



INDIVIDUAL ENROLLMENT APPLICATION INSTRUCTIONS

Thank you for applying for health coverage with Physicians Health Plan of Northern Indiana, Inc. (PHPNI). Please follow these instructions to ensure timely processing of your request for enrollment. Please remember to print clearly using blue or black ink. Applications submitted in pencil will be returned. You, the primary applicant, must complete this application. You are solely responsible for its accuracy and completeness.

NEW ENROLLMENT APPLICATION

APPLICANT INFORMATION

Remember to include the following:

- Date of birth for each applicant.
- Accurate height and weight measurements for each applicant.
- Daytime telephone number and email address.
- The occupation of the primary applicant and spouse.
- United States citizenship of the primary applicant and spouse. *Please note, non-United States citizens may be denied if a copy of your Permanent Residency Card (Green Card) is not included with the application.*
- Desired plan coverage option.
- Preferred billing method. Be sure to complete the bank draft authorization and attach a voided check.
- Social Security Number. A missing social security number will delay processing.

HEALTH HISTORY

- Do not leave any questions blank. If the question is not applicable, mark the question "No."
- Detailed information regarding health history must be provided for all questions answered "Yes."
- If more space is needed, additional sheets may be attached.
All attachments must be signed and dated by the primary applicant and/or adults over age 18 for whom the additional information applies.
- At least one healthcare provider should be listed in either Section 5 or Section 6 for each applicant. Include physician's name, complete address, and telephone number.

SIGNATURES

- The application must be received by PHPNI within 25 days of the signature date.
- All persons age 18 and over must sign the application.
- All family members applying for coverage must be listed on the form titled *Authorization for Use and Disclosure of Health Information*. Signatures must be provided for each

- adult age 18 and over and a signature of the parent or guardian for each child who is under the age of 18.
- Section 9, Statement of Accountability must be completed if the applicant cannot speak, read, or write English.

OTHER HEALTHCARE COVERAGE

- If this policy is replacing other coverage, provide the name of the carrier, specify if it is group or individual coverage, and give both the effective date and the termination date of coverage in Section 2.

GENERAL REMINDERS AND ELIGIBILITY

- Primary applicants must be ages 19-64; all applicants must be under the age of 64 ½ years as of the effective date of this policy.
- Applicants must be legal residents of Indiana and reside within our Service Area (*exceptions may apply to dependent children*).
- Applicants eligible for Medicare will be denied coverage.
- Dependent children must be under the age of 26, and accompanied by a parent or legal guardian age 19 or older. (*Some restrictions may apply.*)
- Coverage is not guaranteed. All applicants must meet the criteria established within the current medical underwriting guidelines in effect at the time of application.
- Written notification will be sent upon approval. Do not cancel existing coverage until you receive this written notification.
- Coverage is not available if any family member is currently expecting a child (*whether or not listed on the application*) or in the process of adoption.
- Any change in health conditions that occur after the signature date but prior to the effective date may be used in the final underwriting decision.
- Alterations to the application must be initialed by the applicant. Do not use corrective fluid or corrective tape.

CHANGE APPLICATION

This application can also be used to request changes to your policy. Specific changes require certain information. **See Page 1 of application for instructions on which sections you must complete for the requested change.**

MAILING INSTRUCTIONS

Mail your application and related correspondence to:

PHPNI
Attn: Individual Underwriting
8101 West Jefferson Blvd
Fort Wayne, IN 46804



INDIVIDUAL ENROLLMENT AND CHANGE APPLICATION

NEW ENROLLMENT

CHANGE REQUESTED (check all that apply):

- Address - **Complete Sections 1 and 9**
- Name Change - **Complete Sections 1 and 9**
- Plan Coverage
 - Upgrade - **Complete Sections 1, 2, 3, 4, 5, 6 and 9**
 - Downgrade - **Complete Sections 1, 3 and 9**

- Add Dependents - **Complete Sections 1, 2, 4, 5, 6 and 9**
- Remove Dependents - **Complete Sections 1 and 9**
- Newborn/Adoption - **Complete Sections 1 and 9**
- Other _____

List Bill Number: _____
(For Employer Billing Only)

SECTION 1 APPLICANT INFORMATION

Application must be completed in full by applicant.
Initial and date all corrections.

Subscriber ID Number
(for change request) _____

Please print in blue or black ink.

