

### APPLICATION INSTRUCTIONS:

Thank you for your request for information on Cox HealthPlans' **Individual PPO Health Plans**. Included for your review is the Benefit Schedule and Rates for our **Traditional (90/10) Plan**, for Adults & Family Coverage, as well as our new **Value First (80/20) Plan**. If you need coverage for just your children, you may choose our **Kids First Plan** available on both the Traditional PPO Plan as well as the Value First Plan.

Before submitting your application, we strongly suggest you give us a call and set up a time to go over the plan you are considering in detail. Or, just give us a call with any questions you might have at **(417) 269-4679 or (800) 664-1244**.

To apply for **Traditional or Value First Individual Health Coverage**, follow the directions and complete the checklist below:

Complete the "Individual Application For Health Insurance" found in the right side of the application packet folder.

**Section I:** Reason for Application - Check mark the "New Applicant" box, if you are applying for new membership.

**Section II:** Coverage Options.

- A - Tobacco Use, Answer "yes" or "no"
- B - The "Requested Effective Date" must always be the 1<sup>st</sup> of the month that you need coverage.
- C - This section is designed to let us know which plan you are applying for, whether or not you want to add the \$30 Physician Office Visit copay, and which deductible you are choosing. **Selecting the Physician Office Visit copay will add \$15 per month per person to your premium. Choosing the "Coinsurance" box just means that when you go to the doctor, your charges will be applied to your deductible. After the deductible is met we will pay 90-80% if you are using in-network providers**
- D - Optional Riders - Select "Kids First Plan" if you are applying for child-only coverage. If you choose Kids First, you must name a Parent/Legal Guardian in the box provided (please print). If you do not want or need the maternity coverage, you will need to checkmark the "Maternity Waiver Rider" box. If this box is not checked and you are a female under age 45, you will be charged the additional premium and will have maternity coverage after the 12-month waiting period. **Please note that if you opt out of maternity coverage at this time, there will be a 12-month wait if you decide you need the maternity coverage in the future.**

**Section III, IV and V:** Complete these sections.

**Section VI:** HIPAA Eligibility - Your answers to this section will let our Underwriter know if you qualify for "Guaranteed-Issue" under the HIPAA law.

**Section VII:** Authorization for Use or Disclosure of Protected Health Information - This section allows you to authorize another person, not listed on your application, to call and talk to us about your claims, billing, etc. For example, you may name your agent, your spouse, or anyone you would want to be able to call and talk to us about your policy

**Section VIII:** Health Statement - It is very important that the person who signs the application as the policyholder completes this section. For your protection, please be very thorough including all medical history that would be discussed in your medical records. Any questions in this section that you answer "yes" to, need to be explained in the space provided on page 4 of 5.

**Section IX:** Agent Certification - This section only needs to be completed if you are working with an insurance agent. The agent must complete this section. If you are not applying through an agent, leave this section blank.

**Section X:** Authorization - The two boxes with the Yes/No choices must be completed as well as the appropriate names and signatures in the space below.

(Continued on back)

**Section XI:** Company Approval – This space will be completed by Cox HealthPlans representatives.

**Premium Payment** – You must submit your first month’s premium payment with your application. Your check will not be cashed until you are approved for coverage. If you are declined coverage with us, we will return your original check. Optional: If you want future premium payments to come out of your checking or savings account, you will need to complete the “Authorization Agreement For Individual Direct Debit” form located in your packet stapled to the “Direct Payment is Now Available” page.

**Mail your completed application and paperwork to: Cox HealthPlans, Attn.: Individual Department, PO Box 5750, Springfield, MO 65801-5750 or, if you are applying from an application packet you received in the mail, use the envelope provided. You may also deliver it to our physical address, 3200 S. National, Springfield, MO 65807.**

You may receive a call from our Medical staff to review your application. This part of the process will only take a few minutes. After underwriting is complete, you will receive a letter notifying you of our underwriting recommendation. If for any reason your application is declined, your original premium check will be returned.

Thank you for considering Cox HealthPlans!

