

### Individual Insurance Application

Please print using ink. If you make corrections, please initial at the spot of the correction.

PRIMARY APPLICANT INFORMATION			
Last Name	First Name	Middle Initial	Social Security Number
Home Address (Include Apt. #, Lot # or Rte. #)		City	State Zip
Home Phone	Work Phone	Cell Phone	
Fax	Email (Must be included for online access)		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height      Weight FT    IN                  LBS
Employer	Occupation	Date of Employment	
Best time to reach you Monday-Friday between 8-5 EST:			

<input type="checkbox"/> Check here to apply for SPOUSE coverage and complete information below:			
Last Name	First Name	Middle Initial	Social Security Number
Spouse Phone Number		Email Address	
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height FT    IN	Weight LBS
Spouse's Employer	Spouse's Occupation	Date of Employment	

<input type="checkbox"/> Check here to apply for DEPENDENT coverage and complete information below:							
Last Name	First Name	SSN	Date of Birth	Gender	Height	Weight	
1				<input type="checkbox"/> M <input type="checkbox"/> F	FT    IN	LBS	
2				<input type="checkbox"/> M <input type="checkbox"/> F	FT    IN	LBS	
3				<input type="checkbox"/> M <input type="checkbox"/> F	FT    IN	LBS	
4				<input type="checkbox"/> M <input type="checkbox"/> F	FT    IN	LBS	

PLAN SELECTION	
Please state <b>one</b> Plan Selection (taken from the attached quote):	
<input type="checkbox"/> <b>IFocus Plans</b> Plan Selection  Do you wish to add a Prescription Drug Rider to your selected <b>IFocus Plan</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please choose a Prescription Drug Rider*: * Any of the Prescription Drug riders can be chosen with any IFocus Plan. Rider Selection	<b>OR</b>
<input type="checkbox"/> <b>IFocus HSA Plans</b> Plan Selection  Do you wish to add a Prescription Drug Rider* to your selected <b>IFocus HSA Plan</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No * The rider elected will have the same deductible as the medical plan with a \$20/60/100 provision for copays following the deductible. The Rx deductible and medical deductibles are combined.	
Will you be selecting the optional Dental Coverage offered by MCNA? <input type="checkbox"/> No <input type="checkbox"/> Yes, please select one <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2	
Will you be selecting Avalon Vision coverage (Discount program is included at no charge)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Plan Selected: <input type="checkbox"/> Standard <input type="checkbox"/> Elite	

APPLICANT	SSN

### MATERNITY RIDER

Do you wish to select the optional Maternity Coverage?  Yes  No

\* Please note that a waiting period of fifteen (15) months will apply for you or your dependents before any benefit will be paid.

If Yes, please list the applicants who have selected Maternity Coverage:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Relationship: \_\_\_\_\_

### EFFECTIVE DATE

I request that Avalon assign (policies are only issued on the first of the month):

The first of the month following underwriting approval

OR

The first of the following month: \_\_\_\_\_

### HIPAA

Federal law provides for waiving of the pre-existing conditions limitation period for qualified persons applying under HIPAA pursuant to section 627.6487 of the Florida Statutes. HIPAA qualified individuals must meet all of the following criteria:

- must have 18 months of continuous creditable coverage
- most recent coverage must be a group, governmental or church plan; or whose most recent coverage was under an individual plan issued in this state and which coverage terminated as a result of the carrier becoming insolvent, or discontinuing the offering of all individual coverage in the state, or due to the insured no longer living in the services area of a carrier that provides coverage through a network plan
- must not be eligible for group coverage, Medicare or Medicaid, or conversion coverage
- cannot have other health insurance coverage
- must have elected and exhausted any COBRA or state continuation coverage
- most recent coverage must not have terminated due to premium lapse or fraud.

Are you or any applicant on this form applying for coverage as a HIPAA eligible individual pursuant to section 627.6487 of the Florida Statutes?  Yes  No

If "yes" please attach your Certificate of Creditable Coverage from your most recent carrier.

