

Application for Health Insurance

Instructions: The information in this application will be used to determine the applicant's eligibility for health insurance and allows selection of payment method. Applications must be submitted by or on behalf of the customer. If additional space is needed, please have applicant include a separate sheet and sign, date and attach to this application.

Please include the following completed forms:

- Software Proposal – An accurate proposal is required.** This will identify which plan/PPO network/options are being applied for.
- Application for Insurance** – Applicant must answer all questions. Applicant and agent signature is required.
- Authorization to Charge Credit Card OR Bank Draft** – Applicant completes if electing to pay with credit card or Bank Draft. Must include a voided check if electing Bank Draft.
- HIPAA Compliant Authorization to Obtain Information** – Applicant must read and sign form.
- Initial Premium** – Including any fees, if applicable
- Preferred Rating Guidelines/Questionnaire** – If applicable
- State Mandated Forms** – If applicable

Utilize the following materials on www.americanrepublic.com:

- Health Underwriting Guide – W1282A

Have any questions about completing the application? Call the Sales Support Team at 800-255-6625.

To be completed by Agent
Agent # _____

Home Office Use Only
Application # _____

A. General Information (please print)

1. Your Information

Name (First, Middle, Last) _____

Address (Street, City, State, ZIP) _____

Home Phone Number _____ Cell Phone Number _____

Best Time to Call: AM PM Home Work Cell

Email Address (It may be used to send you important notices.) _____

Employer (Name, Street, City, State, ZIP) _____

Occupation/Duties _____ Work Phone Number _____

If unemployed or employed part-time, are you seeking full-time employment? Yes No

Driver's License Number/State _____

2. Your Spouse's Information (where different)

Name (First, Middle, Last) _____

Address (Street, City, State, ZIP) _____

Home Phone Number _____ Cell Phone Number _____

Best Time to Call: AM PM Home Work Cell

Email Address (It may be used to send you important notices.) _____

Employer (Name, Street, City, State, ZIP) _____

Occupation/Duties _____ Work Phone Number _____

If unemployed or employed part-time, are you seeking full-time employment? Yes No

Driver's License Number/State _____

3. Persons proposed for insurance.
List first, MI, and last names.

	Birthdate Mo./Day/Yr.	State of Birth	Ht. ft., in.	Wt. lbs.	Sex	Full-time Student	Social Security Number
You					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Residency Information

- a. Do all people requesting coverage live in the same household?..... Yes No
- b. Are all of you U.S. citizens, have established permanent resident status, and have been in the U.S. a minimum of two years? Yes No
- If "No" to a. or b., explain:** _____
- c. Are any of you planning to live, work or attend school outside the U.S. for more than 60 consecutive days?..... Yes No
- If "Yes" to c., explain:** _____

5. Please complete if Life Benefit selected:

Beneficiary (First, Middle Initial, Last) _____	Address (Street, City, State, ZIP Code) _____	Social Security Number _____	Relationship _____
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B. HIPAA Eligible Individual Determination

You may be eligible for guaranteed issue health coverage if you qualify under the rules of the Health Insurance Portability and Accountability Act (HIPAA). The information you provide in this section will help determine whether you qualify under HIPAA. Please answer the following questions for all applicants.

- Was there any period of 63 days or more during the past 18 months when you were not continuously covered by group or individual health insurance, Medicare, Medicaid or any other health insurance?..... Yes No
- If you answered "Yes" to question 1, were you offered coverage under COBRA or a similar state program, and
 - refused coverage?..... Yes No
 - were not covered through COBRA for the full allowable period of coverage available?..... Yes No
 - are presently eligible for such coverage? Yes No
- Are you presently eligible for, or will you be eligible for health coverage provided by an employer? Yes No
- Was your most recent health insurance coverage terminated for non-payment of premium, misrepresentation or fraud?..... Yes No
- Do you currently have health insurance in force? Yes No
- Was your most recent health insurance coverage through an employer-sponsored group plan?..... Yes No

If you answered "No" to questions 1-5, and "Yes" to question 6, you meet the definition of an Eligible Individual.

- I elect to apply as a HIPAA Eligible Individual and understand the rates for this plan will be substantially higher than underwritten-plan rates.
- I am a HIPAA Eligible Individual, but elect to be underwritten and waive any available rights as an Eligible Individual. I understand I will be subject to pre-existing condition exclusions.