Please fill out the following information for each person who is applying for coverage or indicate any changes for currently enrolled members, such as name. *If more space is needed, attach a separate sheet.*

Name (First, Middle Initial, Last)	Height (ft./in.)	Weight (lbs.)	Social Security Number	Birthdate (month/day/year)	Sex
Primary Applicant					<input type="checkbox"/> Male <input type="checkbox"/> Female
Spouse					<input type="checkbox"/> Male <input type="checkbox"/> Female
Child 1					<input type="checkbox"/> Male <input type="checkbox"/> Female
Child 2					<input type="checkbox"/> Male <input type="checkbox"/> Female
Child 3					<input type="checkbox"/> Male <input type="checkbox"/> Female

If one or more applicants do not qualify for coverage, please select one of the following:

- Insure all eligible applicants. Insure no one unless all are accepted for coverage.

Street Address _____

City _____ State _____ Zip _____ County _____

Email Address _____

Requested Effective Date: _____
(No more than 60 days after signature date.)

Billing Address (If different from above - only bills will be sent to this address)

Evening Telephone Number
() -

Daytime Telephone Number
() -

City _____ State _____ Zip _____ County _____

OCCUPATION: _____
Applicant Spouse

SECTION 2 PRIOR COVERAGE

1. Has anyone applying for coverage been declined, postponed, rescinded, reformed, charged an extra premium, or had a portion of coverage excluded for life, disability, or medical insurance? _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Has anyone applying for coverage ever had PHPNI insurance? If yes, please identify the member's name, ID number, and dates covered. _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Does anyone applying for coverage currently have health insurance coverage or held a healthcare policy within the last 18 months with less than a 63 day lapse?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Is anyone applying for coverage currently on, receiving or eligible for Medicare, Medicaid or disability insurance? If yes, please provide details. _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SECTION 3 PLAN COVERAGE

Select one of the following:

COPAY PLANS

- \$1000/\$2000 Deductible
- \$1500/\$3000 Deductible
- \$2500/\$5000 Deductible
- \$3500/\$7000 Deductible
- \$5000/\$10,000 Deductible

COPAY CHOICE PLANS

- \$2500/\$5000 In-Network, \$5000/\$10,000 Out-of-Network Deductible
- \$3500/\$7000 In-Network, \$7000/\$14,000 Out-of-Network Deductible
- \$5000/\$10,000 In-Network, \$10,000/\$20,000 Out-of-Network Deductible

Do you want Maternity Coverage with one of the above Copay Plans? Yes No

HSA PLANS

- \$1500/\$3000 Deductible
- \$2500/\$5000 Deductible
- \$3000/\$6000 Deductible
- \$4000/\$8000 Deductible
- \$5000/\$10,000 Deductible
- \$5950/\$11,900 Deductible

HSA CHOICE PLANS

- \$3000/\$6000 In-Network, \$6000/\$12,000 Out-of-Network Deductible
- \$4000/\$8000 In-Network, \$8000/\$16,000 Out-of-Network Deductible
- \$5000/\$10,000 In-Network, \$10,000/\$20,000 Out-of-Network Deductible
- \$5950/\$11,900 In-Network, \$12,000/\$24,000 Out-of-Network Deductible

Embedded Deductible Plans:

- \$3000/\$6000 Deductible
- \$4000/\$8000 Deductible
- \$5000/\$10,000 Deductible
- \$5950/\$11,900 Deductible

Embedded Choice Plans:

- \$3000/\$6000 In-Network, \$6000/\$12,000 Out-of-Network Deductible
- \$4000/\$8000 In-Network, \$8000/\$16,000 Out-of-Network Deductible
- \$5000/\$10,000 In-Network, \$10,000/\$12,000 Out-of-Network Deductible
- \$5950/\$11,900 In-Network, \$12,000/\$24,000 Out-of-Network Deductible

Maternity coverage not available for HSA plans.

Please refer to our product brochure to make sure you have chosen the benefit plan you want.

SECTION 4 QUESTIONS ABOUT YOUR HEALTH

All questions in this section (Section 4) **MUST** be answered in their entirety. We may return this application to you to complete the missing information if any questions are blank or if questions are only partially answered.

PLEASE NOTE: Section 5 information is required for all questions with a "YES" answer.