Insurance Company: \_\_\_\_\_ Policy No.: \_\_\_\_\_

### OTHER MEDICAL COVERAGE

Are or were you or any of the other applicants for this insurance, covered under another health insurance benefit plan within the last 63 days?  Yes  No

If yes, please list applicant(s) covered: \_\_\_\_\_

Name and phone number of current/prior health insurance Carrier: \_\_\_\_\_

Policy # \_\_\_\_\_ Effective date of coverage \_\_\_\_\_ Termination date \_\_\_\_\_

Is/was current/prior health insurance coverage provided by an employer?  Yes  No

### ADDITIONAL QUESTIONS

Have you or any applicant had any form of health insurance denied, rated-up, changed or rescinded, or had any conditions excluded by rider?  Yes  No

If Yes, please explain, including the date(s) and reason(s) for the action: \_\_\_\_\_

\_\_\_\_\_

Are you and the other applicants U.S. citizens?  Yes  No

If NO, are you or the applicable applicant a legal U.S. resident?

Yes (please attach a copy of a valid visa)  No (please attach a copy of passport)

APPLICANT	SSN

## MEDICAL HISTORY

Please answer the following questions for all persons applying for coverage. Make sure you provide full details as answers will determine eligibility or denial of insurance coverage. Complete details for all "yes" answers must be provided following these questions.

1. In the past **five (5)** years, have you or any applicant, had testing, treatment, diagnosis, consultation, counseling or been prescribed medication by a member of the medical profession for any of the following physical systems, structures or organs, illnesses, injuries, diseases or disorders, whether physical or psychological:

<b>A. Respiratory</b>	<ul style="list-style-type: none"> <li>including</li> <li>• Allergies;</li> <li>• Asthma;</li> <li>• Emphysema or COPD;</li> <li>• Shortness of Breath</li> <li>• Breathing Difficulty</li> </ul>	<ul style="list-style-type: none"> <li>• Other Lung Disorder;</li> <li>• Pulmonary Hypertension;</li> <li>• Chronic Cough;</li> <li>• Bronchitis;</li> <li>• Pneumonia;</li> </ul>	<ul style="list-style-type: none"> <li>• Cystic Fibrosis;</li> <li>• Spitting Up Blood;</li> <li>• Sinusitis;</li> <li>• Tuberculosis</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>B. Circulatory System</b>	<ul style="list-style-type: none"> <li>including</li> <li>• Heart Disease;</li> <li>• Heart Attack;</li> <li>• Coronary Artery Disease;</li> <li>• Low/High Blood Pressure;</li> <li>• Elevated Cholesterol;</li> <li>• Elevated Triglycerides</li> <li>• Stroke or TIA;</li> </ul>	<ul style="list-style-type: none"> <li>• Varicose Veins</li> <li>• Blood Disorder;</li> <li>• Angina Pectoris (Chest Pain);</li> <li>• Mitral Valve Prolapse;</li> <li>• Palpitations/Irregular Heartbeat;</li> <li>• Valvular Disease or Disorder;</li> <li>• Aneurysm;</li> </ul>	<ul style="list-style-type: none"> <li>• Embolism;</li> <li>• Phlebitis;</li> <li>• Anemia;</li> <li>• Blood Clot;</li> <li>• Peripheral Vascular Disease/Vascular Disease or Disorder</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>C. Digestive System</b>	<ul style="list-style-type: none"> <li>including</li> <li>• Ulcer;</li> <li>• Colon Polyps;</li> <li>• Gastritis;</li> <li>• Spleen;</li> <li>• Gallbladder/Gall Stones;</li> <li>• Stomach;</li> <li>• Hernia of Any Kind;</li> <li>• Jaundice;</li> </ul>	<ul style="list-style-type: none"> <li>• Hemorrhoids;</li> <li>• Esophagus;</li> <li>• Reflux (GERD);</li> <li>• Liver, Bile Duct, Biliary;</li> <li>• Enteritis/Gastroenteritis;</li> <li>• Diverticulitis/Diverticulosis;</li> <li>• Colitis, Spastic Colon, Irritable Bowel;</li> </ul>	<ul style="list-style-type: none"> <li>• Ulcerative Colitis or Crohn's;</li> <li>• Cirrhosis;</li> <li>• Anal Fissure;</li> <li>• Rectum;</li> <li>• Elevated Liver Function Tests;</li> <li>• Hepatitis A, B, or C.</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>D. Endocrine System</b>	<ul style="list-style-type: none"> <li>including</li> <li>• Pancreas;</li> <li>• Diabetes;</li> <li>• Goiter;</li> </ul>	<ul style="list-style-type: none"> <li>• High or Low Blood Sugar;</li> <li>• Pituitary Disorder; Thyroid;</li> <li>• Impaired Glucose Tolerance;</li> </ul>	<ul style="list-style-type: none"> <li>• Addison's Disease;</li> <li>• Adrenal or Other Glandular Disorder</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>E. Urinary System</b>	<ul style="list-style-type: none"> <li>Including</li> <li>• Kidney Stones;</li> <li>• Kidney Disorder;</li> </ul>	<ul style="list-style-type: none"> <li>• Urinary Tract Infection;</li> <li>• Prostate;</li> </ul>	<ul style="list-style-type: none"> <li>• Bladder Stones;</li> <li>• Urinary Incontinence</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>F. Male or Female Reproductive System or Genitalia</b>	<ul style="list-style-type: none"> <li>Including</li> <li>• Caesarean Section;</li> <li>• Complications from Pregnancy;</li> <li>• Miscarriage;</li> <li>• Ovaries/Ovarian Cyst;</li> <li>• Infertility;</li> </ul>	<ul style="list-style-type: none"> <li>• Impotency;</li> <li>• Sexually Transmitted Disease;</li> <li>• Genital Warts;</li> <li>• Menstrual Disorders;</li> <li>• Uterine Fibroids;</li> <li>• Uterus;</li> </ul>	<ul style="list-style-type: none"> <li>• Cervix/Abnormal Pap Smear;</li> <li>• Endometriosis;</li> <li>• Premenstrual Syndrome;</li> <li>• Herpes;</li> <li>• Prostate/Elevated PSA.</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>G. Musculo-Skeletal System</b>	<ul style="list-style-type: none"> <li>Including</li> <li>• TMJ/Jaw Disorder;</li> <li>• Back, Spine, or Vertebrae;</li> <li>• Fibromyalgia;</li> <li>• Rheumatism; Bursitis or Tendonitis;</li> <li>• Lupus/Erythematosis;</li> <li>• Connective Tissue Disease or Disorder;</li> <li>• Muscular Dystrophy;</li> </ul>	<ul style="list-style-type: none"> <li>• Collagen Vascular Disorder;</li> <li>• Muscles, Ligaments, Tendons, or Cartilage;</li> <li>• Intervertebral Discs, Bulging, Herniated or Slipped;</li> <li>• Arthritis, Osteo, Rheumatoid, Psoriatic;</li> <li>• Bone Density, Deformity, Infection, Fractures or Dislocation;</li> </ul>	<ul style="list-style-type: none"> <li>• Spinal Manipulation or Chiropractic Adjustments;</li> <li>• Scleroderma;</li> <li>• Joint Disorders or Replacements: Elbow, Knee, Hip, Shoulder, Ankle, Hand, or Foot</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>H. Nervous System</b>	<ul style="list-style-type: none"> <li>including</li> <li>• Epilepsy;</li> <li>• Convulsions;</li> <li>• Seizures;</li> <li>• Paralysis;</li> <li>• Cerebral Palsy;</li> <li>• Head Injury;</li> <li>• Alzheimer's;</li> </ul>	<ul style="list-style-type: none"> <li>• Parkinson's Disease;</li> <li>• Dementia Disease or Disorder;</li> <li>• Multiple Sclerosis;</li> <li>• Brain Disorder;</li> <li>• Severe/Chronic Headaches or Migraines;</li> <li>• ALS (Lou Gehrig's Disease);</li> </ul>	<ul style="list-style-type: none"> <li>• Spinal Cord Injury or Disorder;</li> <li>• Neuropathy;</li> <li>• Down's Syndrome;</li> <li>• Central Nervous System or Neurological Disorder;</li> <li>• Dizziness, Fainting Spells, Loss of Consciousness</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>I. Mental or Nervous Disorder,</b>	<ul style="list-style-type: none"> <li>including</li> <li>• Anxiety;</li> <li>• Depression;</li> <li>• Eating Disorder;</li> <li>• Attention Deficit/ADHD;</li> <li>• Learning/Behavioral Disorder;</li> </ul>	<ul style="list-style-type: none"> <li>• Neuroses or Psychoses;</li> <li>• Mental Retardation;</li> <li>• Bipolar Disorder;</li> <li>• Sleep Disorder;</li> <li>• Chemical Imbalance;</li> </ul>	<ul style="list-style-type: none"> <li>• Suicide Attempt;</li> <li>• Central Nervous System or Neurological Disorder</li> <li>• Psychiatric/Psychological Treatment or Counseling</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>J. Miscellaneous</b>	<ul style="list-style-type: none"> <li>including</li> <li>• Speech;</li> <li>• Breast Disease or Disorder;</li> <li>• Basal Cell or Squamous Cancer;</li> <li>• Cancer, Tumors, Cysts, Polyps, Growths, Lesions of the Skin or Mouth (provide location, type, treatment);</li> </ul>	<ul style="list-style-type: none"> <li>• Skin Disorders, Burns, Acne;</li> <li>• Sleep Disorder, Insomnia</li> <li>• Eyes, Glaucoma, Cataracts, Blurred Vision, Detached Retina;</li> <li>• Immune System Disorder, Chronic Fatigue Syndrome;</li> <li>• Sleep Apnea or Use of a Sleeping Monitoring Device;</li> </ul>	<ul style="list-style-type: none"> <li>• Lymphadenopathy (enlarged lymph nodes);</li> <li>• Nose, Throat or Tongue, Tonsils, Adenoids; Ears, Otitis Media, Tubes in Ears;</li> <li>• Premature Birth/Birth Development Disorders</li> </ul>	<input type="checkbox"/> Y <input type="checkbox"/> N

