



ALTIUS INDIVIDUAL HEALTH PLAN

Please complete this form in its entirety. Any false statements or omission of facts can result in denial of claims and cancellation or termination of your policy from the date of enrollment.

Requested Effective Date: _____

HEALTH PLANS

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

I - APPLICANT INFORMATION

Name Last: _____ First: _____ MI: _____ Occupation: _____

Street Address: _____ Apt. No.: _____

City: _____ State: _____ Zip Code: _____ E-mail Address: _____

Home Phone: () _____ Business Phone: () _____

Spouse's Occupation: _____ Spouse's Business Phone: () _____

Marital Status: Divorced Married Single Widowed

II - COVERAGE OPTIONS

Peak Deductible Option:
 \$ 0
 \$250
 \$500

Peak Traditional Deductible Option:
 \$500
 \$1000
 \$2000

Peak Advantage
 10-15
 20-20

IIa - PHARMACY DEDUCTIBLE OPTIONS: \$500 Deductible (default) No Deductible

III - MEMBERS TO BE ENROLLED

To be eligible for coverage, children must be under 26, unmarried, and dependent upon you for 50% of their support. (Financial dependency not required for court-ordered dependent coverage.) ANY DEPENDENT NOT LISTED WILL NOT BE CONSIDERED FOR COVERAGE.

Soc. Sec. Number	Indicate Relationship	Last Name	First	MI	Birth Date	Age	M	F
	Applicant							

IIIa - RESIDENCY Do any of the proposed insured live, reside, work, or attend school outside the state of Utah at any time of the year? Yes No ♦♦

IV - CURRENT & PRIOR INSURANCE COVERAGE

Are you or any dependent(s) disabled? Yes No If yes, indicate name(s): _____

Do you or your dependent(s) have other health insurance? Medical Rx Medicare

Name of carrier: _____ Phone #: () _____ Policy #: _____

Policy Holder's Name: _____ Effective date of coverage: _____

Name of covered dependents: _____

If this 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 insurance so that Altius can determine whose coverage is Primary.

Do you currently have health insurance coverage? Yes No If you answered "No," when was the last date that you were insured?: _____

If you have had continuous 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 enclose proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier.

♦ Submission of prior coverage information does not automatically waive any Pre-Existing Condition Limitation. However, failure to provide proof of prior coverage will result in an automatic 12-month Pre-Existing Condition Waiting Period.

For Office Use Only	
Group # _____	Agent/Broker _____ Effective Date _____ Tier _____ Premium _____
<input type="checkbox"/> 24 Hour	
PEC _____	Payment Option: <input type="checkbox"/> 6 Month <input type="checkbox"/> Monthly

V - HEALTH HISTORY

Instructions: Answer each question for each individual applying for coverage. Circle the specific item and check the appropriate box for each question. For each "Yes" answer, give complete and specific details in section VI.

Current Health

1. Has anyone been under medical care in the last 12 months? Yes No
2. Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist, or other health care provider within the past three years? Yes No
3. Is any family member currently pregnant or have reason to suspect that they might be pregnant? Yes No
4. Are you or your spouse financially responsible for an unborn child, or anticipating adoption within the next 12 months? Yes No
5. Does anyone have a problem for which they have not sought medical advice or treatment in the last 12 months? Yes No
6. Do you have a spouse or dependent(s) who are not applying for coverage? If yes, complete (a) and (b) below.
 - a. List the reason(s) why your spouse and/or dependents are not applying for coverage on this policy. _____
 - b. Current health status of those not applying for coverage. _____
7. Has anyone used tobacco in the last 12 months? Yes No
8. Has anyone taken any medication, drugs, or shots in the past 12 months? If yes, complete section VII. Yes No

