

Empire Fire and Marine Insurance Company

Group Major Medical Insurance Application

Home Office Endorsement
 Case No.: _____
 Eff. Date: _____
 Other: _____
 Approved By: _____

New Application Add On Rewrite
 Monthly Bank Draft Monthly Direct
 Quarterly Direct Semi-Annual Direct
 Credit Card
 List Bill New Add On
 List Bill Case No. _____
 Third Party Payor Plan New Add On
The cert./policy will be mailed to the insured.

Applicant's Instructions: (If not applying on-line, please print in blue or black ink. Corrections should be lined through and initialed by the applicant. Do not use white out.) For additional dependents, provide required information on the Supplement to the Application, sign and date it. **Applicant 1 is primary applicant. List only persons who are applying for coverage** except on child(ren) only coverage - parent, though not applying, must be listed as primary applicant.

A. General Information

1. a. Applicant's Name (<i>First, M.I., Last</i>) _____ b. Resident Street Address (<i>PO Box not acceptable</i>) _____ c. City, State, Zip _____ d. E-mail Address _____	5. a. Applicant's Employer Address _____ b. Occupation/Title/Duties _____ c. Check if applicable: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partner <input type="checkbox"/> Owner
2. a. Applicant's Billing Address <input type="checkbox"/> Same as Resident Address _____ b. City, State, Zip _____	6. Spouse's Name (if applying) (<i>First, Middle, Last</i>) _____ 7. a. Spouse's Work Phone _____ b. Best Time To Call: <input type="checkbox"/> Home <input type="checkbox"/> Work _____ a.m. _____ p.m.
3. a. Applicant's Home Phone b. Applicant's Work Phone _____ c. Best Time To Call: <input type="checkbox"/> Home <input type="checkbox"/> Work _____ a.m. _____ p.m.	8. a. Spouse's Employer Address _____ b. Occupation/Title/Duties _____ c. Check if applicable: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partner <input type="checkbox"/> Owner
4. Applicant's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	

9. List All Applicants Applying for Coverage (<i>First, MI, Last Name</i>)	Relationship to Applicant	Ht. ft., in.	Wt. lbs.	Birthdate mo./day/yr.	Sex M/F	Child Age 19 & Over Must Be Full- Time Student--List College Attending (This column does not apply in TX.)	Social Security Number or Valid Work Visa Number, if applicable
	Applicant						
	Spouse						
	Dependent Child						
	Dependent Child						
	Dependent Child						
	Dependent Child						

10. Are all applicants applying for insurance living at the same residence? Yes No If no, please provide explanation indicating person(s) and reason _____
11. Is any eligible family member not applying for insurance under this application? Yes No
 If yes, who and why? _____
 Who is to be insured (check all that apply)? Applicant Spouse Children Children Only
12. Has any adult applicant applying for coverage smoked or used any tobacco products such as cigarettes, cigars, pipes, chewing tobacco or snuff at any time during the last 12 months? Applicant: Yes No Spouse: Yes No
13. **Requested Effective Date** (*check one*) (*subject to approval*):
- I do not have existing health insurance coverage and request the Company to assign the first available effective date following underwriting approval (1st or 15th of the month). I understand I cannot change this date.
- I am replacing existing health insurance coverage and request the Company to assign the effective date as follows: The first available effective date following approval (1st or 15th of the month) OR Month _____ 1st or 15th
 I understand this date can only be changed prior to issue and if I have provided proof of coverage from my prior carrier.
- Other Day _____ ("Other" only available to persons applying under HIPAA.)

If the Company is unable to approve the application within 60 days of the application date, a new, currently dated application may be required.
DO NOT CANCEL ANY EXISTING HEALTH INSURANCE UNTIL RECEIVING WRITTEN NOTICE OF APPROVAL.