1. Has anyone applying for coverage taken or been advised to take any prescription medication in the last 12 months?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Has anyone applying for coverage had any of the following procedures in the past 10 years: Placement or revision of a shunt, heart stents, heart catheterization, angioplasty, angiogram, heart valve surgery, pacemaker, or any implantable device?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Has anyone applying for coverage had a diagnosis, treatment or follow-up care for cancer in the last 10 years?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. Is anyone applying for coverage currently pregnant, an expectant parent or in the process of adoption or a surrogate pregnancy?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SECTION 4 QUESTIONS ABOUT YOUR HEALTH (continued)

In the last 5 years, has anyone applying for coverage been diagnosed, consulted a health care provider, received treatment, or taken medications for any of the following:

5. High blood pressure, high cholesterol, chest pain, heart murmur, shortness of breath, heart attack, palpitations, irregular heartbeat, anemia, edema, and/or other heart, circulatory or blood disorders?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Stroke, epilepsy, fainting, dizziness, migraines, headaches, or any disorder of the brain or nervous system?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
7. Any condition of the thyroid, diabetes or any endocrine, glandular, or hormonal conditions?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
8. Tuberculosis, emphysema, chronic bronchitis, asthma, allergies or any respiratory or lung conditions?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
9. Cataract, glaucoma, ear infections, or any disorders of the eyes, ears, nose, and throat?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
10. Ulcer, jaundice, colitis, chronic constipation or diarrhea, hepatitis, acid reflux, hernia, or any other disorder of the stomach, gall bladder, pancreas, liver or intestines?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
11. Urinary tract stones, bladder infection or any disorder kidney, bladder, or prostate?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
12. Heavy menstrual bleeding, fibroids, endometriosis, abnormal pap, or any condition of the ovaries, uterus, gynecological/genital disorders?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
13. Infertility or any other disorder for the reproductive system?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
14. Depression, anxiety, attention deficit disorder, eating disorders, and/or any mental nervous conditions?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
15. Any disorders of the immune system, including Acquired Immune Deficiency Virus (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
16. Any disorder of the joints, tendons, muscles, bones, back, neck and/or spine?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
17. Arthritis, lupus, scleroderma, or any other autoimmune or connective tissue disorders?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
18. Acne, psoriasis, eczema, or any disorders of the skin, cyst, or tumors?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
19. Sleep apnea or any other sleep disorder?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
20. Any congenital disorders including heart, cleft palate/lip, birth defects, or developmental delay?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
21. Do you (or your family) have any medical conditions not disclosed on this application for which you (or your family member) has received medical advice, diagnosis, care or treatment in the last five years? If yes, please list: _____ _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Lifestyle questions:

22. Has an adult used tobacco products in any form or nicotine substitutes in the last 12 months? Yes, please list the name, product type, and date discontinued: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
23. Received or recommend to have any treatment for alcoholism, alcohol or drug abuse or addictions, including but not limited to counseling or attendance at support groups, or been advised by a doctor or their healthcare provider to discontinue to decrease alcohol consumption?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
24. Used illegal drugs, or prescription medications other than as prescribed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
25. Been cited for operating a motor vehicle under the influence of alcohol or drugs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
26. Participated in any motorized vehicle racing (includes drivers, pit crew, owners or mechanics) or any of the following activities: skydiving, ultra light flying, scuba diving, hang gliding, rock or mountain climbing or rodeo participation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SECTION 5 EXPLANATION OF YOUR HEALTH

For each item checked "YES" in Section 4, please provide the details below. Please include the condition or diagnosis, treatment including medication or surgery, and extent of recovery. If more space is needed, attach a separate sheet with your signature and date.

Question # _____ **Person affected** _____ **Date of onset** _____
 Name of Condition/Diagnosis _____ Are you 100% recovered from this condition? YES NO
 Treatment (*lab, surgery, diagnostic tests, etc.*) _____
 Medication/dosage prescribed _____ Frequency medication is taken _____
 Name of physician/hospital/facility _____ Phone # _____
 Address _____ City _____ State _____ Zip Code _____

Question # _____ **Person affected** _____ **Date of onset** _____
 Name of Condition/Diagnosis _____ Are you 100% recovered from this condition? YES NO
 Treatment (*lab, surgery, diagnostic tests, etc.*) _____
 Medication/dosage prescribed _____ Frequency medication is taken _____
 Name of physician/hospital/facility _____ Phone # _____
 Address _____ City _____ State _____ Zip Code _____

Question # _____ **Person affected** _____ **Date of onset** _____
 Name of Condition/Diagnosis _____ Are you 100% recovered from this condition? YES NO
 Treatment (*lab, surgery, diagnostic tests, etc.*) _____
 Medication/dosage prescribed _____ Frequency medication is taken _____
 Name of physician/hospital/facility _____ Phone # _____
 Address _____ City _____ State _____ Zip Code _____

