



INDIVIDUAL MEMBER APPLICATION FOR “ELIGIBLE INDIVIDUALS”

NOTE: See Eligible Individual Certification, page 2, to determine if qualified to apply for this coverage.

APPLICANT NAME				DATE OF BIRTH			SEX		HT.		WT.
LAST	MAIDEN NAME (IF APPLICABLE)	FIRST	MIDDLE INITIAL	MO.	DAY	YR.	MALE <input type="checkbox"/>	FT.	IN.	LBS.	
							FEMALE <input type="checkbox"/>				
HOME ADDRESS							HOME PHONE				
STREET	APT. #	CITY	COUNTY	STATE	ZIP CODE		()				
SOCIAL SECURITY NUMBERS			EMPLOYERS (exact name)		OCCUPATIONS AND DUTIES			BUSINESS PHONE			
APPLICANT:			APPLICANT:		APPLICANT:			()			
SPOUSE:			SPOUSE:		SPOUSE:						
Marital Status		SPOUSE'S FULL NAME				DATE OF BIRTH			HT.		WT.
<input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Spouse Deceased		INCLUDE MAIDEN NAME (IF APPLICABLE)				MO. DAY YR.			FT. IN.		LBS.
Are Dependents (spouse and/or children) to be insured?		No. of Dependents (including spouse and/or children)		Children's Names, Dates of Birth, Social Security Nos. & Sex (M/Male, F/Female), if to be insured							
<input type="checkbox"/> YES <input type="checkbox"/> NO				_____ _____ _____							

A. A dependent child age 19 or over may be eligible for coverage until age 23 (maximum age may vary by state law). Are any of the dependents listed above enrolled as a full-time student (12 credit hours) in an accredited college or university and primarily dependent upon the applicant for support? Yes No
 If "Yes", provide name(s) of child(ren) and the name(s) and address(es) of school(s): _____

B. Are there any dependents listed on this application who are not covered under the policy that is being replaced? Yes No
 If "Yes", please list: _____

C. **The Applicant's check, made payable to Central Reserve Life, equal to the initial insurance premium and administration charge, is required. Agent's checks will not be accepted. No insurance coverage is in effect until you receive written notice of approval from CRL's Home Office. The agent has no authority to change benefits or bind coverage with CRL. If the insurance applied for does not become approved, CRL's only obligation will be to refund the amount paid for insurance premium.**

D. **REQUESTED EFFECTIVE DATE:** _____ If approved, the actual effective date will be determined by CRL's Home Office and may differ from the requested effective date.

E. **PLAN DESIRED:** Basic Standard Basic PPO Standard PPO; PPO Network: _____

F. **METHOD OF PREMIUM PAYMENT AND ADMINISTRATION CHARGE**
 Monthly Quarterly Semi-annually Bank-o-matic (Must be selected in conjunction with a billing mode)

G. **PREMIUM CALCULATION: (TO BE COMPLETED BY THE AGENT)**
 County Code: _____

1. Applicant or Applicant + Spouse Premium	\$ _____
2. Administration Charge	\$ _____
Total Premium and Charges = \$ _____	

The soliciting agent has no authority to waive the requirement of full disclosure of health history on this application. You must check each answer to make sure it is correct and complete before you sign. Do not sign a blank application.

1. Have you or any of your dependents EVER been diagnosed as having or been examined, medically advised, or treated in any way for:
 - a. Heart problem/condition, any circulatory disorder, cancer (malignancy), stroke, any birth defect/disorder, blood disorder, respiratory disorder, digestive/intestinal disorder, urinary system disorder, liver disorder, Multiple Sclerosis or Cerebral Palsy, history of premature birth or infertility or ever tested positive (Elisa-Elisa-Western Blot Series) for HIV (Human Immunodeficiency Virus)? YES NO
 - b. Any nervous, mental, or behavioral disorder, or chemical, alcohol or drug abuse or addiction, or used illegal drugs, or used prescription medication other than prescribed? YES NO
2. During the past FIVE YEARS, have you or any of your dependents consulted, been examined or treated by a doctor or other health care practitioner or been hospitalized or operated on for any condition not listed above? YES NO
3. Are you or any of your dependents (whether or not to be covered) currently under a doctor's care, taking medication, contemplating medical/surgical care, consultation or treatment in the future, or currently pregnant? YES NO

If the answer is "YES" to any of the above questions, provide full details below and address(s) of doctor(s)/ hospital(s) and complete the appropriate section(s) of a Health History Questionnaire.

Name	Name of Doctor/Hospital/Clinic	Address	Reason Seen/Diagnosis

APPLICANT'S "ELIGIBLE INDIVIDUAL" CERTIFICATION:

I certify to CRL that I am an "Eligible Individual" under applicable law and, as such, that I meet all of the following requirements:

1. As of the date on which I am applying for coverage, I have been insured under Creditable Coverage (as defined in Section 2701[c] of HIPAA or other applicable law) for at least 18 months (in general, "Creditable Coverage" is any form of major medical health insurance); and
2. My most recent period of creditable coverage was under a group health plan (an employer-sponsored plan), a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plan); and
3. I am not eligible for any of the following:
 - a. a Group Health Plan (an employer-sponsored plan);
 - b. part A or part B of title XVIII of the Social Security Act (Medicare); or
 - c. a State plan under title XIX of such Act (Medicaid, or any successor program); and
4. I do not have other health insurance coverage; and
5. My most recent health insurance coverage was not terminated for nonpayment of premiums or fraud; and
6. If I was offered the option of continuation coverage under COBRA, or under a similar state continuation program, I did not elect or, if elected, I did not exhaust such coverage because (check all that apply):
 - I neither worked, lived nor resided in the network service area (e.g., a PPO network).
 - I moved out of state and my former employer's group health plan did not provide coverage in the state of my new residence.
 - Other: _____

Please provide your most recent employer's name, complete address, and telephone number: _____

Date(s) of most recent employment: From _____ To _____

Does your current employer (or your spouse's employer, if applicable) offer group health insurance coverage (employer-sponsored)? Yes No If "Yes," provide the reason you declined to enroll: _____

Please attach your Certification(s) of Creditable Coverage to this application.