Total Amount Submitted \$ _____ (Include insurance premiums, one-time **non-refundable** processing fee, monthly administration fee and, if applicable, billing fee.) Make check payable to Empire Fire and Marine Insurance Company. **DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

B. Type of Coverage Requested

1. HealthVantage	Coinsurance/Stop Loss
<input type="checkbox"/> Patriot PPO	<input type="checkbox"/> PPO 80/20 to \$5,000; NonPPO 60/40 to \$10,000 <input type="checkbox"/> PPO 80/20 to \$10,000; NonPPO 60/40 to \$20,000 <input type="checkbox"/> PPO 50/50 to \$5,000; NonPPO 50/50 to \$10,000 <input type="checkbox"/> PPO 50/50 to \$10,000; NonPPO 50/50 to \$20,000
<input type="checkbox"/> Liberty PPO	<input type="checkbox"/> PPO 100/0; NonPPO 70/30 (75/25 in AR) to \$10,000 <input type="checkbox"/> PPO 80/20 to \$5,000; NonPPO 60/40 to \$10,000 <input type="checkbox"/> PPO 50/50 to \$5,000; NonPPO 50/50 to \$10,000
2. Deductible Selected: <input type="checkbox"/> \$500* <input type="checkbox"/> \$1,000* <input type="checkbox"/> \$1,500* <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 (*Not available on Liberty 100/0 plan.)	
Optional Outpatient Rx Drug Card Benefit MUST SELECT ONE: <input type="checkbox"/> No Rx Coverage <input type="checkbox"/> Rx Copay <input type="checkbox"/> Rx Copay w/\$100 Rx Ded. <input type="checkbox"/> Rx Copay w/\$500 Rx Ded. <input type="checkbox"/> Rx Copay w/\$1,000 Rx Ded.	

OR

3. Sentinel PPO Plan	Coinsurance/Stop Loss
	<input type="checkbox"/> PPO 80/20 to \$5,000; NonPPO 60/40 to \$10,000 <input type="checkbox"/> PPO 80/20 to \$20,000; NonPPO 60/40 to \$40,000
	<input type="checkbox"/> PPO 50/50 to \$5,000; NonPPO 50/50 to \$10,000 <input type="checkbox"/> PPO 50/50 to \$20,000; NonPPO 50/50 to \$40,000
4. Deductible Selected: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	
Optional Outpatient Rx Drug Card Benefit MUST SELECT ONE: <input type="checkbox"/> No Rx Coverage <input type="checkbox"/> Rx Copay w/\$500 Rx Ded. <input type="checkbox"/> Rx Copay w/\$1,000 Rx Ded.	

OR

5. HealthVantage Plus	
Plan	<input type="checkbox"/> Heritage <input type="checkbox"/> Sentry
Coinsurance/Stop Loss	<input type="checkbox"/> PPO 80/20 to \$5,000; NonPPO 60/40 to \$10,000 <input type="checkbox"/> PPO 80/20 to \$10,000; NonPPO 60/40 to \$20,000 <input type="checkbox"/> PPO 50/50 to \$10,000; NonPPO 50/50 to \$20,000
6. Deductible Selected: <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500	

OR

7. QualSaver	Coinsurance
<input type="checkbox"/> PPO	<input type="checkbox"/> 100% PPO/80% NonPPO <input type="checkbox"/> 80% PPO/60% NonPPO <input type="checkbox"/> 50% PPO/50% NonPPO
<input type="checkbox"/> Traditional Indemnity	<input type="checkbox"/> 100% <input type="checkbox"/> 80% <input type="checkbox"/> 50%
Individual Deductible: <input type="checkbox"/> \$1,050 <input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,600 <input type="checkbox"/> \$5,000*	
Family Deductible: <input type="checkbox"/> \$2,100 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,200 <input type="checkbox"/> \$10,000* <i>*Available only with 100% PPO/80% NonPPO or 100% Traditional Indemnity coinsurance plans.</i>	

8. **Indicate desired PPO Network** _____

9. **ALL PLANS-Other Optional Benefits:** Supplemental Accident (option not available on QualSaver)

24 Hour Occupational Coverage*: Applicant Spouse (*If elected, the applicable individual(s) must be gainfully employed and a sole proprietor, partner, owner or other individual who are eligible to opt out of Workers' Compensation and done so per questions D1 and D2 below.)

