

HEALTHAMERICA OHIO INSURANCE TRUST
TRUST PARTICIPATION AGREEMENT

In order to receive a certificate evidencing insurance coverage for the undersigned and their dependents under a group sickness and accident insurance policy (the "Policy") issued to the HealthAmerica Ohio Insurance Trust (the "Trust"), and underwritten by Coventry Health and Life Insurance Company, a Delaware corporation doing business as "HealthAssurance", the undersigned requests participation in the Trust. If the undersigned's participation in the Trust is approved by the Trustee (the "Trustee"), then the undersigned is an Insured (as the term is defined in the Trust Agreement) effective as of the date that the Trustee signs this Trust Participation Agreement. But, the undersigned acknowledges and agrees that even if they are approved by the Trustee as an Insured, neither the undersigned nor their dependents are insured under the Policy, until each satisfies the specific eligibility requirements of the Policy, as determined by HealthAssurance. All undefined capitalized terms have the meaning given them in the Trust Agreement.

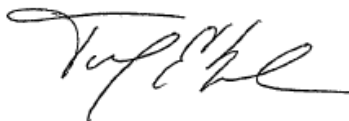
The undersigned acknowledges and agrees to be bound by all the terms and conditions of the Trust Agreement and Policy, as each may be amended from time to time, and specifically acknowledges and agrees: (a) to furnish any information that the Trustee or HealthAssurance requests and that is reasonably related to the proper administration of the Trust or Policy, (b) that they have no right, title or interest in or to the Trust Funds or the Policy, (c) benefits payable under the Policy are solely governed by the terms and conditions of the Policy and all claims and causes of action for benefits may only be asserted against HealthAssurance, and not against any other Insured, the Trust, or the Trustee, (d) Trustee has no rights or obligations under the Policy, (e) the undersigned may withdraw from the Trust and cancel coverage under the Policy upon 30 days prior written notice to the Trustee, (f) failure by an Insured to remit premium amounts when due automatically constitutes withdrawal and cancellation of all coverage effective as of the due date or last day of any applicable grace period, whichever is later.

The undersigned is executing this Trust Participation Agreement on the date set forth after their name.

Print: _____
Date: _____, 20____
Address: _____

ACCEPTED BY:

HEALTHAMERICA PENNSYLVANIA, INC.
As Trustee for the
HEALTHAMERICA OHIO INSURANCE TRUST



By: Timothy E. Nolan
Its: President and Chief Executive Officer
Date: _____, 20____



IMPORTANT NOTICE ABOUT
HealthAmericaOne Insurance Product

The insurance plan you are about to apply for (HealthAmericaOne™) is not an employer-sponsored health plan. Before you apply, you should be aware of the differences between employer-sponsored health plans and HealthAmericaOne.

HealthAmericaOne is offered through an out-of-state, Non-Employer Group Insurance Trust in Ohio. The trust is called the HealthAmerica Ohio Insurance Trust ("Trust"). It was set up to offer group health insurance to individuals who are not eligible for health care coverage through an employer.

The rules for Trusts are different from the rules for employer-sponsored health plans. A few of the differences are that HealthAmericaOne:

- Does not follow the rules of ERISA (Employee Retirement Income Security Act) or HIPAA (Health Insurance Portability and Accountability Act).*
Has a 12 month pre-existing condition exclusion.
If You are accepted for Coverage, Your premium rate will be calculated to include any Pre-existing Medical Condition that You disclosed on Your Enrollment Form, and such conditions will be Covered under the terms of Your Group Contract beginning on Your Effective Date.
Proof of prior creditable coverage does not reduce the exclusion.
Uses your health history to determine how much your premium will cost. This is called medical underwriting.
Can deny you coverage because of medical treatment you had in the past.

A non-employer group insurance trust like HealthAmericaOne has more flexibility to accept individuals who might not be eligible for coverage by an individual plan because of medical underwriting.

I certify by my/our signature(s) below that I/we have read and understand the above information pertaining to HealthAmericaOne pre-existing condition information.

Signature (Primary Applicant)

Date

Signature (Spouse)

Date

Signature (Dependent over 18)

Date

Signature (Dependent over 18)

Date

Signature (Dependent over 18)

Date

*The Employee Retirement Income Security Act of 1974 is a federal law that sets minimum standards for most health plans in private industry. The Health Insurance Portability and Accountability Act of 1996 is a federal law that has a provision to protect health insurance coverage for workers and their families when they change or lose their jobs.



