

Last Name _____ First Name _____ Social Security Number _____

Health Statements — All Questions Must Be Answered Before Application is Processed

Please check the Yes box if you or any person applying for coverage ever received, in the past five years, medical services from a health care provider for any of the conditions listed below. If YES is checked, please explain completely and in detail in the space provided on the next page.

YES NO

- 1. Any arthritis, fibromyalgia, lupus, connective tissue disease, gout, osteoporosis, spina bifida, polio, or temporal mandibular joint (TMJ) disorder.
- 2. Any disease or injury, including fractures, dislocations and bone disorders secured with/without pins or screws.
- 3. Any disease or injury to joint(s) including back, neck and spine, such as diminished range of motion in the joints (if yes, please indicate the joint(s) affected).
- 4. Any loss of limb.
- 5. Any disorder or injury to tendons, including diminished range of motion.
- 6. Chest pain, shortness of breath, heart murmur, irregular heartbeat, heart attack, congestive heart failure, rheumatic fever, heart valve disorder, aneurysm, high cholesterol or high blood pressure or any other heart disorder.
If yes to high cholesterol or blood pressure, please provide readings and date even if no treatment was recommended.
a) Cholesterol reading: _____ Date: _____ b) Blood pressure reading: _____/_____ Date: _____
- 7. Anemia, leukemia, hemophilia, varicose veins, clots, phlebitis, poor circulation or any other vein, artery or blood disease or disorder.
- 8. HIV infection, AIDS, AIDS Related Complex (ARC) or tested positive for HIV or other diseases related to the immune system other than HIV.
- 9. Any disease or disorder of the esophagus, stomach, intestines, bowels, rectum, gallbladder, pancreas or spleen; including reflux, heartburn, gastritis, diverticulitis, diverticulosis, hernia, colitis, hemorrhoids, ulcerative colitis, Crohn's disease or liver disorder including cirrhosis or Hepatitis A, B or C.
- 10. Ear infections, Meniere's disease, hearing impairment, deviated nasal septum, sinusitis, sinus problems or any other disorder of the ear, nose or throat.
- 11. Diabetes, hypoglycemia, thyroid disorder, goiter, pituitary disorder or any other disorder of the glands.
If answer is yes to diabetes, please answer the following: Date of Diagnosis: _____
Controlled by: Diet ___ Oral Medication ___ Insulin ___ (units per day).
Please provide the most current hemoglobin A1C reading completed within the past six months. Reading: _____ Date: _____
- 12. Cystic acne, actinic keratosis, psoriasis, eczema, severe burn, severe scars or any other skin disorder.
- 13. Any disorder of the brain, nervous system, including chronic fatigue syndrome, epilepsy, seizures, convulsion, fainting spells, Lyme disease, meningitis, multiple sclerosis, muscular dystrophy, cerebral palsy, sleep disorder, paralysis, Alzheimer's, Parkinson's disease, stroke, TIAs (Transient Ischemic Attacks), migraine or recurrent headaches. If yes to seizures or convulsion, provide date of last episode.
Date: _____
- 14. Disorder of the male or female reproductive organs including enlarged prostate, prostatitis, menstrual irregularities or disorder, endometriosis, fibroid uterus (benign tumor or mass in or on the uterus), abnormal pap smear, ovarian cyst, polycystic ovaries or sexually transmitted disease, infertility or impotency. (If abnormal pap smears, please provide copies of last two pap smear results.)
- 15. Breast disorders, fibrocystic disease, breast implant (saline or silicone) please specify.
- 16. Nephritis, kidney stones, kidney reflux, bladder infections, kidney infections, blood in urine or any other disease or disorder of the bladder, kidneys or urinary system.
- 17. Any type of cancer, tumors, cysts, polyps or other growth. If yes, please provide the location _____.
- 18. Crossed eyes, detached retina, retinopathy, cataract, glaucoma or any other eye injury or disorder. If glaucoma, give most recent eye pressure reading for each affected eye.
Left Eye Reading: _____ Date: _____ Right Eye Reading: _____ Date: _____
- 19. Allergies (including allergy shots), hay fever, asthma, emphysema, pleurisy, tuberculosis, chronic bronchitis, chronic cough, chronic obstructive pulmonary disease or any other disease or disorder of the lungs or respiratory system.
- 20. Any nervous, mental or emotional conditions, attempted suicide, depression or any of the following disorders such as: bipolar/manic, anxiety, schizophrenia, attention deficit disorder, anorexia or bulimia, mental retardation, individual, marital or family counseling. If any counseling received, provide date of last visit _____. If yes, frequency of visits, (circle one) weekly, monthly, other (explain _____).
- 21. Any other abnormality, deformity or congenital birth defect not listed which you now have or have received treatment for in the last five years?
- 22. Are you or any family member or dependent currently pregnant? (Including any dependent not applying for coverage.)
If yes, Name: _____ Due Date: _____
- 23. Have you or any person applying for coverage ever had or been advised to have a transplant of any type in the last five years including stem cell?
- 24. Within the last 12 months have you or any person applying for coverage been advised to have surgery, treatment, tests or studies that have NOT YET BEEN PERFORMED?
- 25. Have you or any person applying for coverage ever used or been treated or counseled in the last five years due to use of alcohol, sedatives, hallucinogens, illegal substance, narcotics or any other drugs, other than those prescribed by a physician? If yes, please indicate types of use; treatment; and, dates.
Date since last use: _____ Date and type of treatment: _____
- 26. Been convicted of a DUI in the last five years?
- 27. In the past five years have you or any person applying for coverage consulted a physician (MD, DO), psychiatrist, psychologist, social worker, chiropractor, nurse practitioner, physical, occupational or speech therapist or any other health care professional for any reason, including an annual physical or been hospitalized?
- 28. In the last 12 months have you or any dependent to be covered used tobacco?
- 29. In the past five years have you been treated for any condition not listed above? If yes, please indicate the condition:

Date: _____

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Professional Services (Please give COMPLETE details to all yes answers from Page 2)

Question # _____	Date of Onset/Treatment (Month/Year) _____	Last Date Treated _____	Still Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Family Member (As identified on Physician's Record) _____			
Name of Hospital, Clinic and/or Person Providing Care _____			
Street Address _____			
City, State, Zip _____			
Phone Number _____ Fax Number _____			
Name of Condition/Illness _____			
Treatment Rendered (e.g., X-ray, lab, surgical procedure, etc.) / Results: _____			

Question # _____	Date of Onset/Treatment (Month/Year) _____	Last Date Treated _____	Still Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Family Member (As identified on Physician's Record) _____			
Name of Hospital, Clinic and/or Person Providing Care _____			
Street Address _____			
City, State, Zip _____			
Phone Number _____ Fax Number _____			
Name of Condition/Illness _____			
Treatment Rendered (e.g., X-ray, lab, surgical procedure, etc.) / Results: _____			

Question # _____	Date of Onset/Treatment (Month/Year) _____	Last Date Treated _____	Still Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Family Member (As identified on Physician's Record) _____			
Name of Hospital, Clinic and/or Person Providing Care _____			
Street Address _____			
City, State, Zip _____			
Phone Number _____ Fax Number _____			
Name of Condition/Illness _____			
Treatment Rendered (e.g., X-ray, lab, surgical procedure, etc.) / Results: _____			

Applicant Information (Please complete this section at the top of each subsequent page.)

Last Name _____ First Name _____ Social Security Number _____

Question # _____	Date of Onset/Treatment (Month/Year) _____	Last Date Treated _____	Still Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Family Member (As identified on Physician's Record) _____			
Name of Hospital, Clinic and/or Person Providing Care _____			
Street Address _____			
City, State, Zip _____			
Phone Number _____ Fax Number _____			
Name of Condition/Illness _____			
Treatment Rendered (e.g., X-ray, lab, surgical procedure, etc.) / Results: _____			

Question # _____	Date of Onset/Treatment (Month/Year) _____	Last Date Treated _____	Still Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Family Member (As identified on Physician's Record) _____			
Name of Hospital, Clinic and/or Person Providing Care _____			
Street Address _____			
City, State, Zip _____			
Phone Number _____ Fax Number _____			
Name of Condition/Illness _____			
Treatment Rendered (e.g., X-ray, lab, surgical procedure, etc.) / Results: _____			

Question # _____	Date of Onset/Treatment (Month/Year) _____	Last Date Treated _____	Still Under Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Family Member (As identified on Physician's Record) _____			
Name of Hospital, Clinic and/or Person Providing Care _____			
Street Address _____			
City, State, Zip _____			
Phone Number _____ Fax Number _____			
Name of Condition/Illness _____			
Treatment Rendered (e.g., X-ray, lab, surgical procedure, etc.) / Results: _____			

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Creditable Coverage (All applicants **MUST COMPLETE** this section for accurate processing of application)

To be considered a **HIPAA eligible individual** eligible for guarantee issue coverage* and/or not subject to the pre-existing condition exclusion; you must have at least 18 months of creditable coverage without a 63-day break in coverage; your most recent health coverage must have been under a group health plan; you cannot currently be eligible for Medicare or Medicaid or be covered under any other health insurance; your most recent coverage cannot have been terminated due to fraud or non-payment of premiums; and if you were eligible for continuation coverage under COBRA or a similar state program, you elected such continuation coverage and you have fully exhausted that coverage available. *Guarantee issue coverage is available to Missouri Residents only.

Failure to answer the questions under this Section VI accurately may result in the loss of your rights as an eligible individual including the right to a guarantee issue policy and waiver of the pre-existing condition exclusion.