MS RESIDENTS ONLY: I hereby reject the following optional benefits: All Reject ALL except those selected: Diabetes Treatment
 Temporomandibular Joint and Craniomandibular Joint Disorders Routine Mammograms Anesthesia Benefits for Certain Dental Procedures

10. **Initial Premium Rate Guarantee** (option not applicable on HealthVantage Plus and QualSaver One):
MUST SELECT ONE: 6 Mo. 12 Mo. (Premium Rates may change if you move or enter a new age bracket.)

C. Preferred Health Discount Questions for Applicant/Spouse - Age 18-39

I am applying for the Preferred Health Discount Applicant: Yes No Spouse: Yes No
If neither the applicant or the spouse are applying for the Preferred Health Discount, skip to Section D.

In order to pre-qualify for the Preferred Health Discount, the adult applicant and adult applicant's spouse, if applying, must be: • age 18 but not older than age 39; and • applying for Patriot, Sentinel, HealthVantage Plus or QualSaver Plans; and • able to answer "No" to questions 2 through 6 below. The following questions are being presented to "pre-qualify" the adult applicant and adult spouse, if applying, for the Preferred Health Discount. Completion of this section does not guarantee you will qualify for such discount.

	Applicant		Spouse	
	Yes	No	Yes	No
1. Is the applicant or spouse replacing current major medical health insurance?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If the answer is no, have you:				
a) Had a comprehensive physical exam within the last 12 months (inclusive of build, blood, urine and tobacco testing)?; or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you agree to complete a paramedical exam at no cost to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your height and weight fall outside of the normal height and weight requirements? (Refer to the current American Select Field Underwriting Guide.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the applicant or spouse been diagnosed with, treated for, or advised to seek treatment for:				
a) high or low blood pressure within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) a blood pressure reading in excess of 140/90 in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) total cholesterol in excess of 190 mg within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) any mental or nervous disorder or alcohol or drug abuse within the past 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the applicant or spouse (whether applying or not) received any infertility treatments or medication within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the applicant or spouse within the past 3 years:				
a) used any form of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) had any DUI, DWI or reckless driving convictions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) been advised to schedule any tests, seek treatment, or have surgery that is pending or not been pursued?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the applicant or spouse within the past 2 years been prescribed any maintenance dose medication for ongoing treatment of a chronic or persistent medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. General Questions (Must be completed by all applicants.)

- 1. Is the applicant, if applying, covered by Workers' Compensation or similar legislation? N/A Yes No
If no, is the applicant eligible to opt out of Workers' Compensation in their state? Yes No
- 2. Is the spouse, if applying, covered by Workers' Compensation or similar legislation? N/A Yes No
If no, is the spouse eligible to opt out of Workers' Compensation in their state? Yes No
- 3. Has any applicant had prior medical insurance or is currently insured with Empire Fire and Marine Insurance Company? Yes No
If yes, who? _____ Certificate ID # _____ Date such coverage ended _____
- 4. Has any applicant (excluding MO residents) had any form of health insurance (check applicable box): denied ridered rated-up rescinded Yes No
If yes, who? _____ What was the reason? _____
- 5. a. Is each applicant applying for insurance a U.S. citizen? Yes No
b. If no, do they have resident visas or valid work permits and have resided in the U.S. for the prior six (6) months? Yes No
(If yes, must attach copy of valid visa or work permit. If no, applicant is not eligible for this coverage.)

E. Medical History

Please answer the following questions for all persons applying for coverage. Failure to provide full details may result in rescission or reformation of insurance coverage. Complete details for all "yes" answers must be provided in Section F.

- 1. Are you or any family member, whether or not applying for coverage, currently pregnant or an expectant parent or in the process of adopting a child? If yes, then no family member is eligible to apply for coverage even if the pregnant individual is not applying for insurance. Yes No
- 2. Does any applicant fly or plan to fly as a pilot, do any land/water racing, hang gliding, or rodeo activities? Yes No
- 3. Are any applicants currently totally or partially disabled or receiving any payments due to a disability? If yes, who? _____ Yes No
What condition(s) caused the disability? _____
- 4. Has any applicant ever had a sex transformation or commenced medical/drug treatment for a sex transformation? Yes No
- 5. Has any applicant 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
- 6. 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? If yes, identify person(s), supply driver's license number(s) and state of issue Yes No