**Please read below for information on Cox HealthPlans’ membership and reporting practices with the Medical Information Bureau (MIB).**

**Medical Information Bureau (MIB) Reporting:**

Information regarding your insurability will be treated as confidential. Cox Health Systems Insurance Company, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit Membership organization of life insurance companies, which operates an information exchange on behalf of its Members. If you apply to another Bureau Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. If you question the accuracy of information in the Bureau’s file, you may contact the Bureau and send a correction with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau’s information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, and telephone number (617) 426-3660.

Cox Health Systems Insurance Company, or its reinsurers, may also release information in its files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**COX HEALTH SYSTEMS INSURANCE COMPANY  
INDIVIDUAL APPLICATION FOR HEALTH INSURANCE**

**SECTION I: REASON FOR APPLICATION**

New Applicant     Add a Dependent     Dependent to Policyholder     Lower Deductible

**SECTION II: COVERAGE OPTIONS**

**A** In the last 12 months, has anyone applying for coverage smoked cigarettes, pipes, cigars, or used any form of tobacco?     YES     NO

**B** REQUESTED EFFECTIVE DATE:

| C   | PLAN: Check one:                             | COINSURANCE   | OOP Max   | Office Visit - Select one   | Deductible - Select one  |  |  |
|---|--|---------------|---|---|--|--|--|
|   | <input type="checkbox"/> <b>Traditional:</b> | 90/60         | \$2500/\$5000   | <input type="checkbox"/> \$30 COPAY<br><input type="checkbox"/> COINSURANCE   | <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1000<br><input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000 |  |  |
| <input type="checkbox"/> <b>ValueFirst:</b> | 80/50  | \$3000/\$6000 | <input type="checkbox"/> \$30 COPAY<br><input type="checkbox"/> COINSURANCE | <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000<br><input type="checkbox"/> \$10000 |  |  |  |
| <input type="checkbox"/> <b>Other:</b>      |  |               |   |   |  |  |  |

**D** OPTIONAL RIDERS: By selecting any of these riders, you are agreeing to adjusted premiums as applicable.  
 **SPEECH AND HEARING RIDER**                       **MATERNITY WAIVER RIDER** - Removes all maternity benefits  
 **KIDS FIRST PLAN** - Minor Dependent Only Rider. Please print name of parent/legal guardian of minor.

PARENT/LEGAL GUARDIAN:

**SECTION III: APPLICANT INFORMATION**

Please print in ink.

**A** LEGAL NAME (Last, First, MI)

|  |             |             |                       |         |         |
|--|-------------|-------------|-----------------------|---------|---------|
| SOCIAL SECURITY #:                         | BIRTHDATE:  | AGE         | GENDER:<br><b>M F</b> | HEIGHT: | WEIGHT: |
| RESIDENTIAL ADDRESS:                       |             | CITY:       | STATE:                | ZIP:    |         |
| MAILING ADDRESS (If different from above): |             | CITY:       | STATE:                | ZIP:    |         |
| HOME PHONE:                                | WORK PHONE: | CELL PHONE: | FAX:                  | EMAIL:  |         |

**B** MARITAL STATUS:     SINGLE     MARRIED     DIVORCED     WIDOWED

**C** OCCUPATION: Please print

EMPLOYER NAME:

YEARLY HOUSEHOLD INCOME: \$

Do you and your spouse read, write, speak and understand the English language?     YES     NO

**SECTION IV: DEPENDENT INFORMATION** - Please print. If your dependent(s) is 19 years of age or older and handicapped or is a full time student in an accredited institution, please provide documentation of this status.

|       |                              |              |     |                       |                    |
|-------|------------------------------|--------------|-----|-----------------------|--------------------|
| Dep 1 | LEGAL NAME (Last, First, MI) | RELATIONSHIP |     |                       |                    |
|       | SOCIAL SECURITY #:           | BIRTHDATE:   | AGE | GENDER:<br><b>M F</b> | HEIGHT:    WEIGHT: |
| Dep 2 | LEGAL NAME (Last, First, MI) | RELATIONSHIP |     |                       |                    |
|       | SOCIAL SECURITY #:           | BIRTHDATE:   | AGE | GENDER:<br><b>M F</b> | HEIGHT:    WEIGHT: |
| Dep 3 | LEGAL NAME (Last, First, MI) | RELATIONSHIP |     |                       |                    |
|       | SOCIAL SECURITY #:           | BIRTHDATE:   | AGE | GENDER:<br><b>M F</b> | HEIGHT:    WEIGHT: |
| Dep 4 | LEGAL NAME (Last, First, MI) | RELATIONSHIP |     |                       |                    |
|       | SOCIAL SECURITY #:           | BIRTHDATE:   | AGE | GENDER:<br><b>M F</b> | HEIGHT:    WEIGHT: |
| Dep 5 | LEGAL NAME (Last, First, MI) | RELATIONSHIP |     |                       |                    |
|       | SOCIAL SECURITY #:           | BIRTHDATE:   | AGE | GENDER:<br><b>M F</b> | HEIGHT:    WEIGHT: |

