

## Application Packet



Have you:

- Signed all forms necessary for health insurance application?
- Answered all applicable medical questions?
- Selected a method of payment and enclosed a voided check, if you selected Automatic Bank Draft?



# Colorado Individual Application for Health Insurance



P.O. Box 19032, Green Bay, WI 54307-9032  
(920) 661-1111 • (800) 232-5432

New application       Change in Benefits (specify requested date below in Coverage Information)

This application is to be completed by the applicant applying for coverage. For EarlyCare, application is to be completed by the child's parent or legal guardian if child is not of legal age.

**Applicant Social Security Number**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Group No.**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

### Applicant/Person to be covered for EarlyCare

<b>Last Name</b>		<b>First Name</b>		<b>Initial</b>	
<input type="checkbox"/> Single <input type="checkbox"/> Married	<b>Address</b>		<b>City</b>	<b>State</b>	<b>ZIP</b>
				<b>County</b>	
<b>Home Phone No.</b> ( )	<b>Best time to Call</b>	<b>Work Phone No. (if applicable)</b>	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Date of Birth</b> / /	<b>Height</b>
				<b>Weight</b>	<b>Primary Care Physician's Name</b>
<b>Applicant Occupation:</b> _____					
<b>Beneficiary Name</b>		<b>Last</b>	<b>First</b>	<b>Initial</b>	<b>Relationship</b>
<b>Premium Payer Name</b> (for EarlyCare if not Applicant)		<b>Last</b>	<b>First</b>	<b>Initial</b>	<b>Home Phone No.</b> ( )
<b>Premium Payer Billing Address</b> (for EarlyCare if not Applicant)		<b>City</b>	<b>State</b>	<b>ZIP</b>	<b>County</b>

### Dependent Information (If more space is needed, attach an additional sheet of paper, sign and date it.)

First Name & M.I. (last name if different)	Gender	Date of Birth	Height/Weight	Social Security No.	Primary Care Physician's Name
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/	- -	
<b>Spouse's Occupation:</b> _____					
Child:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/	- -	
Child:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/	- -	
Child:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/	- -	
Dependents (age 19 and older) attending school full-time, include name of dependent, name/address of school, and number of credits: _____					

### Eligibility

Yes  No Are you or any family members covered by Medicare/Medicaid? If yes, list family members and their effective date: \_\_\_\_\_

Yes  No Are you or any family members pregnant (including spouse not applying for coverage)? \_\_\_\_\_

Yes  No Are you or any eligible dependent disabled or hospital confined? \_\_\_\_\_

Yes  No Do any family members intend to keep other insurance coverage in addition to coverage under this policy? If yes, list family members: \_\_\_\_\_

List the name of the other insurance company(ies) and the policy number(s): \_\_\_\_\_

Yes  No Are you or any family members currently eligible for or receiving COBRA or State Continuation benefits? If yes, list names, eligibility dates, and date benefits end: \_\_\_\_\_

Yes  No Are you a U.S. citizen? If no, list how long in the U.S.: \_\_\_\_\_ (Attach copy of valid permanent resident card)

### Coverage Information

### Benefit Options: (Only available with medical coverage)

<p><b>Medical:</b> <input type="checkbox"/> Applicant <input type="checkbox"/> Applicant/Family <input type="checkbox"/> Applicant/Spouse <input type="checkbox"/> Applicant/Child(ren) <input type="checkbox"/> Child only</p> <p><b>Requested effective date</b> _____ (Effective date may not be guaranteed)</p> <p><b>Network Name</b> _____ <b>Product Name</b> _____</p> <p><b>Deductible/Copay</b> _____ <b>Coinsurance</b> _____</p> <p>Upon signature of this application, I am indicating that I have selected the plan design within the Coverage Information section and that I fully understand the benefit levels of this plan.</p> <p><input type="checkbox"/> I am a HIPAA Eligible Individual under Public Law 104-191 as defined in the Prior coverage section on page 3 of this application but I choose to apply for a Non-HIPAA Eligible medical plan selected. I understand there is no guarantee of policy issuance and that the pre-existing condition limitations of the selected plan will apply regardless of my status as a HIPAA Eligible person. _____</p> <p>The HIPAA Eligible guarantee issue plan is CoverColorado.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No Supplemental Accident Benefit</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Optional Dental Plan</p> <p>Plan Selected: _____</p> <p>Prescription Drug: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____</p>
---	---

### Home Office Use Only

Depending upon state law, this information may be submitted as evidence of insurability.

