



AllUtahHealthPlans.com

Universal Health Insurance Application
Utah – Use for all Health Insurance Companies

GENERAL APPLICATION INSTRUCTIONS:

- 1) Type in your answers & click on all appropriate boxes
OR print out the form & fill out in BLUE pen.
Note: If you don't have Adobe Acrobat, you won't be able to save the form.
You will have to print it before closing so you don't lose your information!
- 2) The applicant is ALWAYS the oldest person applying. They must sign at the end of the application as the applicant, the younger as "spouse".
- 3) Depending on which company you are applying for, you will need to fill out the Company Specific Additional forms (ie 3-5 extra pages with plan selection, etc.) Fill out the additional forms and send those with this "Universal" application using one of following methods:

a) **Mail**

IBP – Insurance Benefit Plans of Utah
Attn: New Health Insurance
PO Box 95210
South Jordan, UT 84095

b) **Fax**

all pages to: (801) 386-5499

c) **Scan & Email**

to this email address: AllUtahHealthPlans@gmail.com



AllUtahHealthPlans.com • (801) 406-9502



UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

A. APPLICANT INFORMATION

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

Marital Status Legally Married Single Divorced Widowed Domestic Partner

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Street Address _____ Apt. _____ City _____ State _____ Zip _____

Home (or other) Phone (_____) _____ Business Phone (_____) _____

Driver's License Number: _____ Email Address: _____

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? Yes No If yes, % of time _____

Please check one of the following boxes: New Application Dependent Addition Re-apply

B. APPLICANT AND DEPENDENT INFORMATION (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under the policy.

	Social Security # (for internal use only)	Name (Last, First, MI)	Date of Birth	Age	M/F	Weight	Height
Self						lbs.	
Spouse						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. Financial dependency is not required for court-ordered child coverage. Any dependent not listed will not be considered for coverage.

C. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health care coverage, including Medicare or Medicaid, in effect within 24 months prior to the proposed effective date of this policy. Each person applying for coverage must be listed below. If no health care coverage was in effect within the past 24 months, please indicate NONE. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Enrolling Individual's Name (Non-Medicare)	Insurer (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check all that apply) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
		From	To		
Self				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

If you were previously insured on a group plan, have you exhausted your COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

Have you ever been or are you currently insured through HIPUtah? Yes No If "Yes" Date Started _____ Date Ended _____

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

D. EMPLOYMENT INFORMATION

Employer _____ Group Insurer _____ Job Title _____ Hrs/Week _____

Spouse's Employer _____ Spouse's Group Insurer _____ Spouse's Job Title _____ Hrs/Week _____

1. Is any employer reimbursing or paying for any portion of this policy? Yes No

2. Are you self-employed? Yes No If self employed, do you have any full or part-time employees? Yes No



UTAH INDIVIDUAL HEALTH INSURANCE APPLICATION

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Marital Status Legally Married Single Divorced Widowed Domestic Partner

Mailing Address _____ Apt. _____ City _____ State _____ Zip _____

Street Address _____ Apt. _____ City _____ State _____ Zip _____

Home (or other) Phone (_____) _____ Business Phone (_____) _____

Driver's License Number: _____ Email Address: _____

Does any listed proposed insured live, reside, work or attend school outside the state of Utah at any time during the year? Yes No If yes, % of time _____

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Spouse						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	
Dependent						lbs.	

Eligible family members include spouse, natural child, stepchild, adopted child, child placed for adoption, and child for whom you are appointed as legal guardian by the court. To be eligible for coverage, children must be under the age of 26, unmarried, and dependent upon you for 50 percent of their financial support. Financial dependency is not required for court-ordered child coverage. Any dependent not listed will not be considered for coverage.

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Enrolling Individual's Name (Non-Medicare)	Insurer (Including policyholder name, insurer name and phone number)	Date of Coverage Month/Day/Year		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage (Check all that apply) <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
		From	To		
Self				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
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If you were previously insured on a group plan, have you exhausted your COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

If COBRA was not an option for you, have you exhausted your Utah mini-COBRA rights? Yes No NA If "Yes" Date Started _____ Date Ended _____

Have you ever been or are you currently insured through HIPUtah? Yes No If "Yes" Date Started _____ Date Ended _____

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

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Employer _____ Group Insurer _____ Job Title _____ Hrs/Week _____

Spouse's Employer _____ Spouse's Group Insurer _____ Spouse's Job Title _____ Hrs/Week _____

1. Is any employer reimbursing or paying for any portion of this policy? Yes No

2. Are you self-employed? Yes No If self employed, do you have any full or part-time employees? Yes No

E. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED "YES" PROVIDE DETAILS IN SECTIONS G. & H. ON THE FOLLOWING PAGE.