If you have creditable coverage but you do not have Certification(s) of Creditable Coverage from your former insurance carriers or employers, CRL may be able to assist you in obtaining the necessary certification(s) if you provide the following:

The names, addresses, telephone numbers and policy numbers of your previous health insurance issuers (carriers):

IMPORTANT INFORMATION – PLEASE READ CAREFULLY BEFORE SIGNING APPLICATION

I represent that, to the best of my knowledge and belief, all answers given in this application are accurate, complete and true. I understand CRL is relying on my answers in deciding whether to approve this application and that full and complete disclosure of the requested health information must occur for insurance to go into effect and that if I omit any of the requested health information, no insurance will go into effect for myself or my dependents. I understand the agent has no authority to alter or waive this, or any other, condition of coverage.

I have not disclosed to the agent any health information which is not disclosed on this application. I understand that this application, if accepted, shall become a part of the policy(ies) and any incomplete, incorrect or misleading answers may operate to void any insurance provided to me and my dependents. I understand that any Health History Questionnaire, if completed by me, becomes a part of this application.

I understand that limitations exist on coverage of Preexisting Illnesses.

I understand pre-certification of certain outpatient procedures and tests, as well as pre-admission certification of all hospital admissions (both emergency and non-emergency), is required; otherwise, any benefits which may be payable will be reduced according to the terms of the policy.

I hereby waive my physician-patient privilege and authorize any physician, practitioner, hospital, or medically related facility, insurance company, or other organization, institution or person that has my records or knowledge of me or any member of my family to give to CRL, its reinsurer(s), its hospital pre-certification firm or its individual benefits management firms any such records or information. Records or information shall also include, but are not limited to, driving records, use of alcohol, or use of controlled or prohibited substances. Such records or information will be used to determine eligibility for the insurance applied for. I also authorize CRL to provide information to its reinsurer or any other organization which performs services in connection with the insurance relationship including, but not limited to, the Writing Agent and General Agent or as may be lawfully required. CRL reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties without authorization. I have the right to request access to all personal information collected and, upon written request, I may ask CRL to correct, amend or delete any incorrect personal information. In certain states, a "Notice of Insurance Information Practices" is available upon request. This authorization shall be valid for a period of two (2) years from the date signed. A photocopy of this authorization shall be as valid as the original. I understand that I or my authorized representative may receive a copy of this authorization on request.

I understand no insurance exists unless and until I receive approval in writing from CRL's Home Office indicating coverage for me and my dependents and the effective date. If at any time prior to such notification, anyone applying for coverage (including myself, spouse, and dependents) consults a doctor, is hospitalized, or has any change in health, I agree to inform CRL's Home Office immediately. I understand that the agent does not have the authority to vary or waive any of the provisions of this application, nor any of the provisions, terms or conditions of any other forms or materials supplied by CRL nor to bind CRL to any promise of coverage.

I, the undersigned, understand that Central Reserve Life Insurance Company (CRL) will confirm the information on my application for insurance with a verification telephone call. It is my understanding that this verification call takes approximately ten (10) minutes and is a routine process for those applying for coverage with CRL and that this telephone call will be tape recorded. I also understand that my application will not be considered if verification is not completed. I understand that I must tell CRL if my health condition or if the health condition of any of my dependents changes between the date this application is signed and the date I receive written notification of approval, providing coverage is approved by CRL's Home Office.

I or my spouse (if applicable) may be contacted at the telephone numbers listed below. [If you cannot be contacted, please call Central Reserve Life at 1-800-253-4651.]

Member () Spouse () Telephone No. () _____ Time ____ a.m./p.m. Work () Home () Other ()

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NOTICE: For Ohio residents only: We are required by Ohio law to inform you of the following: "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."

Furthermore, by signing below, I acknowledge that:

- (i) I have read this application, the plan brochure, including any state-specific inserts and have had an opportunity to read and review a sample certificate booklet, and that I understand and accept the terms and conditions provided in all of the these materials, including, but not limited to, the plan benefits, exclusions, and limitations.
- (ii) Any disputes arising under the Policy are subject to an appeals procedure, including arbitration, which may be binding, depending on state law.
- (iii) I am an "Eligible Individual" under applicable law.

X _____ Date Signed _____
Signature of Applicant (Signature of Parent or Legal Guardian required if Applicant is under age 18)

X _____ Date Signed _____
Signature of Spouse

(THE APPLICANT MUST SIGN ABOVE IN ORDER FOR ANY COVERAGE TO BE CONSIDERED.)

PLEASE RETAIN A PHOTOCOPY OF THIS APPLICATION FOR YOUR RECORDS.