Question # _____ **Person affected** _____ **Date of onset** _____
 Name of Condition/Diagnosis _____ Are you 100% recovered from this condition? YES NO
 Treatment (*lab, surgery, diagnostic tests, etc.*) _____
 Medication/dosage prescribed _____ Frequency medication is taken _____
 Name of physician/hospital/facility _____ Phone # _____
 Address _____ City _____ State _____ Zip Code _____

Question # _____ **Person affected** _____ **Date of onset** _____
 Name of Condition/Diagnosis _____ Are you 100% recovered from this condition? YES NO
 Treatment (*lab, surgery, diagnostic tests, etc.*) _____
 Medication/dosage prescribed _____ Frequency medication is taken _____
 Name of physician/hospital/facility _____ Phone # _____
 Address _____ City _____ State _____ Zip Code _____

Question # _____ **Person affected** _____ **Date of onset** _____
 Name of Condition/Diagnosis _____ Are you 100% recovered from this condition? YES NO
 Treatment (*lab, surgery, diagnostic tests, etc.*) _____
 Medication/dosage prescribed _____ Frequency medication is taken _____
 Name of physician/hospital/facility _____ Phone # _____
 Address _____ City _____ State _____ Zip Code _____

SECTION 6 YOUR HEALTHCARE PROVIDERS

Please list the full name, complete address including zip code, and telephone number of any healthcare provider(s) that has treated any person applying for coverage not already listed in Section 5. Please make sure that at least ONE healthcare provider for each person who is applying for coverage is listed in this section OR in Section 5. If more space is needed, attach a separate sheet with your signature and the date.

Applicant's Name	Date of Visit	Results	Full Name, Complete Address including Zip Code, and Telephone Number of Healthcare Provider

SECTION 7 PAYMENT INFORMATION

Payment and Billing Options: Please select frequency and method of payment below.

<input type="checkbox"/> Monthly Payment Choose payment method: <input type="checkbox"/> Bank Draft (EFT) <input type="checkbox"/> Credit Card	OR	<input type="checkbox"/> Quarterly Payment (every 3 months) Choose payment method: <input type="checkbox"/> Credit Card <input type="checkbox"/> Check
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If the Credit Card option was selected above, please complete the following:

Type of Credit Card: Visa Mastercard Discover _____

Credit Card Number _____ Expiration Date _____

Credit card account holder name: _____

Address: _____

If the Bank Draft/Electronic Funds Transfer (EFT) was selected above, please complete the following:

Name of Bank _____ Name of Account Holder _____

Type of Account: Checking Savings Account Number _____

Bank Routing Transit Number _____ (Please complete all bank information requested and attach voided check.)
This is the number accompanying your account number at the bottom of your check.

As a convenience to me, I hereby request and authorize Physicians Health Plan of Northern Indiana, Inc. (PHPNI) to initiate the charge to my credit card/bank account payable to the order of PHPNI. I agree that PHPNI's rights in respect to each such credit card/bank draft shall be the same as if it were a check drawn on my bank account and signed by me personally. This authorization will remain in effect until I revoke it in writing at least 10 days prior to the date my account is scheduled to be debited. I agree that if such charges are dishonored, whether with or without cause and whether intentionally or inadvertently, PHPNI shall have no liability whatsoever even though dishonor results in forfeiture of insurance. The first month's premium will be charged upon this application's acceptance. I understand my credit card/bank account will not be charged if this application is denied.

X _____

Signature EXACTLY as it appears on credit card or bank account records Date

SECTION 8 Agent/Broker Agreement (if applicable)

I understand and agree that in acting as the agent/broker for this applicant:

1) The application was completed by the applicant; 2) I am in possession of a valid license issued by the State of Indiana that authorizes me to sell and service health insurance contracts; 3) I have no authority to: a) make, alter, interpret, or discharge an application or contract in the name of PHPNI, or b) waive any of the terms of conditions of the Contract; and 4) I have no authority to assign effective dates or to affect member changes.