### MEDICAL HISTORY

- A.  Yes  No Have you or any eligible dependent ever been declined, postponed, ridered, rescinded, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, explain: \_\_\_\_\_
- B.  Yes  No In the past five years, have you or any person to be insured received treatment, received therapy, taken medication, or consulted a health care provider for symptoms? If yes, explain: \_\_\_\_\_
- C.  Yes  No Are you or any person to be insured currently taking any prescription medication, over-the counter medication, or vitamin therapy? Please indicate the reason for use: \_\_\_\_\_
- D.  Yes  No In the past five years, have you or any person to be insured been advised to have a test or treatment, been advised to obtain equipment or service or been advised of a condition that may require attention or treatment? If yes, explain: \_\_\_\_\_
- E.  Yes  No Has any person to be insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or tested positive for HIV? If yes, list names: \_\_\_\_\_
- F.  Yes  No Has anyone to be insured used tobacco products during the previous 12 months? If yes, list names: \_\_\_\_\_
- G. Within the past five years, has any person to be insured ever had any symptoms that would cause an ordinarily prudent person to seek medical care; had any conditions, diagnosis, consultation, routine follow-up, treatment, therapy, been prescribed any medication, been monitored, or received counseling for any of following?... (Provide details to "Yes" answers below.)

- |   |  |   |  |
|---|--|---|--|
| 1. Abnormal Test Results.....                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 34. Infertility Testing/Treatment.....                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Acne.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 35. Lupus/Systemic or Discoid.....                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Alcoholism/Alcohol Abuse.....                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 36. Lymphadenopathy/Immune System.....                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Allergies.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 37. Menstrual Disorder.....                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Arthritis/Pain Disorder.....                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 38. Mental/Nervous/Psychological.....                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Asthma/Respiratory/Sleep Apnea.....                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 39. Mental Retardation/Down's Syndrome.....                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Back/Muscle/Joints.....                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 40. Multiple Sclerosis.....                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Blood Abnormality.....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 41. Muscular Dystrophy/Cerebral Palsy.....                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Bone Disease/Deformity.....                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 42. Neurological Disease/Disorder/Impairment.....                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Breast Condition/Implants/Fibrocystic Breast Disease..... | <input type="checkbox"/> Yes <input type="checkbox"/> No | 43. Osteoporosis/Osteopenia/Bone-Thinning.....                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Cancer/Leukemia/Hodgkin's/Lymphoma.....                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Ovarian Cysts.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Cholesterol, elevated.....                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 45. Pap Smear, abnormal.....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Colitis/Spastic Colon/Polyps.....                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | 46. Paralysis.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Congenital Abnormality.....                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 47. Prostate.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Cystic Fibrosis.....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Rectum Colitis/Irritable Bowel/Other Intestinal Disorder..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Diabetes/Pancreas.....                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 49. Reproductive Organs.....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Digestive System.....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 50. Sexually Transmitted Diseases.....                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Drug or Substance Addiction/Illicit Use.....              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 51. Sinus.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Ear/Throat/Mouth.....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 52. Skin/Growth/Lesion/Abnormality.....                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Eating Disorder-Anorexia, Bulimia, Other.....             | <input type="checkbox"/> Yes <input type="checkbox"/> No | 53. Spinal Disorder.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Emphysema/Lung/COPD/Tuberculosis.....                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 54. Stroke.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Endocrine System or Hormonal Disorder.....                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 55. Systemic Infection.....                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Epilepsy/Seizure.....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 56. Thyroid/Goiter.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Eye or Cataracts.....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | 57. Transplants.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Esophageal Disorder/Gastric Reflux.....                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 58. Tuberculosis.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. Fracture/Dislocation/Internal Fixation.....               | <input type="checkbox"/> Yes <input type="checkbox"/> No | 59. Tumors/Growths/Cysts/Fibroids/Lesions.....                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. Gallbladder.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 60. Ulcerative Colitis/Crohn's/Regional Ileitis.....              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28. Headaches/Migraines.....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 61. Ulcers-Digestive/Skin/Other.....                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 29. Heart/Murmur/Palpitations.....                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | 62. Urinary Tract/Bladder/Kidney.....                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 30. Heart Valve/Mitral Valve Prolapse.....                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 63. Uterine Fibroids.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 31. Hepatitis/Liver.....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 64. Vascular Abnormality/Poor Circulation.....                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 32. Hernia.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 33. High Blood Pressure/Hypertension.....                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

**Provide details to "YES" answers** (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question Letter/No.	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Physician's Name & Address

## Prior Coverage

### Prior Coverage Information for HIPAA Guaranteed Issue Plans

Do you meet the requirements of a Federally Eligible Individual under HIPAA legislation (P.L. 104-191)?