Application / Health Statement Form

Non-Employer Group PPO Plans for the HealthAmerica Ohio Insurance Trust
Underwritten by Coventry Health and Life Insurance Company

Submit completed Application / Health Statement Form to: Attention: Individual Medical Underwriting Dept P.O. Box 67103 Harrisburg, PA 17106-7103 or by email at HapaApps@cvty.com or by fax at 1-866-347-2380.

To ensure timely processing of this Application:

- ✓ Use only blue or black ink
- ✓ All questions must be answered completely and accurately
- ✓ The Application must be signed and dated in each required section by all required Applicants
- ✓ All corrections must be initialed and dated; correction fluid is not permitted
- ✓ This Application is valid sixty (60) days from the earliest date of signature in the Conditions of Enrollment section.

FOR INTERNAL USE ONLY
EL CODE _____
 ACH
 HSA OPT-OUT PDP

FOR BROKER USE ONLY

Amount quoted for requested effective date:

\$ _____ / Month

Individual Family

Payroll Deduction Program (PDP)

Not Applicable

Name of PDP _____

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Check all that apply:

- New Application
- Plan Benefits Increase
- Plan Benefits Decrease
- Dependent Add
- Reinstatement
- New Minor Child-Only Application (under 18 years old)

REQUESTED EFFECTIVE DATE

1st day of _____ 20____

APPLICANT AND DEPENDENT INFORMATION

PRIMARY APPLICANT If Minor Child-Only Application, complete information about the child(ren)'s parent or legal guardian in this section.

Last name	First name	MI	Home phone () -
Residence address	City	State	ZIP code County
E-mail address	Occupation / Title		Business phone () -
Best time and place to receive a call from HealthAmericaOne regarding this Application, if necessary: <input type="radio"/> Home <input type="radio"/> Business <input type="radio"/> Other () _____ <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Evening			Relationship (if Minor Child-Only Application)
Mailing address (If different from address above)	City	State	ZIP code

PRIMARY APPLICANT'S SPOUSE (If applying for coverage in this Application)

Last name	First name	MI	Home phone () -
Residence address	City	State	ZIP code County
E-mail address	Occupation / Title		Business phone () -
Best time and place to receive a call from HealthAmericaOne regarding this Application, if necessary: <input type="radio"/> Home <input type="radio"/> Business <input type="radio"/> Other () _____ <input type="radio"/> Morning <input type="radio"/> Afternoon <input type="radio"/> Evening			
Mailing address (If different from address above)	City	State	ZIP code

PRIMARY APPLICANT AND ALL DEPENDENTS APPLYING FOR COVERAGE

1. Are all persons applying for coverage in this Application legal residents of the United States? Yes No
2. Have all persons applying for coverage in this Application legally resided in the United States for the past six (6) consecutive months? Yes No

If no, indicate person(s): _____

Country of residency: _____ Date of entry into the United States (mm/yyyy) _____

3. To be eligible to apply for coverage, care must be established with a physician located in the United States as of the date of this Application. Has care been established with a physician located in the United States for all persons applying for coverage in this Application? Yes No

If no, indicate person(s): _____

4. List Primary Applicant and all Dependents applying for coverage in this Application:

Full Name (Last, First, MI)	Gender (circle one)	Relationship to the Primary Applicant	Age	Birthdate (mm/dd/yyyy)	Disabled dependent? ¹	Social Security Number	Height (ft. in.)	Weight (lbs)	Tobacco use? ²
1.	M / F	SELF			N/A				<input type="radio"/> Yes <input type="radio"/> No
2.	M / F	SPOUSE			N/A				<input type="radio"/> Yes <input type="radio"/> No
3.	M / F				<input type="radio"/> Yes <input type="radio"/> No				<input type="radio"/> Yes <input type="radio"/> No
4.	M / F				<input type="radio"/> Yes <input type="radio"/> No				<input type="radio"/> Yes <input type="radio"/> No
5.	M / F				<input type="radio"/> Yes <input type="radio"/> No				<input type="radio"/> Yes <input type="radio"/> No
6.	M / F				<input type="radio"/> Yes <input type="radio"/> No				<input type="radio"/> Yes <input type="radio"/> No
7.	M / F				<input type="radio"/> Yes <input type="radio"/> No				<input type="radio"/> Yes <input type="radio"/> No

¹ Please check the appropriate box if the listed dependent is disabled.