The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

EACH QUESTION MUST BE CHECKED "YES" OR "NO." This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify the insurer of any change in health status while application is pending.							
Respond to the following questions:		YES	NO	Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):		YES	NO
1	Pregnancy/Adoption: Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?			21	Female Reproductive Conditions/Disorders: Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, pelvic inflammatory disease, or any other disorder of the reproductive system?		
2	Pregnancy/Fertility Related Treatment: Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), or miscarriage, complications related to pregnancy (including premature births)?			22	Digestive Conditions/Disorders: Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?		
3	Last Menstrual Period: Have you, your spouse or any dependent (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.			23	Nervous, Mental and Behavioral: Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
Within the past 12 MONTHS has any applicant:		YES	NO	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:		YES	NO
4	Prescriptions/Medications/Immunizations: Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			24	Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?		
5	Conditions Requiring Follow Up Medical Consult/Treatment: Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?			25	Musculoskeletal Conditions/Disorders: Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, spondylolysis, or other musculoskeletal disorder?		
6	Medical Consult/Treatment: Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			26	Digestive Conditions/Disorders: Crohn's disease. Colitis, colostomy, ileostomy, or other digestive disorder?		
7	Conditions Requiring Initial Medical Consult/Treatment: Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has not been sought?			27	Alcohol or Drug Use/Abuse: been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:		YES	NO	28	Eating Disorders/Obesity Treatment: including bulimia, anorexia, or obesity and any surgical services for obesity.		
8	Urinary, bladder, incontinence, kidney or liver conditions or disorders: Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?			29	Respiratory Conditions/Disorders: RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?		
9	Neurological Disorders: Recurring headaches, migraines, head injury, epilepsy, seizures, convulsions, or other neurological disorder?			30	Tobacco use (chewing or smoking)? Quit Date: _____		
10	Metabolic and Endocrine Conditions/Disorders: Lupus, thyroid disorder, goiter, or any other lymph system disorder?			Has any applicant EVER been diagnosed with or treated for any of the following:		YES	NO
11	Eyes, ears, nose, sinus, or throat conditions/disorders or any other respiratory system disorder, including allergies or hay fever?			31	Birth Defects/Congenital Abnormalities: premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
12	Skin Conditions/Disorders: Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			32	Nervous, Mental and Behavioral: Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
13	Breast Conditions/Disorders: Breast lumps, breast augmentation, or breast reduction?			33	Transplant or Implanted Device: Any organ or tissue transplant, pacemaker, or other implanted device?		
14	Heart Conditions/Disorders: Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			34	Heart and Circulatory Conditions/Disorders: Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure?		
15	Back, neck, bone, joint or spinal disorder: bone or joint disorders (including foot, knee, jaw, fracture, dislocation, or joint replacement)?			35	Brain/Nervous System Conditions/Disorders: Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
16	Blood Conditions/Disorders: Hemophilia, anemia, blood, or bleeding disorder?			36	Diabetes (type I or II), insulin resistance?		
17	Male Reproductive Conditions/Disorders: Impotence, prostate or testicular disorder, abnormal PSA, or other reproductive disorder?			37	Immune System Conditions/Disorders: Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
18	Circulatory System Conditions/Disorders: Varicose veins, or any other circulatory disorder?			38	Cancer/Tumors: (including skin cancer or melanoma) or tumors?		
19	Hospitalization/Surgery: Have you, your spouse, or any dependent family member been hospitalized or had surgery?			39	Urinary/Liver Conditions/Disorders: Cirrhosis, hepatitis, or renal failure?		
20	Sexually transmitted diseases?			OTHER MEDICAL INFORMATION		YES	NO
				40	Any medical condition or treatment that you are unsure of where it fits in above?		

I. ACKNOWLEDGMENT & SIGNATURE

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage. When incorporated with the policy, this application will become part of the policy. Once fully signed and executed, insurer and I agree to terms set forth in the policy. In connection with both this application and any coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. I agree to act on behalf of myself and my dependents. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved; that no benefits will be provided for any services which begin before the policy is effective; and that except as expressly provided in the policy, benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT. I understand that no producer or insurer representative is allowed to permit me to answer any question inaccurately, untruthfully, or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the insurer changes in the eligibility of any applicants who become enrolled.