**Other**

Do all dependents reside with applicant?     YES     NO     N/A    *If 'NO' please explain below.*

Do you have an adoption pending?     YES     NO     N/A    *If 'YES' please explain below.*

Details:

**SECTION V: OTHER COVERAGE (Must be completed or will be returned).**

|          |   |  |              |          |           |
|----------|---|--|--------------|----------|-----------|
| <b>A</b> | <input type="checkbox"/> YES <input type="checkbox"/> NO  | Does any person listed on this application have other health, accident, or indemnity insurance?    |              |          |           |
| <b>B</b> | <input type="checkbox"/> YES <input type="checkbox"/> NO  | Will this plan replace existing insurance? If yes, please list below and provide termination date. |              |          |           |
| <b>C</b> | Please list below ALL health insurance carriers by which any person listed on this application has been insured in the last 5 years. Include all pertinent dates. |  |              |          |           |
|          | Name of Insurance Company   | Policy #   | Type of Plan | Eff Date | Term Date |
|          |   |  |              |          |           |
|          |   |  |              |          |           |
|          |   |  |              |          |           |

**SECTION VI: HIPAA ELIGIBILITY (You must complete this section)**

|          |   |  |
|----------|---|--|
| <b>A</b> | <p>The Health Insurance Portability and Accountability Act (HIPAA) and related state laws require insurance carriers or state sponsored plans to offer coverage to eligible individuals. If you do not qualify for our standard issue plans, you may be eligible for a HIPAA guaranteed issue plan. The benefits of the HIPAA plans are the same as the benefits of the standard issue plans, except that there are only 2 deductible options available. Individuals who are eligible for a HIPAA plan are guaranteed acceptance and won't have any exclusions or waiting periods for coverage of existing medical conditions. The premium for the HIPAA plans are considerably higher than standard premiums. <b>An eligible individual is a person who meets ALL of the following requirements:</b></p> <ol style="list-style-type: none"> <li>1. On the date of application for coverage, has had 18 months or more of creditable coverage without a break in continuous coverage of more than 63 consecutive days;</li> <li>2. The most recent prior creditable coverage was under a group health plan, governmental plan, or church plan;</li> <li>3. Does not have other health insurance coverage;</li> <li>4. Has no right to other insurance, such as another group health plan, Medicare or Medicaid, COBRA, or continuation coverage under a state plan. If the individual was offered COBRA or state continuation, they must have elected and exhausted that coverage;</li> <li>5. With respect to the most recent creditable coverage; was not terminated for nonpayment of premium or fraud.</li> </ol> |  |
| <b>B</b> | <input type="checkbox"/> YES <input type="checkbox"/> NO  | <p>Can you answer 'Yes' to all the statements above?<br/>                 If 'Yes', you and your listed dependents are eligible for HIPAA plan coverage and you will need to submit a certification of coverage from your previous group carrier. If a certification is unavailable you will need to submit a copy of your previous carrier's ID card, a copy of your previous carrier's specification page or summary plan document, and a copy of your latest bill. These requirements are necessary for each applicant for HIPAA coverage.<br/>                 Your signature on this form attests that the answer above is correct to the best of your knowledge.</p> |

**SECTION VII: AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

As required by HIPAA of 1996, Cox Health Systems Insurance Company (CHSIC) may not use or disclose your personal health information (PHI) without your authorization. Use this section to authorize persons other than yourself to receive your PHI from CHSIC.