C. General Medical Overview

1. **Within the past 5 years**, have you or any applicant been treated for, been diagnosed as having, or had symptoms of any of the following medical conditions?
 - a. Heart attack, angina, congestive heart failure, heart surgery, bypass or angioplasty? Yes No
 - b. Rheumatoid arthritis, connective tissue disorders or psoriatic arthritis? Yes No
 - c. Addison's Disease, Cushing's Syndrome or pheochromocytoma (tumor of the adrenal gland)?..... Yes No
 - d. Diabetes, including hyperglycemia, insulin resistance or impaired glucose tolerance?..... Yes No
 - e. Inflammatory bowel disease including ulcerative colitis or Crohn's disease? Yes No
 - f. Chronic obstructive pulmonary disease (COPD) requiring oxygen, emphysema requiring oxygen or cystic fibrosis? Yes No
 - g. Schizophrenia, psychoses, Alzheimer's disease or dementias? Yes No
 - h. Stroke/TIA, Parkinson's disease? Yes No
 - i. Liver failure, kidney failure/dialysis?..... Yes No
 - j. Amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), muscular dystrophy (MD) or lupus (systemic)?..... Yes No
 - k. Major organ transplant, including heart, lung, kidney or liver? Yes No
 - l. Cancer including, but not limited to, cancer of any organ, melanoma, sarcoma, leukemia, Hodgkin's or other lymphoma, but excluding basal or squamous cell skin cancers?..... Yes No
2. Are any of you now pregnant, an expectant father, in the process of adopting a child, or planning to serve as a surrogate?..... Yes No
3. Are any of you eligible for Medicare due to a disability? Yes No
4. a. Have you or any applicant ever been diagnosed as having, or been treated by a member of the medical profession as having AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), or any other disease or disorder of the immune system?..... Yes No
 - b. Have you or any applicant ever tested positive for AIDS/HIV (limited to FDA licensed tests)?..... Yes No

Note: Applicant(s) who answers "Yes" to any questions in this section is not eligible for coverage. Please indicate individual(s): _____

D. Comprehensive Medical and Additional History

Please indicate "YES" or "NO" for each category. If you answer "YES", check (✓) the applicable condition and provide details in the space provided in the Explanation of Health Section. Categories do not necessarily include all the conditions related to that category, so please indicate "Other" for any conditions not listed.

Within the last 10 years, have you or any applicant been treated for, diagnosed with or had symptoms of any of the following:

1. **Ears/Eyes/Nose/Throat** Yes No

<input type="checkbox"/> Ear infections/otitis	<input type="checkbox"/> Otosclerosis	<input type="checkbox"/> Double vision	<input type="checkbox"/> Retinal detachment
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Rhinitis
<input type="checkbox"/> Meniere's disease	<input type="checkbox"/> Strabismus/lazy eye	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Optic Neuritis
<input type="checkbox"/> Ear tubes	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma/Increased eye pressure	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Enlarged tonsils/Adenoids	<input type="checkbox"/> Tonsillitis		<input type="checkbox"/> Other _____
2. **Lungs and Respiratory** Yes No

<input type="checkbox"/> Allergic rhinitis	<input type="checkbox"/> Reactive airway disease	<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Chronic obstructive pulmonary disease
<input type="checkbox"/> Allergic sinusitis	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sleep apnea	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Chronic cough		
3. **Heart/Circulatory** Yes No

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Heart surgery (stent placement, coronary artery bypass, angioplasty, valve)	<input type="checkbox"/> High blood pressure/hypertension	<input type="checkbox"/> Claudication
<input type="checkbox"/> Heart valve disorders	<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> High lipid (cholesterol or triglycerides)
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Angina	<input type="checkbox"/> Edema	<input type="checkbox"/> Varicose veins	
<input type="checkbox"/> Heart attack		<input type="checkbox"/> Aneurysm	
<input type="checkbox"/> Irregular heart beat			
4. **Blood/Lymph/Anemia** Yes No

<input type="checkbox"/> Anemia	<input type="checkbox"/> Thrombocytopenia	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hyperglycemia (high blood sugar)		
5. **Digestive** Yes No

<input type="checkbox"/> Esophagitis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Rectal bleeding
<input type="checkbox"/> Gastric reflux/GERD	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hernia	<input type="checkbox"/> Recurrent indigestion	<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Irritable bowel	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Chronic diarrhea	
6. **Liver/Gallbladder/Pancreas** Yes No

<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Fatty liver	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Spleen/pancreas disease	
7. **Urologic/Kidney/Bladder** Yes No

<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Overactive bladder	<input type="checkbox"/> Interstitial cystitis	<input type="checkbox"/> Nephritis
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Pyelonephritis	<input type="checkbox"/> Other _____