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2. In the past five (5) years, have you or any applicant been advised by a physician that they have used alcohol in excess, been diagnosed or treated by a member of the medical profession for alcoholism or alcohol abuse, or been advised to modify drinking habits for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past five (5) years, has any applicant used any illegal drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past five (5) years, have you or any applicant, been informed by a member of the medical profession of an abnormal test result?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you or any applicant ever tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC) caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past five (5) years, have you or any applicant, had or been advised by a member of the medical profession to have any test, examination or surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you or any applicant, ever had surgery on any critical organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you or any applicant ever had testing, treatment, diagnosis, consultation, counseling or been prescribed medication by a member of the medical profession for any of the following: Cancer, melanoma, tumor, cyst, growth, leukemia, Hodgkin's disease, or any other malignancy or any tumor, cyst or growth that has not been biopsied; Heart disorder including but not limited to heart attack, chest pain, arrhythmia, cardiac pacemaker, cardiomyopathy, coronary artery disease or bypass surgery, or heart stent; Palpitations/Irregular Heartbeat; Stroke or TIA; Aneurysm; Blood Clot; Emphysema or COPD; Ulcerative Colitis or Crohn's; Cirrhosis; Hepatitis; Diabetes; Complications from Pregnancy; Sexually Transmitted Disease Lupus Erythematosus; Epilepsy; Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered 'Yes' to any item in questions 1-8 for any person applying for coverage, please provide full details below.**

If additional details need to be added or further information beyond the space provided is necessary, please check here and attach a separate sheet indicating your name and SSN on all attached papers.

Question No.	Person Treated	Date of Diagnosis	Date Last Treated	Ongoing Symptoms/Treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Description: (diagnosis, condition, illness)				
Types of Treatment & Medication: (Testing, Monitoring, Surgery)				
Supervising Physician's Name, Address, & Phone Number.				
Question No.	Person Treated	Date of Diagnosis	Date Last Treated	Ongoing Symptoms/Treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Description: (diagnosis, condition, illness)				
Types of Treatment & Medication: (Testing, Monitoring, Surgery)				
Supervising Physician's Name, Address, & Phone Number.				
Question No.	Person Treated	Date of Diagnosis	Date Last Treated	Ongoing Symptoms/Treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Description: (diagnosis, condition, illness)				
Types of Treatment & Medication: (Testing, Monitoring, Surgery)				
Supervising Physician's Name, Address, & Phone Number.				