I authorize CHSIC to use or disclose information only as indicated below, that pertains to myself and minor dependents listed on this application. I understand that information disclosed pursuant to this authorization may be redisclosed to additional parties by the authorized recipient(s) listed below and no longer protected. I understand that I may revoke this authorization by submitting a request to revoke in writing to CHSIC. I further understand that any revocation does not apply to the extent that persons authorized to use or disclose my information have already acted in reliance on this authorization. (See Section X for complete authorizations).

**I understand that I am under no obligation to complete this section of the application.**

|  |   |
|--|---|
| Type of information:   | For:  |
| <input type="checkbox"/> Protected Health Information                      | <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents |
| <input type="checkbox"/> Claim Status                                      | <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents |
| <input type="checkbox"/> Billing Information                               | <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents |
| <input type="checkbox"/> Other: <input style="width: 150px;" type="text"/> | <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents |

|                        |                            |
|------------------------|----------------------------|
| Authorized Recipients: | Relationship to Applicant: |
|                        |                            |
|                        |                            |
|                        |                            |

**SECTION VIII: HEALTH STATEMENT**

Please print

Please list below all medications any applicant listed is taking or have taken in the last 12 months. Include non-prescription or 'over the counter' medications. (Use additional paper if necessary, sign and date all pages.)

**MEDICATIONS**

| Applicant's name | Diagnosis of Condition | Date medication started | Date medication stopped | Prescription name | Dosage | Frequency taken |
|------------------|------------------------|-------------------------|-------------------------|-------------------|--------|-----------------|
|                  |                        |                         |                         |                   |        |                 |
|                  |                        |                         |                         |                   |        |                 |
|                  |                        |                         |                         |                   |        |                 |
|                  |                        |                         |                         |                   |        |                 |
|                  |                        |                         |                         |                   |        |                 |
|                  |                        |                         |                         |                   |        |                 |
|                  |                        |                         |                         |                   |        |                 |
|                  |                        |                         |                         |                   |        |                 |
|                  |                        |                         |                         |                   |        |                 |

**HEALTH HISTORY**

**IMPORTANT! PLEASE GIVE COMPLETE DETAILS ON PAGE 4 "ADDITIONAL MEDICAL DETAILS" OF EACH YES ANSWER BELOW.**

WITHIN THE LAST 10 YEARS, HAS ANY APPLICANT LISTED BEEN ADVISED OF, DIAGNOSED, TREATED, HAD SYMPTOMS OF, TAKEN MEDICINE FOR, OR CONSULTED WITH A MEDICAL PROFESSIONAL FOR THE FOLLOWING CONDITIONS:

|  |   |
|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | a) The lungs or respiratory system, including but not limited to: hayfever, allergies, sinus infections, asthma, bronchitis, tuberculosis, pneumonia, emphysema, or sleep apnea?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | b) The heart or circulatory system including but not limited to: high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis or elevated cholesterol?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | c) The digestive system including but not limited to: ulcer, gastritis, heartburn, intestinal disorder, colitis, irritable bowel, gallbladder, hemorrhoids, hernia, disorder of the pancreas, spleen, acid reflux, liver, hepatitis, jaundice or cirrhosis?         |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | d) The nervous system including but not limited to: epilepsy, seizures, unconsciousness, convulsions, dizziness, headaches, paralysis, multiple sclerosis, cerebral palsy, Parkinson's disease, stroke, mini-stroke, TIA or brain attack?                           |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | e) The genitourinary system including but not limited to any kidney disorder, kidney stones, cystitis, prostatitis, bladder infections?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | f) The muscular, skeletal, connective tissue or joint disorder including but not limited to: broken bones, arthritis, lupus (SLE), back pain, neck pain, spine disorder or chiropractic therapy?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | g) Injuries on the job, workers compensation, work related injury, disability or athletic injury?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | h) Congenital disorder, birth defects or developmental disorders including but not limited to: Down Syndrome, mental retardation, autism, cleft palate, club foot, congenital heart defects or heart murmur?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | i) Diabetes, high or low blood sugar, disorder of the thyroid, breast, or other glands?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | j) Blood or lymph disorders, tested positive for HIV?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | k) Cancer, tumor, cyst, skin condition, or growth of any kind? Provide location, and treatment  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | l) Any disorder of the eyes, ears, (including ear infections or ear tubes), nose, mouth, throat, tonsils, adenoids, any speech or hearing impairment?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | m) Any disorder of the reproductive organs, including but not limited to: disorders of the penis, testes, vagina, ovaries and cervix, uterus, diagnosed or treated for pelvic pain, endometriosis, ever had an abnormal pap smear, or sexually transmitted disease? |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | n) To the best of your knowledge, are you, your spouse or any dependent now pregnant?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | o) Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage?  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | p) Does any person have any fixation/prosthetic devices present including but not limited to plates, screws, pins, implants (including breast implants), shunts, pacemakers, or valve replacements?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | q) Any surgery, diagnostic testing, or treatment recommended that has not been completed?   |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | r) Been hospitalized or treated at an emergency room? If yes, give name of hospital, and reason for seeking treatment.  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO | s) Mental disease or nervous disorder including but not limited to any emotional disorder, anxiety, depression, attention deficit, hyperactivity, eating disorder, or psychiatric treatment or counseling?  |



