

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:

- Association Application**
- 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

1. Is any person applying for coverage covered by another plan? Yes No
 If "Yes", list name(s): _____
 If "Yes", check all that apply: COBRA Individual Medicare/Medicaid Other Coverage _____
2. Will the plan applied for replace the existing coverage(s)? Yes No
 Effective date of other coverage(s): _____
 Paid-to-date(s) or expected termination date(s) of their coverage(s): _____

 Name(s), policy number(s) and telephone number(s) of other carrier(s): _____

Please Note: Other coverage should not be terminated until a new policy is issued and accepted.

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.
- *(Where applicable)* Association membership and dues may be required to purchase and continue this insurance.
- 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: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

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

Administrative Details

1. **Proposal Required. Submit with application – the proposal documents the type of coverage requested.**
2. **Choice of Requested Date of Coverage:** Underwriting Approval Date Specified Future Date (1st - 28th) _____
3. **Health Savings Account Information:** Applicant requests HealthEquity open an HSA account according to the terms and conditions of the HealthEquity Service Agreement located at www.healthequity.com
4. **Payment Mode: Direct Bill:** Annual Semiannual Quarterly **Monthly:** Bank Draft Credit Card
 List Bill (If requesting a new list bill [if allowed in your state], the current list bill forms are required. Submit only application fee, if any, for initial premiums.)
5. **Payment for Initial Premium:** Check Bank Draft Credit Card
 \$ _____ Total Amount Submitted With Application (The first full premium by mode, association dues, and the application fee must be submitted with this application.)

Application Fees are non-refundable unless required by state law.

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



Important Notice About the Insurance for Which You Have Applied

Complete & Submit

Does Not Apply to Life Insurance

**THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS.
PLEASE READ THE FOLLOWING INFORMATION CAREFULLY**

1. The insurance for which you have applied includes a binding arbitration provision. A copy of which is attached hereto.
2. The arbitration provision requires that any disagreement related to this coverage must be resolved by arbitration and not in a court of law.
3. In an arbitration, an arbitrator (not a judge), who is an independent, neutral party, gives a decision after hearing the position of the parties.
4. The results of an arbitration are final and binding on you and the insurance company and cannot be reviewed in court by a judge and jury, except as provided by the Federal Arbitration Act.
5. From the point in time and forward that you tender an application for consideration of insurance coverage, you agree to resolve any disagreement related to the application and/or the coverage by binding arbitration instead of a trial in court, including a trial by jury.

ACKNOWLEDGMENT OF ARBITRATION AND AGREEMENT TO ARBITRATE APPLICATION ISSUES

I have read and understand that I am voluntarily surrendering my right to have any dispute or disagreement between American Republic Insurance Company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that in consideration of American Republic Insurance Company's agreement to receive and review my application for insurance, I do hereby agree that any dispute or disagreement that arises between me and American Republic Insurance Company that relates in any way to my application for insurance, the accuracy of information disclosed in my application for insurance, or the description or explanation of coverage afforded by the insurance applied for shall be resolved exclusively through binding arbitration according to the procedures set forth in the arbitration clause attached hereto.

Additionally, I understand that upon receipt of the insurance, I should read the arbitration clause contained in this coverage and that I have the right to reject this coverage within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration. I understand that this same type of insurance may be available through an insurance company that does not require that coverage related disagreements be resolved by binding arbitration.

Applicant/Insured

X

Date

Time

a.m. p.m.

Agent's Signature

X

Date

Time

a.m. p.m.

SEE BACK SIDE FOR ARBITRATION CLAUSE

BINDING ARBITRATION

AMERICAN REPUBLIC INSURANCE COMPANY IS COMMITTED TO ATTEMPTING TO RESOLVE ANY DISPUTE OR DISAGREEMENT YOU MAY HAVE THROUGH INFORMAL REVIEW OF YOUR CLAIMS AND OUR APPEALS PROCESS. HOWEVER, ANY DISPUTE OR DISAGREEMENT YOU HAVE WITH AMERICAN REPUBLIC INSURANCE COMPANY OR ANY OF OUR AGENTS OR EMPLOYEES THAT IS NOT RESOLVED TO YOUR SATISFACTION THROUGH INFORMAL PROCEDURES SHALL BE RESOLVED EXCLUSIVELY THROUGH BINDING ARBITRATION PURSUANT TO THE FEDERAL ARBITRATION ACT. THIS INCLUDES ANY DISPUTES OR DISAGREEMENTS YOU HAVE THAT ARISE OUT OF OR IN ANY WAY RELATE TO THE INSURANCE COVERAGE PROVIDED UNDER THIS CONTRACT INCLUDING, WITHOUT LIMITATION, CLAIMS FOR BENEFITS UNDER THIS CONTRACT, CLAIMS RELATING TO YOUR PURCHASE OF THIS INSURANCE CONTRACT, CLAIMS RELATING TO ANY EXPLANATION OR DESCRIPTION OF COVERAGE AFFORDED UNDER THIS CONTRACT, AND ANY CLAIM OF MISREPRESENTATION, IMPROPER DENIAL OF AN INSURANCE CLAIM, OR OTHER DISPUTE OR DISAGREEMENT IN LAW OR EQUITY.