Please indicate yes or no or N/A to the following:

- Yes  No      1. Have you or your dependents had a total of 18 or more months of prior creditable health coverage, the most recent being an employer sponsored plan?
- Yes  No  N/A      2. Are you or your dependents ineligible for coverage under a group plan, Medicare Part A or B, or Medicaid, and do not have any health coverage now in force?
- Yes  No  N/A      3. Was your or your dependents most recent employer sponsored health insurance plan coverage terminated for reasons other than fraud, nonpayment of premiums on your behalf, or intentional misrepresentation of material fact?
- Yes  No  N/A      4. If offered to you and your dependents, did you elect to continue your prior employer sponsored insurance plan coverage under COBRA or a similar state continuation law?
- Yes  No  N/A      5. If you or your dependents elected COBRA or state continuation, has that coverage, or will it soon be, exhausted?
- Yes  No  N/A      6. Have you or your dependents had less than a 63-day break in coverage from the most recent employer sponsored plan?

If you answered **No** to **ANY** of the above questions, the pre-existing condition limitation **MAY** apply to you and any dependents. If you answered **Yes** to **ALL** of the above requirements you or your dependents qualify as a HIPAA eligible person; as a result: 1) we **MAY** waive the pre-existing condition limitation for you and your dependents as allowed by state law, and we will advise you accordingly; or 2) you or your dependents may qualify for a state-sponsored plan. If (2) applies in your or your dependents state, we will advise you or your dependents on how to enroll in the state plan. IF YOU ANSWERED YES TO ALL OF THE ABOVE REQUIREMENTS PLEASE ATTACH A CERTIFICATE OF CREDITABLE COVERAGE FROM THE PRIOR PLAN, OR ANY OTHER DOCUMENTS TO PROVE THAT YOU OR YOUR DEPENDENTS HAD PRIOR COVERAGE.

- Yes  No      7. Are you or your dependents buying this insurance to replace prior **group health** coverage? If no, the pre-existing condition limitation will apply. If yes, according to state law: 1) we may waive the pre-existing condition limitation for you and any dependents; or 2) you may qualify for a state-sponsored plan. If 2) applies in your state, we will advise you on how to enroll in the state plan. If yes, you must also attach a Certificate of Creditable Coverage from the prior plan and complete all of the following:

Prior employer sponsored coverage effective date: \_\_\_\_\_

Prior employer sponsored coverage termination date: \_\_\_\_\_ Reason for prior coverage termination: \_\_\_\_\_

Who was covered? \_\_\_\_\_

Prior coverage was provided by:  your employer sponsored plan     spouse's employer sponsored plan

Give name of prior insurance company, policy/certificate number, address, and phone number: \_\_\_\_\_

- Yes  No      8. If prior coverage was in effect for less than 18 months, did you or your dependents have any preceding health coverage?  
If yes, was the coverage provided by:

your employer group plan     spouse's employer group plan     individual policy you purchased for yourself     other: \_\_\_\_\_

Give name of insurance company and policy/certificate number: \_\_\_\_\_

Who was covered? \_\_\_\_\_

## Terms and Conditions of Insurance

The Applicant shall furnish to American Medical Security Life Insurance Company (AMS) any information required for AMS to underwrite and administer the Insurance. The Applicant shall have records available for AMS to inspect at any time while insurance is in force, and for up to the earlier of three years after termination date, or final adjustment and settlement of claims is made. AMS reserves the right to waive or change any of the above requirements at any time.

### AMS UNDERWRITING REQUIREMENTS

The Applicant is required to submit an Application for Insurance for self and/or for all eligible Dependents to be insured. **Insurance for any person is not effective until the date specified by AMS.** Depending upon the law, AMS may have the right to decline the Application for any person for whom information has been submitted in the Application. AMS will waive the pre-existing limitation for conditions disclosed on this application, but AMS may place an exclusion rider on certain condition(s).

### TERMINATION OF INSURANCE

You may terminate insurance at any time by providing AMS written notice prior to the requested termination date. The termination date will be the first of the month. Insurance will terminate at 12:01 a.m. Central Standard Time on the termination date. AMS will terminate insurance if the Applicant fails to pay premium on the due date, except that coverage continues for a grace period of 31 days after the premium due date. The Applicant may be responsible to pay premium for the grace period coverage. If before any premium due date the Applicant provides advance written notice to AMS of request to cancel, then the grace period coverage does not apply. In addition to reasons for termination that are specified in the Policy, AMS may also reform or rescind for fraud or material misrepresentation. AMS will provide the Applicant with a minimum of 31 days advance written notice of termination date (unless due to nonpayment of premium, fraud or misrepresentation). Termination will not prejudice a valid claim existing on the termination date, unless due to nonpayment of premium, fraud or misrepresentation.

