American Republic
Insurance Company
National Headquarters, Des Moines, Iowa 50309

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

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.

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American Republic Insurance Company
National Headquarters, Des Moines, Iowa 50309

Application to American Republic Insurance Company *(herein called the Company)* for Health Coverage
P.O. Box 2734 • Omaha, NE 68103-2734

Complete & Submit

To be completed by Agent	Home Office Use Only
Agent #	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						☐M ☐F	☐Yes ☐No	
Spouse						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐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

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.

1. 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
2. If you answered "Yes" to question 1, were you offered coverage under COBRA or a similar state program, and
   a. refused coverage? ☐Yes ☐No
   b. were not covered through COBRA for the full allowable period of coverage available? ☐Yes ☐No
   c. are presently eligible for such coverage? ☐Yes ☐No
3. Are you presently eligible for, or will you be eligible for health coverage provided by an employer? ☐Yes ☐No
4. Was your most recent health insurance coverage terminated for non-payment of premium, misrepresentation or fraud? ☐Yes ☐No
5. Do you currently have health insurance in force? ☐Yes ☐No
6. 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.

☐ 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/Transcent Ischemic Attack (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

☐ Ear infections/otitis
☐ Hearing loss
☐ Meniere's disease
☐ Ear tubes
☐ Enlarged tonsils/Adenoids
☐ Otosclerosis
☐ Cochlear implant
☐ Strabismus/lazy eye
☐ Cataracts
☐ Tonsillitis
☐ Double vision
☐ Loss of vision
☐ Macular degeneration
☐ Glaucoma/Increased eye pressure
☐ Retinal detachment
☐ Rhinitis
☐ Optic Neuritis
☐ Sinusitis
☐ Other ______________

2. Lungs and Respiratory ☐Yes ☐No

☐ Allergic rhinitis
☐ Allergic sinusitis
☐ Asthma
☐ Emphysema
☐ Reactive airway disease
☐ Bronchitis
☐ Pneumonia
☐ Chronic cough
☐ Chronic lung disease
☐ Tuberculosis
☐ Sleep apnea
☐ Chronic obstructive pulmonary disease
☐ Other ______________

3. Heart/Circulatory ☐Yes ☐No

☐ Chest pain
☐ Heart valve disorders
☐ Coronary artery disease
☐ Angina
☐ Heart attack
☐ Irregular heart beat
☐ Heart surgery (stent placement, coronary artery bypass, angioplasty, valve)
☐ Heart murmurs
☐ Peripheral vascular disease
☐ Edema
☐ High blood pressure/ hypertension
☐ Phlebitis
☐ Thrombophlebitis
☐ Varicose veins
☐ Aneurysm
☐ Claudication
☐ High lipid (cholesterol or triglycerides)
☐ Other ______________

4. Blood/Lymph/Anemia ☐Yes ☐No

☐ Anemia
☐ Hemophilia
☐ Thrombocytopenia
☐ Hyperglycemia (high blood sugar)
☐ Bleeding disorders
☐ Other ______________

5. Digestive ☐Yes ☐No

☐ Esophagitis
☐ Gastric reflux/ Gastroesophageal Reflux Disease (GERD)
☐ Hernia
☐ Irritable bowel
☐ Ulcers
☐ Gastritis
☐ Recurrent indigestion
☐ Diverticulosis
☐ Ulcerative colitis
☐ Crohn's disease
☐ Hemorrhoids
☐ Chronic diarrhea
☐ Rectal bleeding
☐ Other ______________

6. Liver/Gallbladder/Pancreas ☐Yes ☐No

☐ Cirrhosis
☐ Hepatitis
☐ Fatty liver
☐ Gallstones
☐ Pancreatitis
☐ Spleen/pancreas disease
☐ Other ______________

7. Urologic/Kidney/Bladder ☐Yes ☐No

☐ Bladder infections
☐ Incontinence
☐ Overactive bladder
☐ Kidney stones
☐ Interstitial cystitis
☐ Pyelonephritis
☐ Nephritis
☐ Other ______________

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

8. Reproductive/Breast ☐Yes ☐No

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

9. Skin ☐Yes ☐No

- ☐ Acne/rosacea
- ☐ Hemangioma
- ☐ Eczema
- ☐ Psoriasis
- ☐ Shingles
- ☐ Herpes
- ☐ Keratosis
- ☐ Other ________