D. Comprehensive Medical and Additional History (Cont'd.)

8. Reproductive/Breast Yes No

<input type="checkbox"/> Prostate disorder	<input type="checkbox"/> Ovarian disorders	<input type="checkbox"/> Cesarean section delivery	<input type="checkbox"/> Menstrual disorders
<input type="checkbox"/> Impotence	<input type="checkbox"/> Infertility	<input type="checkbox"/> Breast cysts/lumps	(painful, excessive or
<input type="checkbox"/> Abnormal Prostate Specific Antigen (PSA)	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Abnormal mammogram	irregular bleeding
<input type="checkbox"/> Abnormal PAP smear	<input type="checkbox"/> Complications of pregnancy	<input type="checkbox"/> Gynecomastia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Uterine fibroids	<input type="checkbox"/> Human papillomavirus (HPV)	<input type="checkbox"/> Endometriosis	
<input type="checkbox"/> Mastitis			

9. Skin Yes No

<input type="checkbox"/> Acne/rosacea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Shingles	<input type="checkbox"/> Keratosis
<input type="checkbox"/> Hemangioma	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Herpes	<input type="checkbox"/> Other _____

10. Bone/Muscular/Connective Tissue Yes No

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Gout	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Curvature subluxation	<input type="checkbox"/> Fracture(s)
<input type="checkbox"/> Back/spine conditions	<input type="checkbox"/> Back pain	<input type="checkbox"/> Osteopenia/osteoporosis	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Herniated, bulging or degenerative discs	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Degenerative joint disease	<input type="checkbox"/> Muscular pain		

11. Prosthetic Devices/Plates, Pins, Screws Yes No

<input type="checkbox"/> Plates, pins, screws	<input type="checkbox"/> Artificial limb	<input type="checkbox"/> Shunts	<input type="checkbox"/> Other _____
<input type="checkbox"/> Rods	<input type="checkbox"/> Pacemakers	<input type="checkbox"/> Valve/joint replacement	

12. Nervous System Yes No

<input type="checkbox"/> Dizziness/syncope	<input type="checkbox"/> Restless leg syndrome	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Tourette's syndrome	
<input type="checkbox"/> Muscular weakness	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Convulsions	

13. Endocrine/Thyroid Yes No

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> High blood sugar	<input type="checkbox"/> Impaired glucose tolerance
<input type="checkbox"/> Goiter	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Insulin resistance	<input type="checkbox"/> Other _____

14. Cancer/Tumors Yes No

<input type="checkbox"/> Of internal organ	<input type="checkbox"/> Hodgkin's disease	<input type="checkbox"/> Adenoma	<input type="checkbox"/> Breast cancer
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sarcoma	<input type="checkbox"/> Basal or squamous cell skin cancer	<input type="checkbox"/> Neoplasm
<input type="checkbox"/> Melanoma	<input type="checkbox"/> Other lymphoma		<input type="checkbox"/> Other _____

15. Psychological Yes No

<input type="checkbox"/> Emotional disorder	<input type="checkbox"/> Attention deficit disorder	<input type="checkbox"/> Bipolar (manic depression)	<input type="checkbox"/> Obsessive compulsive disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Psychiatric treatment or counseling	<input type="checkbox"/> Other _____
<input type="checkbox"/> Depression	<input type="checkbox"/> Chemical imbalance		

16. Congenital Disorders/Birth Defects/Developmental Disorders Yes No

<input type="checkbox"/> Down's syndrome	<input type="checkbox"/> Autism	<input type="checkbox"/> Cleft lip/palate	<input type="checkbox"/> Speech impairment
<input type="checkbox"/> Mental retardation	<input type="checkbox"/> Club foot	<input type="checkbox"/> Delayed development	<input type="checkbox"/> Other _____

17. Other Conditions

a. In the past 10 years, have you or any applicant required an emergency room visit, hospital stay, surgery, or treatment? Yes No

b. In the past 10 years, have you or any applicant been recommended to have surgery or to receive treatment from a physician, chiropractor or other practitioner? Yes No

c. Do you or any applicant have any medical conditions/symptoms for which you have not seen a health care provider? Yes No

d. Have you or any applicant had any tests or procedures recommended that have not yet been performed? Yes No

18. Medication Use

a. Have you or any applicant taken or been recommended to take any prescription medication in the last 2 years? Yes No

b. In the last two years have you or any applicant taken any herbal or over-the-counter medication more often than once a week? Yes No