- 7. Has any applicant, in the past 10 years been diagnosed or treated by a member of the medical profession for alcoholism or alcohol abuse, been advised by a physician that they have used alcohol in excess, or been advised to modify drinking habits for any reason? Yes No
- 8. Has any applicant, in the past 10 years, been diagnosed with or been treated by a member of the medical profession for drug (either legal or illegal) misuse, abuse or addiction or for chemical substance use or addiction? Yes No
- 9. Has any applicant, in the past 10 years, used any illegal drugs? Yes No
- 10. Has any applicant, in the past 5 years, been informed by a member of the medical profession of an abnormal test result? Yes No
- 11. Has any applicant ever been diagnosed with or medically treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC) or tested positive for HIV or HTLV III? Yes No
- 12. Has any applicant, in the past 5 years, been advised by a member of the medical profession to have any test, examination or surgery that has not been completed? Yes No
- 13. Has any applicant, in the last 12 months, had a weight loss of more than 15 pounds? If yes, what was prior weight? _____ ... Yes No
Reason for weight loss _____
- 14. Has any applicant, in the past 10 years, had any symptoms, 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 (Where multiple conditions exist under one question, **check all that apply and provide complete details in Section F for each condition.**):

- 14A. *Respiratory System:*
 - Allergies
 - Asthma
 - Emphysema or COPD
 - Shortness of Breath, Breathing Difficulty
 - Other Lung Disorder
 - Pulmonary Hypertension
 - Chronic Cough
 - Bronchitis
 - Pneumonia
 - Cystic Fibrosis
 - Spitting Up Blood
 - Sinusitis
 - Tuberculosis
- No applicant has any of the listed Respiratory System conditions.

- 14B. *Circulatory System:*
- | | | | |
|-------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Low/High Blood Pressure |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Angina Pectoris (Chest Pain) | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Palpitations/Irregular Heartbeat |
| <input type="checkbox"/> Valvular Disease or Disorder | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Embolism | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Peripheral Vascular Disease/Vascular Disease or Disorder | |

No applicant has any of the listed Circulatory System conditions.

- 14C. *Digestive System:*
- | | | | |
|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Spleen |
| <input type="checkbox"/> Gallbladder/Gall Stones | <input type="checkbox"/> Stomach | <input type="checkbox"/> Hernia of Any Kind | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Rectum | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Esophagus | <input type="checkbox"/> Reflux (GERD) |
| <input type="checkbox"/> Liver, Bile Duct, Biliary | <input type="checkbox"/> Enteritis, Gastroenteritis | <input type="checkbox"/> Diverticulitis, Diverticulosis | <input type="checkbox"/> Colitis, Spastic Colon, Irritable Bowel |
| <input type="checkbox"/> Ulcerative Colitis or Crohn's | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Anal Fissure | <input type="checkbox"/> Elevated Liver Function Tests |
| <input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | | | |

No applicant has any of the listed Digestive System conditions.

- 14D. *Endocrine System:*
- | | | | |
|--------------------------------------------------------------|-----------------------------------|-----------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Pancreas | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Impaired Glucose Tolerance | <input type="checkbox"/> High or Low Blood Sugar |
| <input type="checkbox"/> Pituitary Disorder | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Goiter | <input type="checkbox"/> Addison's Disease |
| <input type="checkbox"/> Adrenal or Other Glandular Disorder | | | |

No applicant has any of the listed Endocrine System conditions.

- 14E. *Urinary System:*
- | | | | |
|--------------------------------------------------|-----------------------------------------------|--------------------------------------------------|-----------------------------------|
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Bladder, Bladder Stones | <input type="checkbox"/> Urinary Incontinence | | |

No applicant has any of the listed Urinary System conditions.

- 14F. *Male or Female Reproductive System or Genitalia:*
- | | | | |
|----------------------------------------------|------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Caesarean Section | <input type="checkbox"/> Complicated Pregnancy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Ovaries, Ovarian Cyst |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Impotency | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Genital Warts |
| <input type="checkbox"/> Menstrual Disorders | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Uterus | <input type="checkbox"/> Cervix, Abnormal Pap Smear |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Premenstrual Syndrome | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate, Elevated PSA |

No applicant has any of the listed Reproductive System or Genitalia conditions.