10. Bone/Muscular/Connective Tissue ☐Yes ☐No

- ☐ Arthritis
- ☐ Gout
- ☐ Back/spine conditions
- ☐ Herniated, bulging or degenerative discs
- ☐ Osteoarthritis
- ☐ Joint replacement
- ☐ Back pain
- ☐ Scoliosis
- ☐ Degenerative joint disease
- ☐ Joint pain
- ☐ Curvature subluxation
- ☐ Osteopenia/osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Muscular pain
- ☐ Sciatica
- ☐ Fracture(s)
- ☐ Fibromyalgia
- ☐ Other ________

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

- ☐ Plates, pins, screws
- ☐ Rods
- ☐ Artificial limb
- ☐ Pacemakers
- ☐ Shunts
- ☐ Valve/joint replacement
- ☐ Other ________

12. Nervous System ☐Yes ☐No

- ☐ Dizziness/syncope
- ☐ Cerebral palsy
- ☐ Neuropathy
- ☐ Muscular weakness
- ☐ Restless leg syndrome
- ☐ Carpal tunnel syndrome
- ☐ Headaches/migraines
- ☐ Paralysis
- ☐ Seizures
- ☐ Epilepsy
- ☐ Tourette's syndrome
- ☐ Convulsions
- ☐ Other ________

13. Endocrine/Thyroid ☐Yes ☐No

- ☐ Diabetes
- ☐ Goiter
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ High blood sugar
- ☐ Insulin resistance
- ☐ Impaired glucose tolerance
- ☐ Other ________

14. Cancer/Tumors ☐Yes ☐No

- ☐ Of internal organ
- ☐ Leukemia
- ☐ Melanoma
- ☐ Hodgkin's disease
- ☐ Sarcoma
- ☐ Other lymphoma
- ☐ Adenoma
- ☐ Basal or squamous cell skin cancer
- ☐ Breast cancer
- ☐ Neoplasm
- ☐ Other ________

15. Psychological ☐Yes ☐No

- ☐ Emotional disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Attention deficit disorder
- ☐ Eating disorder
- ☐ Chemical imbalance
- ☐ Bipolar (manic depression)
- ☐ Psychiatric treatment or counseling
- ☐ Obsessive compulsive disorder
- ☐ Other ________

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

- ☐ Down's syndrome
- ☐ Mental retardation
- ☐ Autism
- ☐ Club foot
- ☐ Cleft lip/palate
- ☐ Delayed development
- ☐ Speech impairment
- ☐ 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 *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*

Physician's Name | Physician's Location (City/State) | Phone Number

b. Name | Medical Condition | Date of Onset

Dates of Treatment | Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*

Physician's Name | Physician's Location (City/State) | Phone Number

c. Name | Medical Condition | Date of Onset

Dates of Treatment | Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*

Physician's Name | Physician's Location (City/State) | Phone Number

d. Name | Medical Condition | Date of Onset

Dates of Treatment | Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*

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						
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), certificate number(s) and telephone number(s) of other carrier(s): ____________________
   ____

Please Note: Other coverage should not be terminated until a new certificate 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 certificate 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 certificate.
- The certificate, if issued, will cover accidents that occur and illnesses, the symptoms of which manifest after the date the certificate 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.

Authorization to obtain Information:

I understand American Republic Insurance Company or its reinsurers will gather information regarding me or my family. This information may include the Medical Information Bureau; employer(s); consumer reporting agency; or the Veterans Administration.

I UNDERSTAND the information obtained by use of this Authorization will be used by American Republic Insurance Company to determine eligibility for insurance or benefit determination. Any information obtained will not be released by American Republic Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.

I know I have the right to make a written request within a reasonable time to receive additional, detailed information about the nature and scope of this investigation. I understand that this information will be used by American Republic Insurance Company to determine eligibility for insurance, certificate reinstatement or a change of benefits. I agree this authorization is valid for twenty-four (24) months from the date signed. I know I or my authorized representative has the right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I, the undersigned represent to the best of my knowledge and belief, that all statements contained herein are complete and true. Under the penalties of perjury, I certify that the Social Security Number(s) provided are true, correct and complete.

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 certificate 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 certificate, during the period the certificate 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 ______________________ *Agent Name* ______________ *Agent Number* X ______________________ *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.

Authorization to Charge Credit Card for Premium

Not available in all states.