² 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. If yes, provide details in the Additional Information Section

5. Are all of the Primary Applicant's dependent children accounted for in this Application for coverage? Yes No

If no, explain: _____

6. Is anyone applying for coverage in this Application required to provide health care coverage for a child pursuant to a qualified medical child support order or other court order? Yes No

If yes, explain: _____

7. Do all dependent children included in this Application reside with the Primary Applicant? Yes No

If no, complete the Custodial Parent section below. Note that the Custodial Parent must also sign the Authorization of Release of Information and Conditions of Enrollment Sections of this Application.

Child Name (Last, First, MI)	Custodial Parent Name (Last, First, MI)	Custodial Parent Address	Relationship to child
1.			
2.			
3.			

If no, skip to Lifestyle and Health History section. If yes, continue below:

Applicant Name (Last, First, MI)	Name of Company	Type of coverage (Group, Individual, COBRA, Short-Term, etc.)	Replacing other coverage?*** (Circle one)	If yes, anticipated Policy Term Date (mm/dd/yyyy)
1.			<input type="radio"/> Yes <input type="radio"/> No	
2.			<input type="radio"/> Yes <input type="radio"/> No	
3.			<input type="radio"/> Yes <input type="radio"/> No	

*** Is the coverage being applied for in this Application intended to replace other carrier's coverage?
 DO NOT cancel existing insurance coverage until notified in writing of approval of this Application by HealthAmericaOne.



THE FOLLOWING SECTION IS AN EXTREMELY IMPORTANT PART OF THIS APPLICATION AND REQUIRES YOUR CAREFUL TIME AND ATTENTION TO EACH AND EVERY QUESTION BELOW. YOUR FAILURE TO PROVIDE TRUTHFUL OR ACCURATE LIFESTYLE AND HEALTH HISTORY INFORMATION COULD RESULT IN A LOSS OF COVERAGE OR OTHER PENALTIES. WE RECOMMEND THAT YOU CONSULT YOUR PHYSICIAN IF YOU HAVE ANY QUESTIONS REGARDING THE INFORMATION BEING REQUESTED BELOW.

PLEASE NOTE THAT THE INFORMATION YOU ARE PROVIDING BELOW RELATES TO YOUR LIFESTYLE AND HEALTH HISTORY AND THE LIFESTYLE AND HEALTH HISTORY OF ANY OTHER PERSON APPLYING FOR COVERAGE UNDER THIS APPLICATION.

PLEASE NOTE THE ANSWERS TO THE QUESTIONS BELOW SHOULD BE ANSWERED BY YOU AND NOT BY AN AGENT OR BROKER REPRESENTING YOU.

LIFESTYLE AND HEALTH HISTORY

Check 'Yes' or 'No,' when applicable. Answer all questions completely. Unanswered questions will delay or stop processing. Provide details in the Additional Information section. In order to process your Application, additional information may be required. A HealthAmericaOne representative may call you to discuss your Application. You may be asked to complete a questionnaire or to provide medical records. Failure to obtain the needed information will result in our inability to process the Application.

If the health status of any Applicant herein changes between the signature date of this Application and the latter of the coverage effective date or approval date, HealthAmericaOne must be notified of the change in writing.

LIFESTYLE QUESTIONS

1. Is anyone listed in this Application (whether applying for coverage or not) currently pregnant, an expectant or surrogate parent, or in the process of adopting a child?	<input type="radio"/> Yes <input type="radio"/> No
2. Has any person applying to be covered <u>EVER</u> :	
A) Been advised to seek treatment for alcohol use or been advised to reduce alcohol intake, or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism?	<input type="radio"/> Yes <input type="radio"/> No
B) Been a member of any alcohol or drug support group?	<input type="radio"/> Yes <input type="radio"/> No
C) Used any illegal drugs or substances, or controlled substance not prescribed by a doctor, or been counseled for, diagnosed with, or treated for drug or chemical use or dependence (including prescription, non-prescription, or illegal)?	<input type="radio"/> Yes <input type="radio"/> No
3. In the past <u>FIVE (5) YEARS</u> , has anyone applying for coverage in this Application been cited or convicted of driving under the influence of alcohol or any drug?	<input type="radio"/> Yes <input type="radio"/> No
4. Within the past 12 months, has any person to be covered consumed alcoholic beverages? (Note: Even if only on occasion, please provide the number of drinks consumed on such occasions.)	
Applicant Name _____ # of drinks consumed per week: <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more	<input type="radio"/> Yes <input type="radio"/> No
Applicant Name _____ # of drinks consumed per week: <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more	
Applicant Name _____ # of drinks consumed per week: <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more	
5. Has anyone applying for coverage in this Application <u>EVER</u> been convicted of a felony, or been on, or is currently on probation? If yes, identify the person and details in the Additional Information Section.	<input type="radio"/> Yes <input type="radio"/> No