IF THE SUBJECT OF YOUR DISPUTE OR DISAGREEMENT SOLELY CONCERNS AN INCREASE IN YOUR PREMIUM RATES, YOU MUST FIRST SUBMIT YOUR CLAIM TO NON-BINDING MEDIATION AS A PREREQUISITE TO ARBITRATION. YOU MAY OBTAIN A COPY OF THESE PROCEDURES BY WRITING TO US AT AMERICAN REPUBLIC INSURANCE COMPANY, 601 SIXTH AVENUE, DES MOINES, IOWA 50334.

EXCEPT AS SET FORTH BELOW, ARBITRATION OF YOUR DISPUTE SHALL BE CONDUCTED PURSUANT TO THE FEDERAL ARBITRATION ACT ACCORDING TO THE RULES AND PROCEDURES IN THE AMERICAN ARBITRATION ASSOCIATION'S DISPUTE RESOLUTION PROCEDURES FOR ARBITRATION OF INSURANCE CLAIMS. YOU MAY OBTAIN A COPY OF THESE PROCEDURES FROM THE AMERICAN ARBITRATION ASSOCIATION AT 2200 CENTURY PARKWAY SUITE 300, ATLANTA GEORGIA 30345-3203 OR BY WRITING TO US AT AMERICAN REPUBLIC INSURANCE COMPANY, 601 SIXTH AVENUE, DES MOINES, IOWA 50334.

TO INITIATE AN ARBITRATION PROCEEDING, YOU MUST FIRST NOTIFY US IN WRITING BY REGISTERED MAIL. YOUR LETTER MUST CONTAIN THE FOLLOWING INFORMATION: (1) YOUR REQUEST FOR THE DISPUTE TO BE RESOLVED THROUGH ARBITRATION; (2) YOUR FULL NAME, MAILING ADDRESS AND TELEPHONE NUMBER; (3) THE NAME AND MAILING ADDRESS OF THE POLICYHOLDER; (4) THE POLICY/CERTIFICATE NUMBER; (5) A DESCRIPTION OF THE NATURE OF YOUR DISPUTE OR DISAGREEMENT; (6) THE PARTY OR PARTIES AGAINST WHOM YOUR DISPUTE OR DISAGREEMENT IS MADE; AND (7) THE RESULT YOU ARE WANTING INCLUDING THE DOLLAR AMOUNT IN DISPUTE.

ABSENT OUR MUTUAL AGREEMENT OR OTHER GOOD CAUSE SHOWN, THE ARBITRATION SHALL COMMENCE WITHIN 90 DAYS AFTER THE ARBITRATION IS INITIATED. THE ARBITRATION PROCEEDINGS SHALL BE CONDUCTED IN YOUR COUNTY OF RESIDENCE UNLESS WE MUTUALLY AGREE IN WRITING TO ANOTHER LOCATION.

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THE ARBITRATOR SHALL NOT HAVE JURISDICTION TO DETERMINE WHETHER AMERICAN REPUBLIC INSURANCE COMPANY IS LIABLE FOR THE PROFESSIONAL NEGLIGENCE OF ANY PHYSICIAN, HOSPITAL, OR OTHER HEALTH CARE PROVIDER PROVIDING SERVICES COVERED UNDER THE INSURANCE CONTRACT. AMERICAN REPUBLIC HAS NO RESPONSIBILITY FOR YOUR SELECTION OF A HEALTH CARE PROVIDER NOR FOR THE QUALITY OF HEALTH CARE RENDERED.

ONCE THE ARBITRATOR'S DECISION IS RENDERED, THE ARBITRATION AWARD MAY BE ENTERED IN ANY COURT HAVING JURISDICTION THEREOF. THE ARBITRATION AWARD SHALL NOT BE SUBJECT TO JUDICIAL REVIEW EXCEPT TO THE EXTENT ALLOWED BY THE FEDERAL ARBITRATION ACT.

THIS ARBITRATION PROVISION IS BINDING ON BOTH YOU AND AMERICAN REPUBLIC INSURANCE COMPANY.

Important Notice About the Insurance for Which You Have Applied

Proposed Insured's Copy

Does Not Apply to Life Insurance

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Applicant/Insured

X

Date

MM / DD / YYYY

Time

a.m. p.m.

Agent's Signature

X

Date

MM / DD / YYYY

Time

a.m. p.m.

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