- 14G. *Musculo-Skeletal System:*
- | | | | |
|---------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> TMJ/Jaw Disorder | <input type="checkbox"/> Back, Spine, Vertebrae | <input type="checkbox"/> Vertebrae | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Bursitis or Tendonitis | <input type="checkbox"/> Lupus/Erythematosis | <input type="checkbox"/> Connective Tissue Disease or Disorder |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Collagen Vascular Disorder | <input type="checkbox"/> Muscles, Ligaments, Tendons, Cartilage | |
| <input type="checkbox"/> Intervertebral Discs, Bulging, Herniated or Slipped | | <input type="checkbox"/> Arthritis, Osteo, Rheumatoid, Psoriatic | |
| <input type="checkbox"/> Bone Density, Deformity, Infection, Fractures or Dislocation | | <input type="checkbox"/> Spinal Manipulation or Chiropractic Adjustments | |
| <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Joint Disorders or Replacements: | <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Foot | |

No applicant has any of the listed Musculo-Skeletal System conditions.

- 14H. *Nervous System:*
- | | | | |
|--------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Seizures | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Dementia Disease or Disorder | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Brain Disorder | <input type="checkbox"/> Severe/Chronic Headaches or Migraines |
| <input type="checkbox"/> ALS (Lou Gehrig's Disease) | <input type="checkbox"/> Spinal Cord Injury or Disorder | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Down's Syndrome |
| <input type="checkbox"/> Central Nervous System or Neurological Disorder | | <input type="checkbox"/> Dizziness, Fainting Spells, Loss of Consciousness | |

No applicant has any of the listed Nervous System conditions.

- 14I. *Mental or Nervous Disorder:*
- | | | | |
|--------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Attention Deficit/ADHD |
| <input type="checkbox"/> Learning/Behavioral Disorder | <input type="checkbox"/> Neuroses or Psychoses | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Sleep Disorder | <input type="checkbox"/> Chemical Imbalance | <input type="checkbox"/> Suicide Attempt | |
| <input type="checkbox"/> Central Nervous System or Neurological Disorder | | <input type="checkbox"/> Psychiatric or Psychological Treatment or Counseling | |

No applicant has any of the listed Mental or Nervous Disorder conditions.

- 14J. *Miscellaneous:*
- | | | | |
|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Speech | <input type="checkbox"/> Breast Disease or Disorder | <input type="checkbox"/> Skin Disorders, Burns, Acne | <input type="checkbox"/> Basal Cell or Squamous Cancer |
| <input type="checkbox"/> Sleep Disorder, Insomnia | <input type="checkbox"/> Cancer, Tumors, Cysts, Polyps, Growths, Lesions of the Skin or Mouth (provide location, type, treatment) | <input type="checkbox"/> Immune System Disorder, Chronic Fatigue Syndrome | |
| <input type="checkbox"/> Eyes, Glaucoma, Cataracts, Blurred Vision, Detached Retina | | <input type="checkbox"/> Lymphadenopathy (enlarged lymph nodes) | |
| <input type="checkbox"/> Sleep Apnea or Use of a Sleeping Monitoring Device | | <input type="checkbox"/> Ears, Otitis Media, Tubes in Ears | |
| <input type="checkbox"/> Nose, Throat or Tongue, Tonsils, Adenoids | | | |
| <input type="checkbox"/> Premature Birth/Birth Development Disorders | | | |

No applicant has any of the listed Miscellaneous conditions.

15. Has any applicant, in the last 12 months, taken or been prescribed any prescription drug, whether or not taken, including refills, for any illness or condition? Yes No

16. Has any applicant, in the last 5 years, had any symptoms, or consulted with, received medical advice from, been diagnosed, treated, or prescribed any medication by a member of the medical profession for any condition or illness not listed above? Yes No

17. Has any applicant, in the last 12 months, consulted a physician for a physical examination or check up, been treated in an emergency room or care setting or been hospitalized for any reason? Yes No
If yes, please provide details, results and describe what medical advice was given and what treatment was recommended _____

18. Has any applicant, in the last 12 months, been exposed to hazardous materials, including, but not limited to asbestos or toxic chemicals? Yes No

F. Medical History Details

Please supply complete details for answers to questions in section E. If additional space is needed, please use the Supplement to Application Form or a separate sheet of paper. Please sign and date such attachments.