If any lifestyle questions were answered with 'yes,' the following information must be completed. Please explain and provide FULL DETAILS for each 'yes' answer to any of the preceding lifestyle questions and INDICATE TO WHICH APPLICANT THE INFORMATION APPLIES. If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Q #	Applicant Name (Last, First, MI)	Details of answer: Conditions, treatment, convictions, etc. (Indicate number of occurrences)	Start Date (mm/yyyy)	End Date (mm/yyyy)

HEALTH QUESTIONS

6.	Has anyone applying for coverage in this Application <u>HAVE OR EVER</u> had any signs or experienced symptoms that caused them or would cause an ordinary prudent person to seek advice, treatment or therapy, or consulted or sought medical treatment, been diagnosed, had medical treatment recommended, received medical treatment or therapy, been surgically treated, or been hospitalized for any of the following conditions:	
A)	Cancer, including but not limited to: melanoma, Hodgkin's disease, malignant sarcomas, carcinomas, tumors or cysts? If "Yes", provide location, type, stage, and treatment in the Additional Information Section.	<input type="radio"/> Yes <input type="radio"/> No
B)	Heart attack, heart disease, stroke, aneurysm, multiple sclerosis, or hepatitis B or C; or been a candidate or a recipient of an organ or bone marrow transplant? If "Yes", specify which organ, and/or if bone marrow transplant in the Additional Information Section.	<input type="radio"/> Yes <input type="radio"/> No
C)	Had any implants (breast or penile), devices such as pacemakers, shunts, stents, valve replacements, monitoring devices or internal fixation devices (plates, pins or screws) or prosthetics? If breast implant, specify type: <input type="radio"/> Silicone <input type="radio"/> Saline	<input type="radio"/> Yes <input type="radio"/> No
7.	Within the past <u>TEN (10) YEARS</u> , has anyone applying for coverage in this Application had any signs or experienced symptoms that caused them or would cause an ordinary prudent person to seek advice, treatment or therapy, or consulted or sought medical treatment, been diagnosed, had medical treatment recommended, received medical treatment or therapy, been surgically treated, or been hospitalized for any of the following conditions:	
A)	Cardiovascular disorders, including but not limited to: hypertension, or high blood pressure, chest pain, heart murmur, mitral valve prolapse, palpitations or heart rhythm disturbance or surgery? If history of hypertension, high blood pressure or elevated blood pressure readings, provide three (3) blood pressure readings and dates, including the highest reading within the last <u>SIX (6) MONTHS</u> . These readings must have been taken by a physician. Date _____ Reading _____ Date _____ Reading _____ Date _____ Reading _____ Highest reading in last SIX (6) MONTHS: Date _____ Reading _____	<input type="radio"/> Yes <input type="radio"/> No
B)	Blood disorders, including but not limited to: anemia, hemophilia, purpura, thrombocytopenia, leukemia, sickle cell anemia, abnormal white or red blood cells or abnormal bleeding?	<input type="radio"/> Yes <input type="radio"/> No
C)	Vein or artery disorders, including but not limited to: phlebitis, thrombosis, varicose veins or ulcers, peripheral vascular disease or clots and poor circulation?	<input type="radio"/> Yes <input type="radio"/> No
D)	Connective tissue disorders, including but not limited to: systemic (SLE) or discoid lupus, scleroderma, rheumatoid arthritis, CREST or Sjogren's syndromes?	<input type="radio"/> Yes <input type="radio"/> No
E)	Cerebrovascular disorders, including but not limited to: stroke, transient ischemic attack (TIA), carotid bruits, or cerebral (brain) hemorrhage?	<input type="radio"/> Yes <input type="radio"/> No
F)	Immune or lymph system disorders, including but not limited to: persistent lymph node enlargement, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV), persistent fever, persistent diarrhea, persistent fatigue, or weight loss of unknown cause?	<input type="radio"/> Yes <input type="radio"/> No
G)	Nervous system disorders, including but not limited to: headaches, migraines, dizziness, epilepsy, fainting, tremors, convulsions, seizures, paralysis, autism, Alzheimer's, Parkinson's, amyotrophic lateral sclerosis (ALS) or cerebral palsy?	<input type="radio"/> Yes <input type="radio"/> No
H)	Respiratory system disorders, including but not limited to: asthma, sinusitis, allergic rhinitis, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), dyspnea, tuberculosis, sarcoidosis or sleep apnea?	<input type="radio"/> Yes <input type="radio"/> No
I)	Metabolic or endocrine disorders, including but not limited to: obesity, elevated lipids (cholesterol, triglycerides), Diabetes or sugar intolerance; disorder of the thyroid, pituitary, adrenal, pancreas or other gland or goiter?	<input type="radio"/> Yes <input type="radio"/> No
J)	Musculoskeletal disorders, including but not limited to: arthritis, fibromyalgia, gout, back, neck or spinal column disorders such as herniated disc(s); osteopenia/osteoporosis, ankylosing spondylitis, fractures, dislocations or disorders, polio/post-polio syndrome, muscular dystrophy, amputation, or persistent or recurring pain of the muscles, bones or joints or had spinal adjustments or manipulation therapy?	<input type="radio"/> Yes <input type="radio"/> No