Upon termination, Applicant may request reinstatement of coverage by paying all applicable premium, plus a nonrefundable reinstatement fee when allowed by state law. AMS will deposit payment during review of Applicant's request. Depositing Applicant's check does not mean acceptance and does not guarantee reinstatement. AMS can approve or decline reinstatement request and will notify Applicant in writing.

To be a valid application, your signature and the date you sign it are required.

### Signature Required-Applicant Agreement

I understand that the above answers will be relied upon by AMS in the issuance of a Policy of insurance. I declare all statements contained in this entire form about me and my dependents to be insured are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand and agree that AMS is not bound by any statement made by or to any agent unless written herein. **I agree that no insurance will be effective until the date specified by AMS in the Policy of insurance. The actual effective date may not be the requested effective date.**

To assist with determining my creditable coverage, I authorize any insurance company, third-party administrator, plan administrator, or other carrier or provider of health benefits to release to AMS certificates of creditable coverage and all such information.

State law may require a group health plan to follow rules for use of medical history, rating, renewability, and replacement of prior coverage when the plan is issued to a self-employed individual, a sole proprietor, an independent contractor, a partner, or a sole employee of a Subchapter S or Chapter C Corporation. If such law applies to my state of residence, the agent has advised me about the law and I hereby certify that I do not qualify for such group health plan.

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

For a business group of one only: I meet the definition of a self-employed person who is eligible under Colorado Law. The form waiving my rights to small group plan coverage is attached.

- I also hereby acknowledge receipt of the "Protecting Your Privacy" and "Protecting Your Health Information" notices. I understand that I may request an additional copy of these notices at any time.
- I understand this policy will not pay benefits during the first 12 months after the effective date for a disease or physical condition I now have or have had in the past that has not been disclosed on this application.

Applicant Signature X \_\_\_\_\_ Date \_\_\_\_\_

(If applicant for EarlyCare is not of legal age, signature must be the child's parent or legal guardian.)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant. \_\_\_\_\_

Spouse Signature X \_\_\_\_\_ Date \_\_\_\_\_

(If spouse is to be insured)

Regional Office \_\_\_\_\_

Agent Name \_\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_ Identification Number \_\_\_\_\_

**I certify that I delivered the "Protecting Your Privacy" and the "Protecting Your Health Information" notices to this applicant, as required by law.**

I, \_\_\_\_\_, acting on behalf of AMS certify that the marketing and sale of this health plan comply with the provisions of Section 10-8-601.5 (1)(c)(1) Colorado Law, concerning sale of individual coverage to a business group of one. If this is not the case, I understand that this plan may be regulated as a small group health plan.

Licensed Agent Signature X \_\_\_\_\_

## Signature Required/Authorization To Release Medical Information For Underwriting

Please clearly print all information.

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under an existing policy/certificate of insurance for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining insurance coverage, my revocation will not prevent American Medical Security Life Insurance Company (AMS) from the right to contest a claim under the policy if another law so allows. Should me or my dependents refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Customer Signature X \_\_\_\_\_ Date \_\_\_\_\_  
(For EarlyCare, signature must be the child's parent or legal guardian if customer is not of legal age.)

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

\_\_\_\_\_  
Spouse Signature X \_\_\_\_\_ Date \_\_\_\_\_  
(If spouse is covered)

Signature of Each Covered Dependent Age 18 and over:

X _____	Date _____	X _____	Date _____
X _____	Date _____	X _____	Date _____

# METHOD OF PAYMENT

(Please Print Clearly)

Applicant Name: \_\_\_\_\_

## Credit Card Authorization — (Available for FIRST month payment only. Select ongoing method of payment below.)

VISA     MasterCard     Discover

Cardholder Name: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Cardholder Phone: \_\_\_\_\_

I authorize American Medical Security Life Insurance Company (AMS) to bill my credit card account for the total amount due. This authority is to remain effective until the initial premium payment has been paid to AMS or I provide AMS with written notification of cancellation. I understand that adequate time will be needed to implement any action.

Note: If effective date of coverage is the 15<sup>th</sup> of the month, you will be charged for 1½ months of premium for the initial payment.

→ Signature of Cardholder: \_\_\_\_\_

## Please Select the Method of Payment

- Automatic Monthly Bank Draft (Complete Authorization below)     Quarterly Direct Bill  
 Semi-Annual Direct Bill     Annual Direct Bill  
 List Bill\* (Additional forms required, please see agent for details.) \* Not available in some states

## Automatic Bank Draft Authorization

Name of Depositor/Payer: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_  
Print exact name as it appears on financial institution records.