Question No. (e.g. 14A)	Name of Person Treated	Dates of Treatment From To Mo/Yr Mo/Yr	Name of Condition and Diagnosis (Explain Treatment including hospitalizations, surgery and results of any tests)	Name of Drugs & Dosage Prescribed, If Any	Degree of Recovery (Full Recovery or Ongoing)	Treating Physician's Name, Address and Phone Number

G. Prior Carrier Information

Are or were you or any of your dependents applying for this insurance, covered under another health insurance benefit plan, excluding short term medical insurance, within the last 90 days? Yes No If yes, please list person(s) covered: _____

Name and phone number of current/prior health insurance carrier: _____

Policy # _____ Effective date of coverage _____ Paid-to-date of coverage listed or expected termination date _____

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

Failure to disclose complete prior carrier information may result in a delay of processing your application.

H. Health Insurance Portability and Accountability Act (HIPAA)

Federal law provides for waiving of pre-existing conditions limitation period for qualified persons applying under HIPAA. 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 • must not be eligible for group coverage, medicare or medicaid • 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. Persons residing in the following states who desire to obtain coverage under HIPAA must apply through the state's alternative mechanism. Empire **WILL NOT** accept HIPAA applicants in these states: AL, AK, AR, CO, CT, GA, IL, IN, IA, KS, LA, MI, MN, MS, MT, NE, NM, ND, OK, OR, PA, SC, TX, WI, or WY.

Do you or any dependent desire to apply under HIPAA? Yes No If yes, who? _____
 If yes, complete and submit the HIPAA Eligibility Questionnaire. Additional premium is required. All questions on the application must be completed. Your responses to health and avocation questions will not be used to determine HIPAA eligibility.

EMPIRE FIRE AND MARINE INSURANCE COMPANY
AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
for Enrollment/Eligibility for Benefits Determinations

I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; health care providers, MIB Group, Inc., MIB, Inc. (MIB), e-nable Corporation, IntelRx, LLC, insurance companies and their business associates and those persons or entities providing services to the insurers' business associates which are related in any way to their insurance plans to disclose my health information and the health information of my minor dependents. 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, such as HIV and/or AIDS. However, this authorization does not include use or disclosure of "psychotherapy notes". Medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date are not considered "psychotherapy notes".

Empire Fire and Marine Insurance Company and its business associates (specifically including, but not limited to, **Insurers Administrative Corporation (IAC)** and/or **NIA Corporation (NIA)**) and those persons or entities providing services to Empire's business associates (specifically including **Management Research Services, Inc. (MRS)** and **Executive Management Services, Inc. (EMSI)**) which are related in any way to Empire's health plans 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 reformed if I have made any omission(s) or misrepresentation(s) in my application which are material to the underwriting process.

I understand that if I refuse to sign this authorization, my application for insurance with Empire Fire and Marine Insurance Company will be rejected. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I also understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself, by sending a written revocation to Empire Fire and Marine Insurance Company, c/o Privacy Officer, ASIM, PO Box 150489, Denver, CO 80215.

This authorization will expire 24 months after the date signed. This authorization revokes any previous restrictions concerning access to such information. **A copy of this authorization is as valid as the original. I understand that, if done, my electronic signature to this form operates as my original signature.**

I/We, the undersigned, hereby request and authorize:

Name: _____

Address: _____

to release the specified information from my records.

Signature of each Individual over Age 18 (and Parent or guardian on behalf of any minor dependent to be covered):

	Signature	Soc. Sec. No.	Date
Applicant	_____	_____	_____
Spouse (if applying)	_____	_____	_____
Dependent over 18 (if applying)	_____	_____	_____
Dependent over 18 (if applying)	_____	_____	_____

You must complete the following if applying for coverage for a minor dependent:

Please check the appropriate box if you are signing for one or more minor dependents:

- Parent Legal Guardian Trustee (If trustee or legal guardian, please supply legal documentation)

PRE-AUTHORIZED CHECKING PLAN PAYMENT OPTION (The total amount submitted will be deposited or, if applying online, debited upon receipt of this application.)