K) Urinary tract disorders, including but not limited to: kidney or bladder stones, cystitis or other urinary tract infections, urethral stricture or stenosis, kidney transplant or dialysis, renal failure or polycystic kidney disease?	<input type="radio"/> Yes <input type="radio"/> No
L) Hernias, including but not limited to: inguinal, scrotal, hiatal (diaphragmatic) or umbilical?	<input type="radio"/> Yes <input type="radio"/> No
M) Female reproductive system disorders, including but not limited to: infertility, irregular menstruation, uterine fibroids, uterine prolapse, endometriosis, abnormal PAP smears, caesarean section or other complications of pregnancy? Date / results of most recent PAP smear: Date (mm/yyyy): _____ Results: _____ Date / results of first prior PAP smear: Date (mm/yyyy): _____ Results: _____	<input type="radio"/> Yes <input type="radio"/> No
N) Ear, eye, nose, throat or skin disorders, including but not limited to: recurrent ear infections, Meniere's disease, deafness, blindness, cataracts, detached retina, glaucoma, optic atrophy, deviated nasal septum, nasal polyps, psoriasis, acne or skin tumors?	<input type="radio"/> Yes <input type="radio"/> No
O) Breast disorders, including but not limited to: breast cysts or tumors, fibrocystic breast disease, gynecomastia, mastitis or abnormal mammograms?	<input type="radio"/> Yes <input type="radio"/> No
P) Male reproductive disorders, including but not limited to: prostate disorder(s), elevated PSA testing, erectile dysfunction, infertility or male genital disorder?	<input type="radio"/> Yes <input type="radio"/> No
Q) Mental or nervous disorders, including but not limited to: attention deficit disorder, anxiety, depression, eating disorders, bipolar disorder, schizophrenia or psychotic disorder?	<input type="radio"/> Yes <input type="radio"/> No
R) Intestinal or rectal disorders, including but not limited to: Crohn's disease, ulcerative colitis, intestinal polyps, hemorrhoids, irritable bowel syndrome (IBS), diverticulitis / diverticulosis?	<input type="radio"/> Yes <input type="radio"/> No
S) Sexually transmitted diseases, including but not limited to: gonorrhea, chlamydia, human papillomavirus (HPV), syphilis, genital warts or genital herpes?	<input type="radio"/> Yes <input type="radio"/> No
T) Digestive system disorders, including but not limited to: gastroesophageal reflux disease (GERD), esophageal stricture, esophageal varices, cirrhosis or other liver disorder, spleen disorder, stomach or duodenal ulcer(s), gallbladder disease or gall stones?	<input type="radio"/> Yes <input type="radio"/> No
U) Abnormal diagnostic tests, including but not limited to: abnormal blood tests, abnormal MRI or CT scan, x-ray, bone density, abnormal electrocardiogram (EKG) or echocardiogram?	<input type="radio"/> Yes <input type="radio"/> No
8. Within the past FIVE (5) YEARS, has any person applying for coverage in this Application:	
A) Consulted or been examined or treated by any physician, chiropractor, psychologist, or other health care practitioner?	<input type="radio"/> Yes <input type="radio"/> No
B) Been to a clinic, hospital, emergency room, or other medical facility for treatment, confinement, or observation?	<input type="radio"/> Yes <input type="radio"/> No
C) Plan to, had, or been advised to have a procedure, tests or treatment that have not yet been performed except an AIDS test?	<input type="radio"/> Yes <input type="radio"/> No
D) Had any disease, disorder, ailment, injury or condition not listed in this Application for which there have been, or are plans or intentions to seek advice, diagnosis, or treatment?	<input type="radio"/> Yes <input type="radio"/> No