19. Substance Abuse/Advice to Reduce or Eliminate Use _____

a. In the past 5 years, have you or any applicant ever been evaluated or treated for alcoholism, frequently used alcoholic beverages to excess or intoxication, or been advised to modify drinking habits for any reason? Yes No

b. In the past 5 years, have you or any applicant ever used non-prescribed sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substances, or received treatment or evaluation for drug abuse or chemical dependency? Yes No

20. Tobacco Use

In the past 12 months, has anyone used cigarettes, cigars, pipes, oral tobacco or nicotine replacements? Yes No

If "YES", list name(s): _____

21. High Risk Activities

In the past 2 years, has anyone participated in hazardous activities, including activities like hang-gliding, scuba diving, rodeoing or racing (including automobile, motorcycle, etc.)? Yes No

If "YES", list name(s): _____

Activity: _____ Frequency: _____

D. Comprehensive Medical and Additional History (Cont'd.)

22. Driving Violations

In the past 2 years, has anyone been convicted of any driving violation, including DUI, DWI, license suspension or revocation, or 3 or more speeding violations?..... Yes No

Name: _____ Date: _____ Violation _____
 Name: _____ Date: _____ Violation _____

23. Insurance Declination

In the past 5 years, has anyone's health insurance been declined, rescinded, rated or issued with waivers?..... Yes No

Name(s) _____
 Insurance Company(ies) _____ Date(s) _____
 Reason(s) _____ Details _____

24. Complete ONLY if applying for Critical Illness/Cancer Care

Has any applicant's biological parents, brothers or sisters, either living or deceased, been diagnosed prior to age 55 with any of the following: diabetes, heart disease, stroke, kidney disease, internal cancer or MS, Alzheimer's, Parkinson's? Yes No

Name	Family member's relationship	Condition	Age at onset	Current age/ Age at death

Explanation of Health

Provide details for all questions 1 through 19 with "YES" answers. If you need additional space, please include a separate sheet and sign, date and attach to this application.

a. Name	Medical Condition	Date of Onset
Dates of Treatment	Treatment (<i>prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery</i>)	
Physician's Name	Physician's Location (City/State)	Phone Number
b. Name	Medical Condition	Date of Onset
Dates of Treatment	Treatment (<i>prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery</i>)	
Physician's Name	Physician's Location (City/State)	Phone Number
c. Name	Medical Condition	Date of Onset
Dates of Treatment	Treatment (<i>prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery</i>)	
Physician's Name	Physician's Location (City/State)	Phone Number
d. Name	Medical Condition	Date of Onset
Dates of Treatment	Treatment (<i>prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery</i>)	
Physician's Name	Physician's Location (City/State)	Phone Number

Physician Information

	Name of Primary Physician	Location City/State	Phone Number	Date Last Seen	Reason for Visit	Results
Primary						
Spouse						
Dependent						
Dependent						
Dependent						

Please add any additional information you feel will be helpful in evaluating your application on a separate sheet and sign, date and attach to this application.

E. Other Coverage

Statement: a) You normally do not require more than one policy; b) If you purchase this policy, you may want to evaluate your health coverage and decide if you need multiple coverages; c) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplement policy; and d) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program.

Questions: (If "Yes" for any proposed insured, please complete section below and submit any required replacement forms.) To the best of your knowledge:

1. Do you have another insurance policy or contract in force? Yes No
 If so, with which company? (Name and address) _____

 If so, do you intend to replace your current accident and sickness insurance with this policy (contract)?..... Yes No
2. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy? Yes No
 If so, with which company? (Name and address) _____

 What kind of policy? _____
3. Are you covered for medical assistance through the state Medicaid program? Yes No
 As a Specified Low Income Medicare Beneficiary (SLMB)? Yes No
 As a Qualified Medicare Beneficiary (QMB)? Yes No
 For other Medicaid medical benefits? Yes No

F. Verification Information – Business Group of One

Self-Employed Business Group of One Determination (To be completed by all applicants.)

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care to your employees? Yes No
2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage? Yes No
3. Do you have a gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: Substantial part of your income means income derived from business activities of the Business Group of One that are sufficient to pay for the annual premiums for the Business Group of One's health benefit plan? Yes No
4. Do you work a minimum of 24 hours a week on a permanent basis? Yes No

Yes to all questions qualifies applicant as a Self-Employed Business Group of One.

For those meeting the definition of a Self-Employed Business Group of One, please complete this section.