Bank Name: \_\_\_\_\_  Checking Account     Savings Account

9 Digit ABA Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

I (we) hereby authorize AMS to initiate debit entries to my (our) account and the financial institution named above to debit the same to such account. AMS will not be held responsible for policy lapse or cancellation due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid. AMS is not responsible for charges incurred to the customer from their bank due to late notification of the termination or change. This authority is to remain effective until I (we) provide AMS and the financial institution with written notification of cancellation. I (we) understand that adequate time will be needed to implement any action.

Note: If effective date of coverage is the 15<sup>th</sup> of the month, you will be charged for 1½ months of premium for the initial payment.

If payment is submitted by your employer, you will need to complete a Payment Disclaimer form, when required and/or permitted by state law.

Please attach a voided check to the back of this form.

→ Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

## For Early Care (Complete if Child Only)

Premium Payer Name: \_\_\_\_\_

Premium Payer Billing Address: \_\_\_\_\_

If the VISA/MasterCard/Discover request for payment is declined, or the Automatic Bank Draft or direct payment by check transactions is returned for any reason, a \$25 nonrefundable service fee will be applied when allowed by state law. All total costs will be withdrawn on or around the first of the month.



## Additional Information

- Optional Forms (Signature Required)
  - Authorization to Disclose Medical Information for Customer Service
  - Consent to Release Medical Information
- Notifications
  - Protecting Your Privacy
  - Protecting Your Health Information
  - Federal Women's Health and Cancer Rights Act of 1998



# PROTECTING YOUR PRIVACY

American Medical Security Group, Inc. (AMS)\* strives to protect the personal financial information of current and former customers.

We want you to know that the information you provide is safe and used responsibly. To maintain the level of service you expect from AMS, we may need to share limited personal financial information within our family of companies and with selected business partners.

*You can be certain that protection of your personal financial information is one of our priorities.*

## SAFEGUARDS IN PLACE AT AMS

We use data encryption and storage technology that protect your sensitive personal information. At AMS, we have administrative, technical, and physical safeguards in place to ensure privacy.

These include:

- Policies and procedures for handling information.
- Limited access to facilities where information is stored.
- Requirements for third parties to contractually comply with privacy laws.
- Continuous review of company security practices.

We provide training on confidentiality and customer privacy to ensure employees are dedicated to keeping your personal information safe and secure.

## YOUR PROTECTION ON THE INTERNET

We collect limited data from our Internet site, such as the date, time, and areas of our site that are visited. This general information helps us improve our site and makes it easier and more convenient for you to use.

If we ask for personal information on the Web site, you will enter a "secure" mode. The following security features keep your information safe:

- A secure server using 128-bit encryption and authentication technologies, verified by Verisign, Inc. (a leading provider of secure, online certificates).
- Site design to limit display of customer information to only what is necessary.
- Specific user names and passwords to protect sensitive information.

## TYPES OF INFORMATION WE GATHER AND USE

In administering health benefit plans, we gather and maintain information that may include nonpublic personal information:

- From applications, supporting documents, and other forms (e.g., phone/Social Security/account numbers, income, and employment history).
- About your transactions with us or our affiliates (e.g., payment history and other account information).
- From business partners, vendors, and service companies (e.g., payment processing center or credit union).
- From health-care providers, insurance companies, and third-party administrators (e.g., medical records, claim payment information).

At times, we need to disclose your nonpublic, personal information to our business partners as necessary to affect, administer, or enforce our transactions with you. We may also share all of this information with companies that perform services on our behalf, provided they contractually agree to keep the information confidential.

## IN CERTAIN STATES, YOU MAY BE ABLE TO ACCESS AND CORRECT PERSONAL INFORMATION

You may have the right to access and correct personal information we have collected about you. Personal information includes information that can identify you (e.g., your name, address, Social Security number, etc.).

## OUR COMMITMENT TO YOU

You're a valued customer, and the information you provide to us is safe and used responsibly. We'll continue to maintain your privacy and provide you with information about how we share your nonpublic personal financial information.

If you have questions about our privacy guidelines, please call us toll-free at (800) 232-5432, Ext. 15201, or visit the Web site at [www.eAMS.com](http://www.eAMS.com) and click on Privacy Policy. Customer service representatives are available 24 hours a day, 365 days a year.

\*AMS includes American Medical Security Life Insurance Company and its affiliates. It also includes a contracted and non-affiliated entity, Carolina Benefit Administrators, Inc.