I understand that the data obtained by the use of this authorization will only be used to determine eligibility for coverage and for future benefit administration. I understand that my choice of health care providers whose services will be covered may be restricted by the policy, and I agree that coverage for any services that are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied. I understand the policy for which I am applying may limit or exclude certain conditions, regardless of whether or not they are pre-existing. I also understand that the policy may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the date I apply for coverage, according to the pre-existing conditions limitation provisions of the policy.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE. According to information furnished, you may intend to lapse or otherwise terminate existing accident and health insurance and replace it with a new policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new plan. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present coverage.
2. You may wish to secure the advice of your present insurer or its producer 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 coverage and replace it with a new policy, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though the 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.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the health information on pages two and three of this application, is correctly recorded, true, and complete. I understand that material omissions or intentional misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. **If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to the insurer. A change of information prior to the effective date of the policy may void an offer to provide coverage.**

I understand there may not be participating providers in all specialty fields.

I understand that credit for prior coverage will be based upon the information contained in this application and/or proof of prior coverage, such as a Certificate of Creditable Coverage that I have obtained from my prior health care insurer(s) and provided to the insurer.

If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the policy null and void and canceling the policy retroactive to its original effective date; or imposing the pre-existing condition waiting period and denying claims that are pre-existing, subject to credit for prior coverage.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER. THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I further certify that all information completed on this form is true, correct and complete and acknowledge the policy is subject to cancellation or other action permissible at law, if any completed information is found to be false or incorrect.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed an authorization to disclose protected health information, if such form accompanies this application.

Applicant Signature _____ Date _____

(A faxed signature shall be valid as an original signature.)

Spouse Signature _____ Date _____

(Required if applying for coverage. A faxed signature shall be valid as an original signature.)

Requested Effective Date _____ (Coverage is not in force until the insurer approves your application and determines the effective date.)



ALTIUS ONE HEALTH PLAN APPLICATION

SUPPLEMENTAL FORM



10421 South Jordan Gateway, Suite 400
South Jordan, Utah 84095

I - APPLICANT INFORMATION

Name _____ SSN _____ Requested Effective Date _____

II - UTAH COVERAGE OPTIONS

Peak Plus Platinum

80% 70%

Deductible Option:

- \$250 \$500
 \$1,000 \$2,000
 \$5,000

Peak Plus Gold

80% 70%

Deductible Option:

- \$250 \$500
 \$1,000 \$2,000
 \$5,000

Peak Plus Silver (70%)

Deductible Option:

- \$500 \$1,000
 \$2,000 \$5,000

Peak Plus Qualified High Deductible Health Plan

80% 100%

- \$1,200 \$3,000
 \$1,500 \$5,000
 \$2,000

Are you electing the Altius One preferred Health Savings Account (HSA) vendor?

- Yes No

NetCare (70%)

Deductible Option:

- \$2,000
 \$4,000

Pharmacy Deductible Options (Platinum and Gold)

- No Deductible \$500 Individual Deductible
 \$250 Individual Deductible \$1,000 Individual Deductible

If any employer is reimbursing or paying for any portion of this plan, you are not eligible to apply for an Altius One policy.

For Office Use Only

Agent/Broker _____ Effective Date _____ Tier _____ Premium _____
PEC _____ Payment Option Automatic withdrawal Monthly billing

(CONTINUED)

III - METHOD OF PAYMENT

Please choose one of the following premium payment options:

- Monthly Automatic Withdrawal (complete Section IV)
- Monthly Billing (a \$5 administrative fee will be added to your monthly billing statement)

Payment is due on the first day of each month.

A \$25 service charge will be assessed if your check is returned or we cannot deduct the premium amount from your account due to insufficient funds.

IV - MONTHLY AUTOMATIC WITHDRAWAL

If you choose to pay by monthly automatic withdrawal, please attach your voided check or savings deposit slip here. Please complete the following:

I (we) authorize Altius Health Plans to initiate debit entries to my (our) Checking Account Savings Account

I (we) understand that debit entries will be submitted to my (our) account on or about the 10th of each month, regardless of my (our) Policy's effective date. I further understand that if my application is approved or accepted after the date coverage is to become effective, the first premium withdrawal may not occur until the 10th of the following month. The first premium withdrawal will be twice the normal monthly amount to pay for both the first and second months of coverage.

Account Holder's Signature _____ Date _____

MONTHLY AUTOMATIC WITHDRAWAL

PLEASE ATTACH A VOIDED CHECK OR VOIDED SAVINGS DEPOSIT SLIP HERE

Do not use a deposit slip for a checking withdrawal.
Checking deposit slips do not always contain the necessary routing information.