5-Year Health History

9. Within the past 5 years, has any proposed insured been diagnosed, treated, or had any of the following conditions:
 - a. Advised to be hospitalized, have tests, have surgery or take medication, but has not done so? Yes No
 - b. Fertility. Is anyone infertile, had miscarriages, or complications of pregnancy? Yes No
 - c. Ulcers, hernia, chronic diarrhea or other digestive problems? Yes No
 - d. Urinary problems or urinary incontinence? Yes No
 - e. Irregular bleeding, abnormal pap smears, pelvic inflammatory disease, endometriosis, prostate or testicular problems, venereal disease or any disorder of the reproductive system? Yes No
 - f. Unconsciousness, epilepsy, seizures, or convulsions? Yes No
 - g. Mental health counseling, psychotherapy, had a mental or nervous disorder, depression, stress or anxiety that interfered with daily life? Yes No
 - h. Cysts, growths (except warts), breast lump(s), breast augmentation or reduction? Yes No
 - i. Skin disorder that required medical attention? Yes No
 - j. Thyroid disorder, disorder of the lymph nodes, or lymph system? Yes No
 - k. Chest pain, high blood pressure, or high cholesterol? Yes No
 - l. Disorder of the eyes, ears, nose, or throat? Yes No
 - m. Back, neck, spinal problems, or a joint disorder that required medical attention and/or interfered with daily functioning? Yes No

10-Year Health History

11. Within the past 10 years, has any proposed insured been diagnosed, treated, or had any of the following conditions:
 - a. Been hospitalized or had surgery? Yes No
 - b. Hepatitis, colitis, rectal disease, spleen problems, jaundice or other digestive problems? Yes No
 - c. Gout, arthritis, or lupus? Yes No
 - d. Any indication of, but not limited to the following: ankylosing spondylitis, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolysis, or spondylolysis? Yes No
 - e. Obesity, bulimia, anorexia, medically supervised weight control, stomach stapling, or gastric bypass? Yes No
 - f. Tuberculosis, asthma, pleurisy, emphysema, or any disorder of the lungs or respiratory system? Yes No
 - g. Alcohol use, or attended Alcoholics Anonymous? Yes No
 - h. Drug dependency, abuse of, or reaction to drugs? Yes No
 - i. Been a user of any drug not prescribed, such as opiates, stimulants, depressants and/or hallucinogens? Yes No

Life Health History

12. Has any proposed insured been diagnosed, treated, or had any of the following conditions within their lifetime:
 - a. Any birth defect, developmental or learning disability, physical, neurological or mental impairment(s)? Yes No
 - b. Kidney disorder, liver problems, cirrhosis or pancreas problems? Yes No
 - c. Cancer or tumors? Yes No
 - d. Diabetes? Yes No
 - e. Multiple sclerosis, muscular dystrophy, cerebral palsy, or any other neurological disorder? Yes No
 - f. Any blood disorder, tested positive for Human Immunodeficiency Virus (HIV) or been treated for or been diagnosed with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any disease or disorder of the immune system? Yes No
 - g. Any heart condition or problem, heart murmur, heart attack, rapid, slow, or irregular heartbeat, blood clot, stroke, or other circulatory problem? Yes No

Misc. Health Information

13. In the last 5 years, has anyone been unable to work or been unable to perform routine daily functions for more than 2 weeks (other than pregnancy)? Yes No
14. Does anyone have any conditions, symptoms, or problems, in the last 10 years, not otherwise mentioned in connection with answering the questions above? Yes No
15. To the best of your knowledge, has anyone been denied or turned down for other health or life insurance or been issued a modified or rated policy? Yes No

10. List below the height, current weight, and last year's weight for the applicant and spouse.

APPLICANT:

Height _____ ft. _____ in. Current Weight _____ Last Year's Weight _____

SPOUSE:

Height _____ ft. _____ in. Current Weight _____ Last Year's Weight _____

IX - PAYMENT OPTION

Method of Payment

Altius requires that premium payments be paid by a direct payment withdrawal from your financial institution or pre-paid 6 months at a time.

Select a method for premium payment:

- Monthly automatic withdrawal - your first month's premium is due with the submission of the application
- 6-month prepayment - six months' premium is due with the submission of the application

NOTE: Your employer cannot pay for any portion of the policy premium, either directly or through reimbursement.

X - MONTHLY AUTOMATIC WITHDRAWAL

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

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) Plan's effective date. I (we) understand that a \$25 service charge will be assessed if the premium amount cannot be deducted from my (our) account for any reason.