APPLICANT	SSN

Question No.	Person Treated	Date of Diagnosis	Date Last Treated	Ongoing Symptoms/Treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Description: (diagnosis, condition, illness)				
Types of Treatment & Medication: (Testing, Monitoring, Surgery)				
Supervising Physician's Name, Address, & Phone Number.				
Question No.	Person Treated	Date of Diagnosis	Date Last Treated	Ongoing Symptoms/Treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Description: (diagnosis, condition, illness)				
Types of Treatment & Medication: (Testing, Monitoring, Surgery)				
Supervising Physician's Name, Address, & Phone Number.				
Question No.	Person Treated	Date of Diagnosis	Date Last Treated	Ongoing Symptoms/Treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No
Description: (diagnosis, condition, illness)				
Types of Treatment & Medication: (Testing, Monitoring, Surgery)				
Supervising Physician's Name, Address, & Phone Number.				

9. Do you currently have physician who has your most recent and complete medical records regarding your medical history? Yes    No

Applicant Name	Physician Name	Physician Address	Phone Number

10. Within the last 3 years, have you or any applicant consulted a physician or practitioner or had a complete examination performed (including a gynecological exam and emergency room visits)? Yes    No

Person Treated	Date of Visit	Reason for Visit/Condition; Ongoing Treatment	Supervising Physician's Name, Address, and Phone No.

11. Is any immediate family member (whether named or not in this application) pregnant, an expectant father, or in the process of adoption? Yes    No

Family Member Name	Due Date	Please list any complications to date.	Multiple Births/Children Expected?

APPLICANT	SSN

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12. Within the last five (5) years, have you or any of the applicants used tobacco products (i.e. cigarettes, cigars, pipes, smokeless tobacco products, chewing tobacco, etc.)? Yes No

Applicant Name	Tobacco Product Used	Date Started Use	Date Stopped Use

13. Are you or any of the applicants currently totally or partially disabled or receiving any payments due to a disability? Yes No

Applicant Name	Disability Type/Condition	Partial or Total Disability?

14. Have you or any of the applicants ever had fixation/prosthetic devices present including, but not limited to: plates, screws, pins, implants (including breast implants), pacemakers, valve replacements or transplants? Yes No

Applicant Name	Type of Device	Currently Present?	Supervising Physician's Name, Address, and Phone No.

Reason for the Device:

15. Has any applicant ever been arrested for, or had his/her driver's license suspended or revoked for, driving while under the influence of alcohol and/or illegal drugs? Yes No

Applicant Name	Date of Occurrence

16. In the last 12 months, have you or any applicant had a weight loss of more than 15 pounds? Yes No

Applicant Name	Reason for Weight Loss

If medical condition please note: Condition, Treatment/Medication, Supervising Physician Contact Info:

17. In the last 12 months, have you or any applicant taken or been prescribed any prescription drug, whether or not taken, including refills, for any illness or condition? Yes No

Applicant Name	Name of Drug (incl. Dosage & Frequency)	Reason for Taking	Date Last Taken

APPLICANT	SSN

**AUTHORIZATION**

I hereby apply for individual coverage for me and the other people listed on this Application. By signing this Application, I am certifying that all the information contained in this Application is correct to the best of my knowledge and belief for me and for each of the applicants, and that no material information has been withheld or omitted. I also understand that the statements made herein will be used by Avalon Healthcare to underwrite this Application for coverage, and that the information will be relied upon to determine eligibility for coverage.

I understand that this policy limits coverage for pre-existing conditions. This limitation may be waived per Florida Statute 627.6487 if conditions for having prior credible coverage are met.

I acknowledge that Avalon Healthcare must be notified immediately of any change in the health condition or status of either myself or any of the applicants from the date of this Application until the effective date of coverage.

You understand and agree that failure to remit and pay premium by due date or during the grace period will be considered a default in premium payment, and that coverage will be terminated by us retroactively to the premium due date. Your coverage will be terminated in accordance with the termination section of the Plan Certificate.

**I further acknowledge that any person who knowingly and with the intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.**

\_\_\_\_\_  
 Primary Applicant Signature  
 (Parent/Guardian if Primary Applicant is under the age of 18)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Spouse Signature (if applicable)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Dependent Signature (if over 18)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Dependent Signature (if over 18)

\_\_\_\_\_  
 Date

**AGENT INFORMATION**

I hereby acknowledge that the Applicant has completed this information or that I have completely and accurately recorded all the information given to me by the Applicant. I personally know of no other medical conditions pertaining to the Primary Applicant or any of the other applicants that is not disclosed on this Application. I have thoroughly and clearly explained all of the benefits and limitations of this insurance policy. I have instructed the Applicant that I have no authority or right to bind insurance coverage and that no coverage will be binding until approved in writing by Avalon Healthcare. Additionally, the Applicant has been advised not to cancel any policies currently in place prior to receiving written notice of coverage.