I acknowledge that I meet the definition of a self-employed business group of one. I understand that by purchasing an individual policy instead of a small group policy, I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carried for a period of three years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three-year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase are plan design, attained age of insured, health related factors, utilization trends, number of individuals insured, policy duration from issue, and a factor that reflects the cost of care in the specific geographical area of where I live. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited by plan design, my age, overall cost and utilization trends (index rate), my family size, and a factor that reflects the cost of care where I live.

I have been given a health plan benefit description form showing the benefits under Colorado's small group Standard Health Benefits Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying.

The state of Colorado requires that If a Business Group of One is applying for an individual medical plan, and is applying for family coverage, American Republic Insurance Company must accept or reject the entire family, unless the proposed insured waives coverage for a family member who has other coverage in force.

I certify that the following family members have other health insurance coverage in force. (List the names of all your dependents, whether listed on the application or not.)

<u>Name</u>	<u>Relationship</u>	<u>Type of Coverage and Name of Carrier</u>	<u>Effective Date</u>

After consideration, it is my decision to waive coverage under the American Republic Insurance Company Policy for the family member(s).

Please Read, Sign and Date

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid and a policy is delivered.**
- The information furnished is complete, true and correctly recorded to the best of my knowledge.
- Any false statement or misrepresentation may result in loss or reduction of coverage or an increase in premium.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- I must tell the Company if the health of any applicant changes prior to delivery of the policy.
- The policy, if issued, will cover accidents that occur and illnesses, the symptoms of which manifest after the date the policy is issued.
- Health conditions present before the application is signed will be covered only if listed on this application and not excluded from coverage.
- I will be informed of the status of coverage within 90 days.

I represent that the following information is correct and true as it relates to the health insurance being applied for:

1. no portion of the premium will be paid, during the period the policy is in force, by or on behalf of my employer, either directly, or through wage adjustments or other means of reimbursement;
2. neither I, nor my spouse, nor my dependents, nor my employer intends to treat the policy, during the period the policy is in force, as part of a plan or program under Section 162 (other than Section 162(1)), Section 125, or Section 106 of the United States Internal Revenue Code.

Please Note: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Signed at _____ this _____ day of _____, _____.
(City/State) (Date) (Month) (Year)

X _____
Your Signature

X _____
Your Spouse's Signature, if applying

X _____
Dependent's Signature, if 18 or older

X _____
Dependent's Signature, if 18 or older

X _____
Dependent's Signature, if 18 or older

Please Complete for Applicant Demographics

Business Name _____ Business Phone Number _____

Business Address (Street, City, State, ZIP) _____

Type of Business _____ Number of Employees _____

For Agent Use Only

I certify that the answers given to the foregoing questions in this application were provided by the applicant and accurately recorded. I have no information to add to the application that could affect the acceptance or rejection of the risk. I have provided the applicant with the Special Notice Federal Fair Credit Report Act and an outline of coverage where required.

Are you aware of any information, not recorded on the application, which might have a bearing on insurability of any person proposed for insurance? (If Yes, please list details below.) Yes No

X _____ **X** _____
Agent Name Agent Number Agent Signature Date

Agent Phone Number Agent Cell Phone Number Agent Fax Number Agent Email Address

HIPAA Authorization

I authorize any person described below who has health or non-health information about me or my minor dependents to disclose such information to American Republic Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives. The purpose of the disclosure is so that the information may be used to underwrite and determine eligibility for the insurance plan(s) for which I have applied.

Health information includes information on past and present physical or mental conditions (including, but not limited to, drug and/or alcohol conditions). It includes complete medical files. These files may include, but are not limited to: doctors' notes, lab reports, testing results, consulting doctor reports and test results. The information authorized for disclosure does not include psychotherapy notes.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; or the Medical Information Bureau (MIB).

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.

- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: American Republic Insurance Company, P.O. Box 2734, Omaha, Nebraska 68103-2734.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it.
- I have the right to ask for and obtain a copy of any consumer report made about me to the Company.

I agree that a copy of this Authorization is as valid as the original.

Date

_____ **X**

Your Name (Please Print) Your Signature

_____ **X**

Your Spouse's Name (if applying) (Please Print) Your Spouse's Signature (if applying)

_____ **X**

Your Child's Name (if 18 or older) Your Child's Signature (if 18 or older)

_____ **X**

Your Child's Name (if 18 or older) Your Child's Signature (if 18 or older)

Your Child(ren)'s Name(s) if younger than 18 (Please Print)

1. _____ 3. _____

2. _____ 4. _____

A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Person(s) to be Insured (Please Print)

My relationship to applicant(s) (Please Print)

X _____
Personal Representative

Authorization to Disclose Information

I authorize American Republic Insurance Company (the Company) to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention.