Account Holder's Signature: _____

Date: _____

**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:

◆ **Payment does not guarantee acceptance.**

Coverage is not in effect until your application is approved and an effective date is determined by Altius Health Plans. **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.

Applicant's Name: _____

Applicant's Soc. Sec. #: _____

Signature _____ Date _____

XI - AGENT BROKER AGREEMENT

I understand and agree that in acting as the agent/broker 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 authorizing me to sell and service health insurance contracts.
3. I must be an Altius-appointed broker or agent to sell Altius Individual Health Plans.
4. I have no authority to do the following: make, alter, interpret, or change an application or contract in the name of Altius Health Plans Inc.; or waive any of the terms or conditions of the contract.
5. I have no authority to assign effective dates or to effect membership changes.
6. Cancellation of this Health Care Agreement by either the subscriber or Altius Health Plans Inc. will terminate the Agency Agreement.

Agent/Broker Name: _____ Agency: _____

Phone Number: () _____ Date Signed: _____

Fax Number: () _____

Agent/Broker Signature: _____

XII - CHECKLIST

Send the following completed forms:

- Application
- Certificate of Creditable Coverage (This certificate is provided by your previous health insurance carrier and must be submitted to receive credit for your Pre-Existing Condition Waiting Period. If you are currently covered with Altius Health Plans, this is not necessary.)
- Voided check for auto-payment option and down payment check or...
 - Check for 6 month premium
- Signature on Section XV

Payment does not guarantee acceptance of coverage. If your application is rejected, your original check will be returned to you.

You may submit your application to Altius through your Altius-appointed agent or broker, or directly to Altius Health Plans at the following address:

**Altius Health Plans
Underwriting Department - Individual Health Plans
10421 South Jordan Gateway, Suite 400
South Jordan, UT 84095**

www.altiushealthplans.com

XIII - AUTHORIZATION & ACKNOWLEDGMENT

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with Altius Health Plans Inc. (Altius). When incorporated with the policy, this application and the individual benefit summary become part of the policy. Once fully signed and executed, Altius and I agree to the terms set forth in the policy. In connection with both this application and any plan coverage that may be obtained, I am acting as agent and/or as natural guardian for my spouse and other dependents. Further, in dealing with Altius, 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 by Altius, that no benefits will be provided for any services which begin before the coverage 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: On behalf of myself and the other applicants, I authorize any physician, dentist, medical practitioner, hospital, clinic, or any other provider of health or dental care, insurance company, or person to disclose to the plan or its representatives all information and records of the applicants relating to diagnosis, treatment, medical history, physical or mental conditions, and evaluation for which coverage by the plan is sought. Access to medical records is limited to persons who are providing coordinating, evaluating, or improving health care, subject to applicable law. By receiving services from providers compensated by Altius, on behalf of myself and the other applicants, I agree to the release of medical record information for the uses specified above, and to the release of claims related information to insurance companies or other third parties to assist in paying our health care costs. I understand that no agent or Plan representative is allowed to permit me to answer any questions inaccurately, untruthful or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to the Plan changes in the eligibility of any applicants who become members.

I understand that the data obtained by the use of this authorization will be used only to determine eligibility for coverage and for future benefit administration. All information will remain confidential. I understand that my choice of health care providers whose services will be covered may be restricted by the policy, and I agree that any services which are obtained without or contrary to required preauthorization/precertification requirements in the policy may be denied coverage.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the Health information on pages 2 and 3 of this application is correctly

recorded, true and complete. I understand that material omissions or 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 Altius Health Plans.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE: According to information you have furnished, you may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Altius. Your new policy provides 10 days within which you may decide, without cost, whether you desire to keep the 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 that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. 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 policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I understand the coverage for which I am applying excludes certain conditions/procedures for twelve months, regardless of whether or not they are pre-existing. I also understand that the coverage may limit or exclude conditions for which a family member (including myself) has received, or been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the coverage effective date, according to the pre-existing conditions limitations provisions of the policy. I understand that this application will become part of the policy.

XIV - SIGNATURE

Signature: _____

Date Signed: _____