PRESCRIPTION MEDICATIONS AND INJECTION THERAPY

List all medications and injection therapy taken or prescribed within the last **TWELVE (12) MONTHS** for any Applicant listed on this Application. Please include any over-the-counter (OTC) medications taken on a regular basis. If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Applicant Name (Last, First, MI)	Medication / Dosage / Frequency (e.g., Lopressor™ / 100mg / daily)	Reason Prescribed / Taken	Date Prescribed (mm/dd/yyyy)	Still taking?	Date discontinued (mm/dd/yyyy)	Name, Address and Phone Number of Prescribing Physician
				<input type="radio"/> Yes <input type="radio"/> No		
				<input type="radio"/> Yes <input type="radio"/> No		
				<input type="radio"/> Yes <input type="radio"/> No		
				<input type="radio"/> Yes <input type="radio"/> No		

ADDITIONAL INFORMATION

If any health history questions were answered with 'yes,' the following information must be completed. Please explain and provide FULL DETAILS for each 'yes' answer to any condition(s) checked in the preceding questions and INDICATE TO WHICH APPLICANT THE INFORMATION APPLIES. If additional space is needed, list on a separate sheet of paper and attach to this Application to include the signature and date signed by the Applicants.

Q #	Applicant Name (Last, First, MI)	Conditions, treatment, operations (Indicate number of occurrences)	Date of onset (mm/yyyy)	Date of recovery (mm/yyyy)	Days in hospital	Last checkup for condition (mm/yyyy)	Results	Name, Address and Phone Number of Health Care Provider

NAMES OF HEALTH CARE PROVIDERS NOT LISTED ABOVE

Applicant Name (Last, First, MI)	Name, Address and Phone Number of Health Care Provider	Details of Last Visit		
		Date (MM/YYYY)	Reason for Visit	Result (Circle one. If abnormal, explain) Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal
				Normal / Abnormal

CONDITIONS OF ENROLLMENT

I represent that all information on this Application form is complete and accurate and true to the best of my knowledge. I understand that my answers to the questions on this form will be used as the basis to determine eligibility for coverage. I further understand that if any information is omitted or misrepresented, it could provide the basis to refuse, reform or rescind coverage and to adjust as applicable, or refund any premiums paid as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent statements I make voids my coverage or reduces my benefits. I understand that if my Application for coverage is declined, I may not apply for HealthAmericaOne coverage for six (6) months. I understand that if my health or any of the answers or statements provided herein change between the signature date of this Application and the latter of the coverage effective date or approval date, I must inform HealthAmericaOne of such in writing. I understand that failure to do so may result in the denial, reformation or rescission of coverage.

I understand and acknowledge that the selling agent, if applicable to this Application for coverage, has no authority to promise coverage to Applicants herein or to modify HealthAmericaOne underwriting policy or the terms of HealthAmericaOne coverage.

OHIO: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE 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.

PENNSYLVANIA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

THE EFFECTIVE DATE OF COVERAGE OF APPLICANTS LISTED HEREIN IS ASSIGNED BY HEALTHAMERICAONE AT ITS DISCRETION, SUBJECT TO MEDICAL UNDERWRITING AND AN OFFER OF COVERAGE AND PREMIUM AMOUNT BEING PRESENTED AND ACCEPTED.

DO NOT CANCEL EXISTING INSURANCE COVERAGE UNTIL NOTIFIED IN WRITING BY HEALTHAMERICAONE OF APPLICATION APPROVAL.

	DATE	SPOUSE'S SIGNATURE (If applying for coverage)	DATE
	DATE		DATE
*Required age 18 and over. If minor child-only application (under the age of 18), this section must be signed by the minor child (children's) parent or legal guardian identified in the Applicant and Dependent Information Section. <input type="radio"/> Check here if N/A			
	PRINT NAME	RELATIONSHIP TO APPLICANT	DATE

PREMIUM PAYMENT

Premiums due for coverage under a policy pursuant to the approval of this Application and acceptance of coverage will be paid from funds automatically deducted from either a checking or savings account, upon the Account Holder's authorization herein, subject to the HealthAmericaOne approval of this Application and the acceptance of an offer coverage. To facilitate the premium withdrawal this section must be completed in its entirety. This payment information does not guarantee approval or coverage.

