revoke an authorization, in writing, at any time, except to the extent that an action has been taken in reasonable reliance on the use or disclosure indicated in the authorization.

6. Your Rights:

The following is a description of your rights with respect to your PHI and a brief description of how you may exercise those rights.

Inspect and Copy Your PHI: You may obtain and inspect a copy of your PHI that is in a designated record set for as long as Celtic maintains it. However, federal law prohibits Celtic from allowing an inspection or copy of psychotherapy notes; privileged information compiled in reasonable anticipation of or use in a legal proceeding; or PHI that is subject to a law which prohibits its access. If you wish to receive a copy of your PHI, your request must be made using Celtic's "Medical Records Request" form. You may request this form by submitting a written request to Attn: HIPAA Records Request Department, Celtic Insurance Company, 233 S. Wacker Dr., Suite 700, Chicago, IL 60606. Note that there is a fee of $25 per provider that must be received by Celtic from you before records will be released. Since your health care providers are the original source of this information, and they may or may not charge a fee for copies, you may wish to request this information from your provider(s) before requesting it from Celtic.

Place a Restriction on Your PHI: You may request that Celtic not use or disclose your PHI. Your request should be in writing, it must state the specific restriction requested, and it must state to whom the restriction applies. Your request should be sent to: Attn: Policyowner Service Department, Celtic Insurance Company, P.O. Box 33839, Indianapolis, IN 46203-0839. Celtic is not required to agree to a request for such a restriction, but will deny such a request only for a reasonable reason and will provide a written explanation of the reason for the denial. If Celtic agrees to the restriction, it may still disclose your PHI as permitted by law, or if your restricted PHI is needed for emergency medical treatment.

Alternative Means of Receiving Confidential Communications: You have the right to request that Celtic send and/or receive confidential communications by alternative means or to an alternative location. Celtic will accommodate your reasonable requests. Your request should be sent to: Attn: Policyowner Service Department, Celtic Insurance Company, P.O. Box 33839, Indianapolis, IN 46203-0839.

Amend Your PHI: You may request an amendment to your PHI in a designated record set for as long as Celtic maintains this information. Your request must be in writing, provide a reason to support the requested amendment, and sent to Attn: HIPAA Records Request Department, Celtic Insurance Company, 233 S. Wacker Dr., Suite 700, Chicago, IL 60606. In certain circumstances, Celtic may deny your request for an amendment. If Celtic denies your request for an amendment, you have the right to submit a statement of disagreement and Celtic may prepare a rebuttal to your statement. Celtic will provide you with a copy of any rebuttal. Since your health care providers are the original source of this information, you may consider making a request to amend your PHI directly to the individual providers.

Receive an Accounting of Certain Disclosures: You have the right to request an accounting of disclosures Celtic has made of your PHI. However, this right does not include any disclosures Celtic has made for purposes of treatment, payment or healthcare operations as described in this notice, nor does it include disclosures made for notification purposes. Please note that at the current time Celtic does not disclose PHI for any reason other than treatment, payment or healthcare operations.

Complaints: You have the right to voice a complaint to the U.S. Secretary of Health and Human Services if you believe your privacy rights have been violated. You also may file a complaint with Celtic by sending it to Attn: HIPAA Privacy Officer, 233 South Wacker Drive, Suite 700, Chicago, IL 60606. Celtic will not retaliate against you for filing a complaint.

Insured by Celtic Insurance Company

Celtic Group Company