# PROTECTING YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

American Medical Security Group, Inc., its affiliates and subsidiaries, collectively AMS\*, responsibly use your individually identifiable health information (referred to as "confidential information"). Confidential information includes information that is created or received by a health-care provider, health plan, employer, or health-care clearinghouse. It also includes information related to your past, present, or future physical/mental health and payment for the provision of your health care.

*AMS may use and/or disclose your confidential information without your authorization for the following purposes:*

- Rating and other activities relating to the placement or renewal of health benefits.
- Billing, claims payment, review of health-care services, and the management of health-care and related services by health-care providers.
- Providing appointment reminders or information about treatment alternatives, other health-related benefits, and services.
- Providing information for treatment (coordination and management of health-care related services), payment, or health-care operations.

We may also use and/or disclose your confidential information without your authorization as permitted or required by law (e.g., public health authority or Food and Drug Administration matters; public health intervention or investigation purposes; evaluation relating to the medical surveillance of the work place; work-related illnesses or injuries; civil, administrative, or criminal investigations and/or inspections; judicial and administrative proceedings; local, state, and federal law enforcement purposes). We may also use it for disclosures to the sponsor of a group's health plan, health insurance issuer, or HMO.

Your authorization is required for AMS to use your confidential information to determine eligibility for enrollment and continued eligibility under your health plan. An authorization must also be submitted if you choose to appoint individuals, other than those allowed by law, to receive information about you. You may revoke the authorization in writing at any time unless we are acting or have acted in reliance on an existing authorization from you.

*You have the right to:*

- Request an alternate address or other method of contact if you believe that sending your confidential information to its original location may endanger you.
- Inspect and copy your confidential information.
- Request restriction on certain uses or disclosures; however, these restrictions are subject to agreement by AMS.
- Receive an accounting of the disclosures we make involving your confidential information.
- Amend your confidential information (in limited situations).

AMS will maintain the privacy of confidential information as required by law and by the notice currently in effect. AMS is also required to provide this notice of our legal duties and privacy practices related to protected health information. This notice is effective April 1, 2003. We reserve the right to make changes or revisions to the terms of this notice and will send you a new notice if any material changes are made.

If you believe your rights have been violated, you may contact AMS or the secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. You may send information to AMS at the address listed below:

American Medical Security Life Insurance Company  
Attn: Customer Service Department/Privacy Officer  
P.O. Box 19032  
Green Bay, WI 54307-9032

If you wish to contact the Department of Health and Human Services, please call us and we'll provide you with the appropriate address.

You have the right to receive another paper or electronic copy of this notice. To request another copy or to get more information, you may call AMS at:

**(800) 232-5432, Ext. 15201**

Or visit the Web site at:

**[www.eAMS.com](http://www.eAMS.com)**

Customer service representatives are available to assist you 24 hours a day, 365 days a year.

\*AMS includes American Medical Security Life Insurance Company and its affiliates. It also includes a contracted and non-affiliated entities, including Carolina Benefit Administrators, Inc. and Health Plan Administrators, Inc.

# AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE

## Optional Authorization — You are not required to sign.

Please clearly print all information.

For the purpose(s) of customer service and related activities, I hereby agree, on my behalf and on behalf of my minor dependents, that information available regarding coverage or any claim regarding me or my minor dependents may be released by American Medical Security Life Insurance Company (AMS)\* to me, my spouse, my parents (for dependents age 18 or over), my medical providers, my plan sponsors/employers, my agent(s) of record, as applicable, or as may be otherwise lawfully permitted, or as I may further authorize in the box below.

### Optional Additional Authorized Individuals

I additionally authorize the following individual(s) to receive the above-named information.

Full Name: \_\_\_\_\_ Relationship to Customer: \_\_\_\_\_

Full Name: \_\_\_\_\_ Relationship to Customer: \_\_\_\_\_

Please Note: An Authorization is not needed for disclosures related to my or my minor dependents' treatment, the payment for such treatment, or related health-care operations as defined under 45 CFR parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information. I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the authorized recipient and may no longer be protected by state or federal law. This Authorization does not apply to psychotherapy notes.

I agree that a photographic copy of this Authorization shall be as valid as the original and that this Authorization shall expire 15 months after the termination of any coverage I obtain (In Georgia and Texas, 24 months from the signature date). I understand that I may request a copy of this Authorization. I understand that I may revoke this Authorization at any time in writing unless action has been taken in reliance on my Authorization. I understand that I may refuse to sign this Authorization. If I choose to sign this Authorization, I understand that I have the right to request access to my protected health information that may be used or disclosed.