**SECTION IX: AGENT CERTIFICATION (To be completed by agent representing applicant(s).)**

|                       |  |  |                                |              |
|-----------------------|--|--|--------------------------------|--------------|
| <b>AGENT USE ONLY</b> | <input type="checkbox"/> YES <input type="checkbox"/> NO | Each question has been read by each proposed insured. I represent the information to be complete and accurate to the best of my knowledge and belief, and understand that this application and other required parts shall not be binding until approved by Cox Health Systems Insurance Company. I certify that each person proposed for insurance has read the completed application and that I have witnessed the signatures on the application.                     |                                |              |
|                       | <input type="checkbox"/> YES <input type="checkbox"/> NO | The undersigned Agent realizes any false statement or misrepresentation, if material to the risk, may result in loss of this insurance coverage, and requires the applicant(s) to reimburse Cox Health Systems Insurance Company for claims paid and due to these false statements or misrepresentations. <b>I understand Cox Health Systems Insurance Company will diligently review submitted medical claims and filled prescriptions to enforce this provision.</b> |                                |              |
|                       | NAME OF WRITING PRODUCER PRINTED:                        |  | SIGNATURE OF WRITING PRODUCER: | DATE SIGNED: |
|                       | MISSOURI PRODUCER LICENSE #:                             |  |                                |              |

**SECTION X: AUTHORIZATION (This must be completed, signed, and dated).**

|  |   |  |   |  |
|--|---|--|---|--|
| <b>APPLICANT MUST READ, COMPLETE, AND SIGN THIS SECTION.</b> | <input type="checkbox"/> YES <input type="checkbox"/> NO  | I have personally completed this application. I represent the information to be complete and accurate to the best of my knowledge and belief, and understand that this application and other required parts shall not be binding until approved by Cox Health Systems Insurance Company. The undersigned Applicant(s) certify that each person proposed for insurance has read the completed application.  |   |  |
|  | <input type="checkbox"/> YES <input type="checkbox"/> NO  | The undersigned Applicant(s) realize any false statement or misrepresentation, if material to the risk, may result in loss of this insurance coverage, and requires the applicant(s) to reimburse Cox Health Systems Insurance Company for claims paid due to these false statements or misrepresentations. <b>I understand Cox Health Systems Insurance Company will diligently review submitted medical claims and filled prescriptions to enforce this provision.</b> |   |  |
|  | <p>I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Cox Health Systems Insurance Company (CHSIC), its legal representative or any medical records retrieval service CHSIC may engage.</p> <p>This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data and EKG's. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by CHSIC pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.</p> <p>I understand that this authorization is required in order to enable CHSIC to make eligibility or enrollment determinations, and underwriting or risk rating determinations, relating to me and/or my minor children. If I refuse to sign or revoke this authorization, CHSIC may refuse to consider my application for enrollment.</p> <p>I understand that I may revoke this authorization at any time by submitting an Authorization Revocation form, available upon request, to Cox Health Systems Insurance Company. Such revocation will not be valid if CHSIC has taken action in reliance on the authorization.</p> <p>Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Cox Health Systems Insurance Company.</p> |  |   |  |
|  | PRINTED NAME OF APPLICANT   |  | PRINTED NAME OF SPOUSE APPLYING FOR COVERAGE (REQUIRED)         |  |
|  | SIGNATURE OF APPLICANT/OR PERSONAL REPRESENTATIVE   |  | SIGNATURE OF SPOUSE APPLYING FOR COVERAGE (REQUIRED)            |  |
|  | DATE SIGNED:  |  | DATE SIGNED   |  |
|  | PRINTED NAME OF PERSONAL REPRESENTATIVE*  |  | PRINTED NAME OF DEPENDENT AGE 18 OR OVER APPLYING FOR COVERAGE. |  |
|  | RELATIONSHIP TO APPLICANT   |  | SIGNATURE OF NAMED APPLICANT ABOVE / OR PERSONAL REPRESENTATIVE |  |
|  | DATE SIGNED   |  | DATE SIGNED   |  |
|  | *If you are the Personal Representative of the applicant and are not the parent or legal guardian, you must attach documentary evidence of your authority to act as the individuals' representative for this authorization to be valid.   |  |   |  |