\_\_\_\_\_  
 Agent's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 FL License Number

\_\_\_\_\_  
 Print Name

\_\_\_\_\_  
 Agent's Avalon ID (required)

\_\_\_\_\_  
 Agent's Email

\_\_\_\_\_  
 Agent's Phone

\_\_\_\_\_  
 Agent's Fax

\_\_\_\_\_  
 Agent's GA or MGA Name and Company Name

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**PAYMENT INFORMATION**

Please select a payment option below:

**Check Enclosed**

I understand that my check will be deposited when coverage is approved. An additional [\$30] fee will be applied for any returned checks. My account will be set up to be billed monthly unless another option is selected below.

**Credit Card as Payment**

For my initial payment, if no check is enclosed with the application, I understand that my card will be charged when coverage is approved. Also, by checking here I am indicating that, if I am approved for coverage, I wish for my monthly premium to be automatically charged on a recurring basis to my credit card. My credit card account will be charged on the 28<sup>th</sup> of the month prior to the first of the coverage month. Fifteen days written notice will be required to alter this selection.

I hereby authorize Avalon Healthcare, Inc. to bill my premium to my  **VISA**  **OR**  **MasterCard**

Cardholder's Signature	Card Number	/
Print Name as it Appears on Card	CSV Number <small>(last 3 digits on signature panel on back of card)</small>	Expiration Date <small>Month/Year</small>

Billing Address (if different from Primary Applicant's home address)

**OPT-OUT OF RECURRING PAYMENT OF PREMIUMS BY CREDIT CARD**

By checking here I am indicating that, if I am approved for coverage, I am paying my first month premium by credit card but I **DO NOT** wish for my monthly premium to be automatically charged on a recurring basis to my credit card. I understand that my account will be set up to be billed monthly.

**Bank Draft (ACH) as Payment**

I hereby authorize Avalon Healthcare, Inc. to debit my monthly approved premium to my  **Checking Account**  **Savings Account** For my initial payment, if no check is enclosed with the application, I understand that my account will be debited when coverage is approved. An additional [\$30] fee will be applied for returns of payment for insufficient funds.

By checking here I am indicating that, if I am approved for coverage, I wish for my monthly premium to be automatically debited on a recurring basis from my bank account. My bank account will be debited three (3) business days prior to the first of the coverage month. Fifteen days written notice will be required to alter this selection.

Account Holder's Signature	Account Number	Routing Number
Name on the Account	Relationship to Primary Applicant	

Bank Name ( )	Bank Address
Bank Phone No.	

**OPT-OUT OF RECURRING PAYMENT OF PREMIUMS BY ACH/BANK DRAFT**

By checking here I am indicating that, if I am approved for coverage, I am paying my first month premium by bank draft but I **DO NOT** wish for my monthly premium to be automatically debited on a recurring basis to my bank account. I understand that my account will be set up to be billed monthly.

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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, veterans administration facility, urgent care facility or other medical or medically related facility, insurance company, medical information services organization, or any other provider of health care that has any records or knowledge of me or my health, or any member of my family or their health to release any such information to Avalon Healthcare, Inc. or its business associates. I understand that this protected health information will be used to locate or underwrite insurance for me, and/or my family, or to determine whether a valid claim for benefits has been made. This specifically includes the release of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions.

Avalon Healthcare, Inc. and any related business associates are authorized to receive and use my health information to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or changed if I have made any omission(s) or misrepresentation(s) in my application which are material to the underwriting process.

A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for ten years from the date of signature. I understand that I am entitled to receive a copy of this authorization and that I may revoke this authorization at any time in writing unless action has been taken on my authorization.

\_\_\_\_\_  
 Primary Applicant Signature  
 (Parent/Guardian if Primary Applicant is under the age of 18)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Spouse Signature (if applicable)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Dependent Signature (if over 18)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Dependent Signature (if over 18)

\_\_\_\_\_  
 Date