### Information Needed To Identify Your Plan

Primary Customer Identification Number (See ID card for Customer Identification Number): \_\_\_\_\_

Primary Customer Name Printed Clearly: \_\_\_\_\_

→ Customer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*For EarlyCare, the signature must be the child's parent or legal guardian if the customer is not of legal age.*

→ Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*If spouse is covered.*

→ Legal Representative Signature: \_\_\_\_\_ Authority: \_\_\_\_\_ Date: \_\_\_\_\_

*If signed by a legal representative of the customer, please indicate the legal representative's authority to act on behalf of the customer.*

Signature of each covered dependent age 18 and over:

→ Dependent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

→ Dependent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

→ Dependent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

→ Dependent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For copies of this Authorization, visit [www.eAMS.com](http://www.eAMS.com) and click on Privacy Policy or call (800) 232-5432, Ext. 15201. You may fax Authorizations to (920) 661-4415 or mail them to American Medical Security, Attn: Imaging Department, P.O. Box 19032, Green Bay, WI 54307-9032.

\_\_\_\_\_  
Group Number  
For office use only.

\_\_\_\_\_  
Certificate Number

\*AMS includes American Medical Security Life Insurance Company and its affiliates. It also includes a contracted and non-affiliated entity, Carolina Benefit Administrators, Inc.

# CONSENT TO RELEASE MEDICAL INFORMATION

## Optional Consent — You are not required to sign.

Please clearly print all information.

This Consent will permit any physician, medical practitioner, hospital, clinic, Veterans Health Administration facility, insurance/reinsurance company, or other appropriate entity having information about the onset or cause, diagnosis, treatment, prognosis related to any physical or mental condition including drug or alcohol abuse, communicable disease, accident, or injury of you or your minor children, as indicated below, to release to American Medical Security Life Insurance Company or its legal representatives any and all such information. The information you consent to release may include confidential information or a personal medical history for you or your minor children. This information will be used solely for the determination of benefits on the claim and will be held in strict confidence.

As required by state regulations, we need to inform you that the information you authorize for release may include documentation regarding the presence of a communicable disease or venereal disease. This information may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS).

If the documentation received includes information regarding domestic abuse/violence, we cannot use this as a basis for denying, refusing to issue, or canceling your insurance coverage. Nor can this information be used as a basis to restrict or exclude coverage or benefits under your plan. We want to assure you that we are in no way indicating that your records will include this type of information.

You may revoke this Consent at any time upon your written request. It will expire automatically following six months from the date of signature below, except in North Carolina and Wisconsin. In North Carolina this Consent is valid for the term of the policy. In Wisconsin this Consent is valid for the term of the policy or while the claim(s) is pending, whichever is longer. A copy of this document shall be as valid and effective as the original and is available upon request at any time.

The nature of the information consented to be disclosed may include, but is not limited to, the following:

Anesthesia Notes	Drug/Alcohol/Substance Abuse Records	Nurses' Notes	Physicians' Orders
Consult Report	History and Physical	Operative Report	Police/Accident Report
Dental Records	Hospital Records	Pathology/Lab Reports	Progress Notes
Discharge Summary	Medical Records	Pharmacy Records	Therapy Records

If you or any of your dependents have used another name (for example, maiden name, stepchild, etc.), please write the name(s) here:

→ **Customer Signature:** \_\_\_\_\_ **Customer Social Security Number:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*For EarlyCare, signature must be the child's parent or legal guardian if the customer is not of legal age.*

If signed by a representative of customer, please indicate the representative's authority to act on behalf of the customer.

→ **Spouse Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*If spouse is covered.*

Signature of each insured dependent age 18 and over:

→ **Dependent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
→ **Dependent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
→ **Dependent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
→ **Dependent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

For copies of this Consent form, visit [www.eAMS.com](http://www.eAMS.com) and click on Privacy Policy or call (800) 232-5432, Ext. 15201.

\_\_\_\_\_  
Group Number  
For office use only.

\_\_\_\_\_  
Certificate Number

## FEDERAL WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The federal Women's Health and Cancer Rights Act of 1998 requires that benefits must be provided for:

- Reconstruction of a surgically removed breast;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment for physical complications from all stages of mastectomy, including lymphedemas.

These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible, and coinsurance provisions. They are also subject to medical insurance limitations and exclusions.

This notification is a requirement of the act. If you have any questions, our customer service representatives are ready to assist you 24 hours a day, 365 days a year at (800) 232-5432.

American Medical Security Life Insurance Company is the underwriter for fully insured products and administrator for self-funded plans.

Insurance products are underwritten by American Medical Security Life Insurance Company, a wholly owned subsidiary of PacifiCare Health Systems, Inc.