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you or any person applying for coverage had a minimum of 18 months of continuous health coverage most recently under a group health plan that is still active or that ended within the last 63 days for a reason other than fraud or non-payment of premium? If yes, please list names:
_____ |
| | | PLEASE PROVIDE CERTIFICATE(S) OF CREDITABLE COVERAGE. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Did you or any person applying for coverage elect COBRA or state continuation? If no, please explain. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. If COBRA or state continuation was elected, have you or any person applying for coverage exhausted COBRA or state continuation coverage? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you or any person applying for coverage have other health insurance coverage, or are eligible for any group health plan, Medicare or Medicaid? If yes, please list names and explain. |

Name	Medicare/Medicaid Policy Number	Effective Date	Medicare			
			Part A		Part B	
			Yes	No	Yes	No
			Yes	No	Yes	No

5. **For HIPAA eligible individuals only.** If you or any person applying for Advanced Choice coverage qualify as a HIPAA eligible individual then such individual is not subject to any pre-existing condition exclusion. However, a surcharge of approximately 10% of the underwritten premium will be added to your premium. You may elect to have the pre-existing condition exclusions apply on our ADVANCED CHOICE plans and no surcharge will be applied to the underwritten premium. **Do you wish to have your pre-existing conditions covered on the ADVANCED CHOICE health plan you elected in Section II for an additional surcharge? If so, we will notify you of the premium rate for this coverage.**

***If you mark 'no', pre-existing conditions will not be covered under the ADVANCED CHOICE plan for 12 consecutive months beginning on your effective date of coverage.**

If you are an Eligible Individual who resides in Missouri, your request for coverage cannot be denied due to your health conditions and you will not be subject to a pre-existing condition exclusion. You may not be eligible for the coverage you requested, but you will be offered, on a guaranteed issue basis, our \$500 Value Plus plan and \$1,000 Value plan. Please call us at (816) 271-1247 or (800) 990-9247 for rates on our guaranteed issue plans. Even if you meet the criteria for a guarantee issue policy, we will review your application for coverage to determine whether you qualify for another policy (with lower rates than our guarantee issue policies).

If you do not meet criteria to be HIPAA eligible, your contract will include a 12-month exclusion for pre-existing conditions.

Notice of Women's Health and Cancer Rights Act: Along with benefits detailed in your Certificate of Coverage and Schedule of Benefits, your benefits include coverage for (1) breast reconstruction in connection with a mastectomy, including reconstruction of the other breast to produce a symmetrical appearance; (2) prosthesis; and (3) treatment of physical complications from all stages of mastectomy, including lymphedemas. This coverage is subject to copayments, coinsurance and deductible consistent with other benefits under your plan. This notice is being provided in accordance with the Women's Health and Cancer Rights Act of 1998, a federal law.

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Agreement

I request coverage under the Advanced Choice Contract ("Contract") issued by Community Health Plan ("CHP"). I understand services will be available subject to the exclusions, limitations and benefits described in the Contract(s). I understand that the Contract is conditioned upon the truth contained herein. **I acknowledge that if I or any dependent is employed, such employer is not contributing toward the cost of this coverage.** I understand that any misstatement on this enrollment application may result in a denial of a claim, re-rate of the premium, discontinuation or rescission of coverage. **I understand that if at any time it is determined by CHP that a person listed on this application did not meet the Policy's definition of dependent, or I misrepresented any of the information contained herein; CHP and/or its subsidiaries have the right to re-rate, terminate or rescind coverage for that person or for all persons under the application and to recover any benefit payment for such person or persons.** I understand that in the absence of fraud, all statements I will make are considered representations and not warranties and no statement made by me voids coverage or reduces benefits unless the statement is material to the risk assumed and contained in the written application. Furthermore, after my coverage has been in force for two (2) years from the Effective Date, no statement except fraudulent statements I have made will void the coverage or reduce the benefits. I authorize health care providers, insurers, health plans, claims administrators and employers to provide CHP, or its representatives, any requested information available about my, and/or my dependents' employment and/or medical history, condition and treatment. This authorization also specifically applies to information relating to psychiatric histories and treatment, or HIV status. I authorize CHP to share such information as reasonably necessary with its representatives, provider organizations, or any other health plan or claims administrators. Such information may only be used for the following purposes: determining eligibility for coverage and benefits; administering coverage and claims for benefits; utilization review and case management; provider peer review; coordination of care; quality improvement; quality assessment and measurement, including surveys of members; accreditation; billing; or resolution of appeals and/or grievances. I authorize CHP to share such information with any provider for treatment purposes and to any such person who has an authorization to obtain such authorization, as may be required or permitted by law. I understand my medical records will be maintained with strict confidentiality by CHP in accordance with applicable federal and state laws. **(PARENT OR GUARDIAN SIGNATURE REQUIRED FOR MINORS YOUNGER THAN AGE 18.)**

Applicant's Signature _____	Spouse's Signature _____
Printed Name _____	Printed Name _____
Date _____	Date _____

Broker Representation (if applicable)

Printed Broker's Name _____

Broker Signature _____ Date _____

Agency Name _____

Pay Commission Checks to: Agency Broker Taxpayer ID Number (for Payee): _____

Telephone Number ____ (____) _____ E-Mail Address _____

Auto Debit is your easy monthly payment option!

- With Auto Debit electronic funds transfer, your monthly premium is automatically deducted from your checking account.
- Your premium will be paid automatically, on time, each month.
- Your account will be drafted on the 1st of each month or next business day.

Complete the section below, sign and attach a VOIDED check.

Name _____ Social Security Number _____

Yes, I want Auto Debit. Attached is a VOIDED check for my account.

Signature _____ Date _____