☐ **VISA** ☐ **MasterCard**

Credit Card Authorization: *I authorize American Republic Insurance Company to bill my VISA/MASTERCARD account for full premium, and any applicable association dues and application fee.* ***NOTE:*** **We will debit your account for the application fee upon submission of the application. The premium and any application association dues will be debited upon certificate approval which may not coincide with the effective date of the certificate.**

Account Number ___ ___ ___ ___ — ___ ___ ___ ___ — ___ ___ ___ ___ — ___ ___ ___ ___ Exp. Date ___ ___ / ___ ___

X________________________________ Date ________________
Signature

Phone Number ___ ___ ___ — ___ ___ ___ — ___ ___ ___ ___

Authorization to Honor Checks Drawn by American Republic Insurance Company

If you select the Bank Draft option, please complete the following:
I (we) hereby authorize American Republic Insurance Company (American Republic) to initiate debit entries to the account and depository (Depository) indicated below, to debit the same to such account. This authority is to remain in full force and effect until American Republic and Depository have received written notification from me (or either of us) of its termination in such time and in such manner to afford American Republic and Depository a reasonable opportunity to act on it.

I understand that the withdrawal will be made on the effective date of the certificate. ***NOTE:*** **We will debit your account for the application fee upon submission of the application. The premium and any application association dues will be debited upon certificate approval which may not coincide with the effective date of the certificate.**

Signature of Payor ________________________________ *Date Signed* ________________

☐ **To begin Bank Draft withdrawals:**

Withdrawal day will be effective day of certificate.

Bank Name ________________________

Address ________________________

City ________________ State ______

☐ **To add this certificate to an existing Bank Draft:**

Certificate Number ________________________

Jane Doe
2139 S. 33 St.
AnyTown, USA 12345
1234
Date ____________
________________________________ $
________________________________ Dollars
Bank Name
Memo ________________ ________________
(Routing #) *(Account #)*

Routing *(9 digits)* ________________________ Account # ________________

You must either submit a voided check, or complete the routing and account information. Do not send a deposit slip. Please print clearly.

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 may request to be interviewed in connection with the preparation of a consumer report and, upon written request, receive a copy of the report.

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.

X_______________________
Personal Representative

Person(s) to be Insured (Please Print)	***My relationship to applicant(s) (Please Print)***

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.

X_______________________
Personal Representative

Person(s) to be Insured (Please Print)	***My relationship to applicant(s) (Please Print)***

American Republic Insurance Company

Complete & Submit

Preferred Rating Guidelines/Questionnaire

Guidelines

To be eligible to apply for Preferred Rates, the proposed insured and/or proposed insured spouse*:

(a) must be between the ages of 18 and 60;

(b) must not have a health exclusion rider or health rate-up;

(c) must answer "No" to questions 1-5 listed below; and

(d) may be required to submit an oral fluid test.

Note: Information that is compiled during the application process concerning medical conditions, occupations, or medications you are taking may keep you from becoming eligible for Preferred Rates.

*Dependents are not eligible for Preferred Rates.

Questionnaire

To be eligible for Preferred Rates, each proposed insured must answer the questions below and be within the Build Chart for Preferred Risks.

Question	Proposed Insured	Proposed Insured's Spouse
1. Within the past 12 months, have you had a blood pressure reading that exceeded 140/90 (greater than 140 systolic and/or greater than 90 diastolic) or been treated for high blood pressure?	❏ Yes ❏ No	❏ Yes ❏ No
2. Within the past 12 months, have you had total cholesterol readings that exceeded 220 or been treated for elevated cholesterol or triglycerides?	❏ Yes ❏ No	❏ Yes ❏ No
3. Within the past 2 years, have you had any DUI or DWI convictions or more than 2 moving violations?	❏ Yes ❏ No	❏ Yes ❏ No
4. Has it been more than 90 days since you had health coverage (group or individual) in force?	❏ Yes ❏ No	❏ Yes ❏ No
5. If you are over age 50, has it been more than 2 years since your last physical exam?	❏ Yes ❏ No	❏ Yes ❏ No

I understand and agree that this questionnaire, if completed, is part of the application for health insurance coverage with American Republic Insurance Company.

X ____________________ __________
Signature of the Proposed Insured   Date

X ____________________ __________
Signature of Spouse   Date

X ____________________ __________
Signature of Licensed Agent   Date

____
Agent Number

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

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