Please Provide: Checking Account Savings Account

Name of Bank or Savings Institution: _____

9-Digit Routing Number: |_|_|_|_|_|_|_|_|_|

Account Number: _____

(A voided check or savings account deposit slip should be attached in support of content in this section)

Name of Account Holder: _____

Relationship of Account Holder to the Primary Applicant: Self Spouse Other _____

Permanent Address of Account Holder: _____

NAME _____ 0123
 ADDRESS _____
 CITY, STATE, ZIP _____ 01-23456789
 DATE _____
 PAY TO THE ORDER OF _____ \$ _____
 BANK NAME _____ DOLLARS
 ADDRESS _____
 CITY, STATE, ZIP _____
 FOR _____
 MICR LINE: @0123456789 @12345678901234 @123
 ROUTING # ACCOUNT #

Applicable Premium amount is automatically withdrawn from the account provided herein on the 10th day of each current coverage month, or next business day. The initial premium withdrawal may not occur until the 10th of the month following the first month of coverage and will account for the total amount owed from the original effective date. For example, if the first months' premium is calculated beginning on the 15th of the month but not withdrawn until the 2nd month of coverage, the amount due in the 2nd month will equal one and one half (1½) the total monthly premium amount. If the first months' premium is calculated beginning on the 1st of the month but not withdrawn until the 2nd month of coverage, the amount due in the 2nd month will be twice the total monthly premium amount.

Account Holder hereby authorizes HealthAmericaOne to collect the premium payment due on the 10th of the month, or next business day, via electronic funds transfer (EFT) or automatic withdrawal from the account identified and provided herein or then current.

By signing below, I authorize HealthAmericaOne to initiate automatic withdrawal of applicable premium payments from the account listed above.

I, the Account Holder, acknowledge and understand that it is my responsibility to notify HealthAmericaOne at 1-866-874-2624 should the payment information provided herein change while a policy of coverage pursuant to this Application remains in force and effect.

Account Holder Signature: _____ Date: _____

BROKER INFORMATION

The following sections are to be completed by the broker.

Broker Name:	Broker ID #:	Broker Email Address:
Broker Signature:	Agency Name:	Broker/Agency Phone: ()
Name of General Agent:	Payee (who is paid the commissions) <input type="radio"/> Broker <input type="radio"/> Agency <input type="radio"/> General Agent	Payee Tax ID#

PRODUCER CERTIFICATION

I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this Application or any supplement to it. I have not advised the Applicant to withhold any information regarding the answers to the questions and have advised the Applicant to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that all my answers recorded above are correct, complete, and wholly true to the best of my knowledge and belief.

Producer Signature _____ Date _____

AUTHORIZATION OF RELEASE OF INFORMATION

I, for myself and any of my Dependents who are under the age of 18 who and are applying for coverage hereunder, hereby make the following authorizations, which are valid for up to thirty (30) months from the date signed:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to HealthAmericaOne or its authorized representatives, my (or my Dependents') personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I also authorize the release of information relating to mental illness.

In addition, I authorize HealthAmericaOne to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by HealthAmericaOne for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for HealthAmericaOne to consider my Application and to determine whether or not an offer of coverage will be made. No action will be taken on my Application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by HealthAmericaOne as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request.

I authorize HealthAmericaOne to use or disclose the information I provide in this Application (or that the HealthAmericaOne has or receives from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by law. Any revocation will not affect the activities of HealthAmericaOne prior to the date such revocation is received by HealthAmericaOne.

PRIMARY APPLICANT'S SIGNATURE	DATE	SPOUSE'S SIGNATURE (If applying for coverage)	DATE
DEPENDENT APPLICANT SIGNATURE*	DATE	DEPENDENT APPLICANT SIGNATURE*	DATE
*Required age 18 and over.			
If minor child-only application (under the age of 18), this section must be signed by the minor child (children's) parent or legal guardian identified in the Applicant and Dependent Information Section. <input type="checkbox"/> Check here if N/A			
PARENT / LEGAL GUARDIAN SIGNATURE	PRINT NAME	RELATIONSHIP TO APPLICANT	DATE