(800) 232-5432 • [www.eAMS.com](http://www.eAMS.com)



Insurance products are underwritten by American Medical Security Life Insurance Company,  
a wholly owned subsidiary of PacifiCare Health Systems, Inc.

# SUPPLEMENTARY REPLACEMENT APPLICATION

Colorado regulation 4-2-1, Replacement of Accident and Health Insurance requires that we provide you with information and questions concerning any prior insurance you may have. The information is used to determine whether as of the date of the application, you have accident and sickness insurance or if accident and sickness insurance is intended to be replaced.

Please review the following statements and complete the questions that follow. Your agent will complete the section titled, Other Insurance Sold to Applicant.

## APPLICANT

---

### Statements

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

### Questions

To the best of your knowledge:

1. Do you have another insurance policy or contract in force?  Yes  No
  - a. If so, with which company? \_\_\_\_\_
  - b. If so, do you intend to replace your current accident and sickness insurance with this policy? \_\_\_\_\_
  
2. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy?  Yes  No
  - a. If so, with which company? \_\_\_\_\_
  - b. What kind of policy? \_\_\_\_\_
  
3. Are you covered for medical assistance through the state Medicaid program:
  - a. As a Specified Low Income Medicare Beneficiary (SLMB)?  Yes  No
  - b. As a Qualified Medicare Beneficiary (QMB)?  Yes  No
  - c. For other Medicaid medical benefits?  Yes  No

## AGENT

---

### Other Insurance Sold to Applicant

List policies sold which are in force: \_\_\_\_\_

List policies sold in the past five years which are no longer in force: \_\_\_\_\_

## SIGNATURES

---

Please sign and send with your application of insurance.

Applicant Signature: X \_\_\_\_\_ Date \_\_\_\_\_

Agent Signature: X \_\_\_\_\_ Date \_\_\_\_\_

If it is determined that your intent is to replace accident and sickness insurance, Colorado regulation 4-2-1 requires that we provide you with the following notice. Please review, complete, sign the notice and send it with your application. A copy of the notice should be kept for your records

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

American Medical Security Life Insurance Company  
3100 AMS Blvd  
Green Bay WI, 54307

According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by American Medical Security Life Insurance Company.

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

### STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

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

- Additional benefits
- No Change in benefits, but lower premiums
- Fewer benefits and lower premiums
- Other (please specify) \_\_\_\_\_

1. Health conditions which you may presently have (i.e. pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
3. If, you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

Agent Signature: X \_\_\_\_\_ Date \_\_\_\_\_

Agent Name: \_\_\_\_\_

Address: \_\_\_\_\_

Applicant Signature: X \_\_\_\_\_ Date \_\_\_\_\_



P.O. Box 19032, Green Bay, WI 54307-9032  
(920) 661-1111 • (800) 232-5432



## COLORADO DETERMINATION OF SELF-EMPLOYED Business Group of One Form

A person who answers "yes" to all four questions below meets the legal definition of a "self-employed business group of one" in Colorado.

### SECTION 1

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

If you answered "yes" to all of the above questions, complete Sections 2 and 3 and sign and date the form. If you answered "no" to any of the above questions, skip Sections 2 and 3 and sign and date the form.

### SECTION 2

When a Business Group of One applies for an individual health benefit plan to include coverage for his/her family, Colorado law requires that the insurance carrier accept or reject the entire family, unless the applicant waives coverage for a family member who has other coverage in effect. If you are applying for coverage for your family, please list the names of all your dependents and provide the information requested.

	Full Name (Please Print)	Birth Date	Waiving Coverage	Type of Other Health Coverage	Effective Date of Other Coverage
Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent 1			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent 2			<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent 3			<input type="checkbox"/> Yes <input type="checkbox"/> No		

### SECTION 3

Please read and sign the following disclosure required by Colorado law:

I, \_\_\_\_\_, meet the definition of a self-employed business group of one as attested to on the Determination of Self-Employed Business Group of One section of this form (Section 1). I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three (3) year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of type of health plan, persons covered, selected plan options, geographic location, age and sex of applicants and covered dependents, Medicare eligibility status, mandated state requirements, and industry classifications. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, my age, overall cost and utilization trends ("index rate"), my family size, and a factor that reflects the cost of care where I live.

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

**I, \_\_\_\_\_, attest that the answers to the questions contained in this form are true and correct. I further certify that the statements and representations contained in Sections 2 and 3 of this form, if applicable, are true and correct. I understand that this form will become part of my application for insurance provided by American Medical Security Life Insurance Company if I am a "self-employed business group of one" person.**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Applicant's Business \_\_\_\_\_