**SECTION XI: COMPANY APPROVAL**

|  |               |             |
|--|---------------|-------------|
| This application has been approved for issuance by Cox Health Systems Insurance Company. |               |             |
| SIGNATURE OF OFFICER OF COMPANY  | COMPANY TITLE | DATE SIGNED |



## **DIRECT PAYMENT IS NOW AVAILABLE!!!**

**Cox Individual Health Plans would like to offer you the option of having your monthly premium automatically withdrawn from your checking or savings account.**

This option is **FREE!** There is no service charge for using this payment method. It's **Convenient!** No more hassle with writing a check each month and making sure it gets to the Post Office in time. It's **Safe and Secure!** Bank account information is safeguarded; payment information will **NOT** be disclosed for any reason other than processing this transaction.

### **Participating in Direct Payment is Easy!**

- ✓ Just complete the enclosed Authorization Agreement.
- ✓ Attach a voided check to the Authorization Agreement. Please note that we must have a check. No deposit slips will be accepted.
- ✓ Your savings or checking account will be debited on the 1<sup>st</sup> of each month.  
**Keep in Mind, in order to begin your automatic withdrawal from your bank account on the 1<sup>st</sup>, we must receive your Authorization Agreement (the attached form) in our office no later than the 20<sup>th</sup> of the previous month.**

You will continue to receive a monthly invoice. If you have direct deposit, this statement will only be to advise you of the amount that will be debited from your account.

All debits will be made on the 1<sup>st</sup> of each month. If for any reason your account has insufficient funds, another attempt will be made to withdraw money from the account. Please note that if after two attempts funds are not available, your policy will be terminated. In the event that you would need to terminate or change your account information, please contact our office. Please note that it may take up to 10 working days to change account information.

If you have additional questions, please feel free to contact our office at **417-269-4679** or **800-664-1244**.



**COX HEALTH SYSTEMS INSURANCE COMPANY**  
**PO BOX 5750**  
**SPRINGFIELD, MO 65801-5750**

**AUTHORIZATION AGREEMENT FOR INDIVIDUAL  
DIRECT DEBIT**

MEMBER NAME \_\_\_\_\_

New Application     Change account information     Terminate Direct Debit

I (we) hereby authorize Cox Health Systems Insurance Company ("Cox") to initiate debit entries, and the Financial Institution named below to debit, my/our Checking/Savings account in the amount of my/our monthly premium on the 1<sup>st</sup> of each month, which shall be applied by Cox for the payment of my/our health insurance premium. **I/We acknowledge and agree that the timely payment of premiums is my/our sole responsibility and that Cox is not responsible for a policy cancellation due to nonpayment if the direct debit request is presented but not honored or for any other reason the premium is not timely paid.**

FINANCIAL INSTITUTION \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TRANSIT/ABA NO. \_\_\_\_\_ ACCOUNT NO. \_\_\_\_\_

This authorization to debit my/our account will remain in full force and effect until Cox and the above-named Financial Institution receive written notice of termination from me (or either of us), which is effective ten (10) days after receipt or first date on which Cox and the Financial Institution have a reasonable opportunity to act on it, whichever is later.

NAME(S) \_\_\_\_\_

\_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

**Attach voided check here**