If not applying online, attach a voided check here. After the initial deposit or debit, all subsequent withdrawals will be on the first of the month.

To initiate the Monthly Bank Draft payment plan, all of the following must accompany your application:

- *A voided check.
- *Signed MBD form
- *A personal check for the initial premium

Empire Fire and Marine Insurance Company, or its designated administrator, is hereby authorized to debit my checking or savings account until this authorization is terminated. I understand that: • the non-refundable processing fee will not be returned; • if the application is declined or withdrawn only the premiums paid will be refunded; • if the coverage is issued no premium will be refunded after the Right to Examine period. I further authorize the bank named below to pay the charge to my account those payments that are drawn on my account by Empire Fire and Marine Insurance Company, and I agree that the bank named below shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorization above remains in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Empire Fire and Marine Insurance Company in writing.

Signature of Account Holder **X** _____ Date _____

Name (please print) _____ Relationship to Applicant _____

Name of Bank _____ Address _____

Checking Account Number _____ Bank Routing Number _____

Savings Account Number _____ Coverage purchased by check is subject to clearance of the check.

CREDIT CARD PAYMENT AUTHORIZATION IF PAYING VIA CREDIT CARD

- Visa
- Master Card

Upon receipt of this application at the administrator's office, I authorize Empire Fire and Marine Insurance Company or its administrator to debit my Visa or Master Card for the Total Initial Amount due and subsequent payments due. I understand that: • the non-refundable processing fee will not be returned; • if the application is declined or withdrawn only the premiums paid will be refunded; • if the coverage is issued no premium will be refunded after the Right to Examine period. Payment by credit card is subject to acceptance of the credit card issuer and clearance of the debit.

Cardholder Name _____ Cardholder Signature _____

Account No. _____ Expiration Date ____/____/____

CONSUMER BENEFITS OF AMERICA (CBA) ASSOCIATION MEMBERSHIP ENROLLMENT FORM

Please enroll me as a member of the Consumer Benefits of America Association. My membership entitles me to all the money saving Association benefits. I understand that my monthly membership dues will be collected by mode selected. **Application for Group Major Medical Insurance is only available to CBA Members.**

Name _____ Male Female Home Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Applicant's Signature **X** _____ Date _____

Consumer Benefits of America, Association Member Benefits Office, PO Box 281248, Denver, CO 80228

HELPFUL HINTS AND REMINDERS

- Processing the application will be delayed if the following information is missing:
 - If not paying by credit card, initial premium check payable to Empire Fire and Marine Insurance Company, and void check if Monthly Bank Draft
 - If not paying by credit card, MS and TX residents must make a separate check payable to CBA for initial mode dues.
 - Plan selected, as well as any optional benefits and desired PPO network if PPO plan selected
 - Medical History Details to health questions answered "yes"
 - Applicant(s) signatures
 - Initials on strikethroughs or overwrites or use of white out
 - CBA enrollment form missing applicant signature
 - Producing Agent information
- Underwriting process may be expedited if an Attending Physician Statement (APS) and/or Doctor's records are included with Doctor's Statement certifying number of pages.
- All underwriting correspondence is mailed to the applicant and a copy sent to the writing agent. Please allow at least 30 days processing time if an APS is being requested.
- If a PPO plan is elected, explain the COST SAVINGS associated when using a PPO provider. Explain the ADDITIONAL COST associated with using a non-PPO provider on PPO plans.
- Copy of rating software quote provided to the applicant must be included with submitted application.
- If not applying online, ALL APPLICATIONS MUST BE SENT DIRECTLY TO YOUR MANAGER.**

Never advise or permit an individual to omit reporting current or past medical history, conditions, doctors visits, tests (whether completed or recommended), or medications. Providing the applicant's physician's name and address does not mean that records will automatically be requested. Medical records will only be requested if required by Underwriting.