Important Note:

Coverage is not in effect until Altius Health Plans approves your application and determines an effective date.

We strongly suggest that you carefully consider the impact of changing coverage, and do not cancel any current coverage until you are officially notified by Altius Health Plans Inc. of approval. We reserve the right to reject coverage for any individual.

If you do not have an agent, please sign below and one will be assigned to you.

Applicant Signature _____ Date Signed _____

V - CHECKLIST

Send the following completed forms:

- Utah Individual Health Insurance Application
- Altius One Application Supplemental Form
- Certificate of Creditable Coverage (This certificate is provided by you previous health insurance carrier and should be submitted to receive credit for your Pre-Existing Condition Exclusion Period. If you are currently covered with Altius Health Plans, this is not necessary.)
- Voided check for Monthly Automatic Withdrawal option
- Signature on Section VII

You may submit your application to Altius through your Altius-appointed agent or broker, or directly to Altius Health Plans by facsimile, email, or mail.

Facsimile:

Altius One
801-323-6100

Email:

altiusone@ahplans.com

Mail:

Altius Health Plans
Altius One
10421 South Jordan Gateway, Suite 400
South Jordan, UT 84095

VI - AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, for myself and any of my dependents who are under the age of 18 and who are applying for coverage hereunder, hereby make the following authorizations:

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 Altius Health Plans Inc. (Altius) 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 Altius to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by Altius for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for Altius 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 Altius 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 Altius to use or disclose the information I provide in this Application (or that Altius 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 Altius prior to the date such revocation is received by Altius.

VII - SIGNATURE

I have read and agree to the statements above.

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



**Altius Health Plans Inc.
(South Jordan, Utah)**

Medical Records Release Authorization Form

This form must be completed by each Applicant

NAME: _____ Maiden name or other _____

ADDRESS: _____

SSN: _____ Date of Birth: _____

I hereby request and authorize any physician indicated below or as may be requested by Altius Health Plans Inc.:

PHYSICIAN NAME: _____

ADDRESS: _____

PHYSICIAN NAME: _____

ADDRESS: _____

PHYSICIAN NAME: _____

ADDRESS: _____

To release the specified information from my medical records to:

**MANAGEMENT RESEARCH SERVICES, Inc.
P.O. BOX 510304, NEW BERLIN, WI 53151
(262) 789-0933 FAX: (866) 422-6603**

Medical records should include copies of the physician's charts/notes as well as the results of any laboratory or diagnostic tests performed in the last 24 months.

Applicant's Authorization for Release of Medical Records

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility provider, insurance company, or other organization, institution or person, that has any records or knowledge of me or my health, or any of my legal dependents' health to release such information to Altius.

I understand that the information to be disclosed may indicate the presence of or include diagnosis, prognosis and treatment for physical, psychiatric and emotional illness, treatment of alcohol or drug abuse, communicable or non-communicable venereal disease, Acquired Immune Deficiency Syndrome, HIV testing, Hepatitis A, B, C, and sickle cell anemia.

A photographic copy of this authorization shall be recognized as valid and as the original. This consent may be revoked at any time upon written request executed by the undersigned and directed to the releaser, except to the extent that the action has been taken in reliance thereon. Patient has a right to inspect and obtain a copy of the record and this authorization. The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA rule. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining the individual's authorization. Patient has a right to refuse to sign this authorization.

If the Individual Health Insurance Application has been submitted on-line, by entering my name below I am indicating my intent to electronically sign this form and warrant that all the information I have provided is true, complete and accurate.

Authorization must be signed by patient or authorized representative of the patient.

Applicant/Parent or Legal Guardian: _____
Signature Date

J. PRODUCER AGREEMENT AND COMPENSATION DISCLOSURE (If applicable)

I understand and agree that in acting as the producer for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah that authorizes me to sell and service health insurance;
3. I have no authority to: a) make, alter, interpret, or discharge an application or policy in the name of a insurer; or b) waive any of the terms or conditions of the policy.
4. I have no authority to assign effective dates or to effect member changes.

Producer Name _____ License # _____ Agency _____ Phone (____) _____

Producer Signature Gregory W. Davis _____ Date Signed _____

(A faxed signature shall be valid as an original signature.)

Producer Compensation Disclosure:

(Compensation includes commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration.)

I have received written disclosure that the producer will receive compensation from the insurer or a third party administrator for the placement of insurance, including the amount or type of compensation.

Applicant Signature _____ Date _____