I understand that I do not have to authorize this disclosure to MIB.

Issuance of coverage will not be conditioned on me signing this authorization. Yes No

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and

must send my written request to: American Republic Insurance Company, P.O. Box 2734, Omaha, Nebraska 68103-2734.

I understand that this authorization will expire 24 months from the date I sign it.

I acknowledge that I, or my authorized personal representative, am entitled to and have received a copy of this form.

Date

_____ **X**

Your Name (Please Print) Your Signature

_____ **X**

Your Spouse's Name (if applying) (Please Print) Your Spouse's Signature (if applying)

A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Person(s) to be Insured (Please Print)

My relationship to applicant(s) (Please Print)

X _____
Personal Representative

Build Chart for Preferred Risks

Male		Female	
Height	Weight (lbs.)	Height	Weight (lbs.)
4' 6"	80-131	4' 6"	79-126
4' 7"	83-134	4' 7"	82-129
4' 8"	86-138	4' 8"	83-132
4' 9"	89-142	4' 9"	87-135
4' 10"	92-145	4' 10"	90-138
4' 11"	95-149	4' 11"	92-140
5' 0"	98-152	5' 0"	94-143
5' 1"	101-155	5' 1"	96-146
5' 2"	103-159	5' 2"	98-150
5' 3"	105-162	5' 3"	101-153
5' 4"	107-166	5' 4"	104-158
5' 5"	110-171	5' 5"	107-163
5' 6"	112-175	5' 6"	109-168
5' 7"	115-181	5' 7"	112-173
5' 8"	118-186	5' 8"	115-178
5' 9"	121-191	5' 9"	117-185
5' 10"	124-197	5' 10"	119-192
5' 11"	126-203	5' 11"	122-197
6' 0"	129-208	6' 0"	123-202
6' 1"	132-215	6' 1"	126-207
6' 2"	135-220	6' 2"	130-212
6' 3"	139-226	6' 3"	134-217
6' 4"	143-232	6' 4"	138-222
6' 5"	146-240	6' 5"	142-227
6' 6"	149-246	6' 6"	146-232
6' 7"	153-252	6' 7"	150-237
6' 8"	156-258	6' 8"	154-242
6' 9"	160-264	6' 9"	158-247
6' 10"	163-270	6' 10"	162-252
6' 11"	167-276	6' 11"	166-257



Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by American Republic Insurance Company. Your new policy will provide 10 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- Other. (please specify)

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you 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 and health history. 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 has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative*

X

Type Name of Issuer or Producer

Type Address of Issuer or Producer

Applicant's Signature

X

Date

MM / DD / YYYY

*Agent Signature not required for direct response sales.

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3. If, you 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 and health history. 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 has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative*

X

Type Name of Issuer or Producer

Type Address of Issuer or Producer

Applicant's Signature

X

Date

MM / DD / YYYY

*Agent Signature not required for direct response sales.

COLORADO HEALTH INSURANCE APPLICANT AND AGENT QUESTIONNAIRE

This form must be completed and signed by the applicant and the agent and submitted to American Republic Insurance Company with the application.

TO BE COMPLETED BY THE APPLICANT:

The health insurance policy you are applying for should be considered an individual insurance policy exempt from the laws which regulate the small group market. American Republic is not a small group carrier.

Please answer the following questions to determine whether or not the coverage you desire would be considered individual coverage or small group coverage.

- 1) Will any portion of the premium for this policy be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement? NO YES
- 2) Does any proposed insured intend to treat the policy as a health benefit plan under United States Internal Revenue Code: Section 162 - Trade or Business Expenses, Section 125 - Cafeteria Plans, or Section 106 - Contributions by Employer to Accident and Health Plan? NO YES
- 3) Was this health coverage marketed through your employer's place of business? NO YES

If any of the above questions is answered yes, the coverage you desire would be considered small group coverage according to the Colorado Division of Insurance and you should request small group coverage from an authorized small group carrier.

 Signature of Applicant

 Date

 Signature of Spouse, if to be insured

TO BE COMPLETED BY THE AGENT:

Was this policy marketed through any proposed insured's employer's place of business? NO YES

If yes, do NOT submit the application. Advise the applicant to seek group coverage from an authorized small group carrier.

 Signature of Agent

 Date