Agent/Broker Name _____ Agency _____

Phone Number _____ Fax Number _____ Email _____

Agent Signature _____ Date _____

SECTION 9 STATEMENT OF UNDERSTANDING**A. Authorization and Acknowledgment**

I hereby apply to be enrolled with my listed dependents, if any, for coverage with PHPNI. Once the Contract is fully signed and executed, PHPNI and I agree to the terms set forth in the Contract. I am acting as agent and/or as natural guardian for my spouse and other dependents with regard to both this Application and any PHPNI coverage that may be obtained. Further, in dealing with PHPNI, I agree to act on behalf of myself and my dependents. I understand that this Application will become part of the Contract.

I understand and agree that: 1) coverage depends on meeting certain underwriting criteria; 2) no coverage will be in force until each person listed above is approved by PHPNI; 3) no benefits will be provided for any service which begins before the coverage is effective; 4) benefits will not extend beyond the termination of either my coverage or the Contract, except as expressly provided in the Contract; 5) coverage may be declined for health conditions; 6) rates may be higher upon issue than the original quoted rates; 7) final rates cannot be determined until this Application is processed and completed; and 8) PHPNI has the right to deny my Application, and if it does so, I will be notified in writing.

I understand and agree to pay the premium required with this Application. This payment is a deposit which will be: 1) returned if my Application is denied; or 2) applied to the premium charges if my Application is accepted.

Consent at enrollment. I understand and confirm that an agent or PHPNI representative has not asked me or allowed me to answer any questions: 1) inaccurately; 2) untruthfully; or 3) incompletely. I understand that it is my continuing responsibility to report to PHPNI changes in the eligibility of any applicants who become members.

I understand that: 1) the data obtained by this authorization will only be used to determine eligibility for coverage and to administer benefits; and 2) my choice of healthcare providers whose services will be covered may be restricted by the Contract. I agree that any services which are obtained without or contrary to the required prior authorization requirements in the Contract may be denied.

I understand that provisions of the Contract may: 1) limit or exclude coverage for certain conditions; 2) exclude coverage for conditions for myself or a family member who has received any medical diagnosis or treatment, or taken any medication or where symptoms were or should have been evident prior to his or her coverage effective date.

I understand that I am applying for individual health coverage for myself (and my family). I further understand that this application for health insurance will be fully medically underwritten and coverage is not guaranteed. I personally am paying the entire premium for this coverage, it is not part of an employer sponsored plan.

I request and agree to obtain my Indigo Individual Contract information on PHP's website and will be notified by PHP when they are available, and understand that at any time I may opt out and request a free paper copy by submitting a written request to PHP.

Notice to applicant regarding replacement of accident and sickness insurance. You may intend to lapse or otherwise terminate existing insurance and replace it with an individual policy to be issued by PHPNI. Your new policy provides a free-look period, as indicated in your contract, during which time you may decide, without cost, whether you want to keep the policy. For your own protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under this new policy.

1. Pre-existing health conditions may not be immediately or fully covered under the new policy. This could result in a denial or delay of a claim for benefits under the new policy. Under your present policy, a similar claim might have been payable.
2. You may wish to secure the advice of your present insurer or agent regarding the proposed replacement of your present policy. This is your right. It is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still choose to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning medical or health history.
4. Failure to disclose known medical information on the Application shall be deemed to be intentional misrepresentation of material fact. If this occurs, PHPNI may deny any future claims, rescind the policy (upon proper notice) and refund your premium as though your policy had never been in force. After the Application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

I hereby declare that to the best of my knowledge and belief, the information on this Application, which includes the health information, is correct, true, and complete. I understand that omission or misrepresentation of information on this Application may cause PHPNI to: a) deny an incurred health service; b) enforce the pre-existing condition exclusion provision of the Contract; c) issue a retroactive rate adjustment; d) issue a waiver; and/or e) void any coverage by rescinding the policy. If I later become aware of different information than what was provided, I agree to promptly provide the additional information to PHPNI.

I agree and understand: _____ (primary initials)

SECTION 9 STATEMENT OF UNDERSTANDING (continued)

NOTICE: By signing this application, you give Physicians Health Plan of Northern Indiana, Inc. (PHPNI) the right to gather medical information about you and your dependents for whom you have legal authority to sign (e.g. a minor child). PHPNI typically gathers both paper and electronic records. This information helps PHPNI make decisions about insuring you and your dependents, and make coverage decisions should you become an enrolled member.

B. Authorization for the Use and Disclosure of Health Information

I hereby authorize the following to release any information that is requested about me: PHPNI; all healthcare providers; pharmacies, Pharmacy Benefit Managers; and pharmacy-related service organizations; the Medical Information Bureau; consumer reporting agencies; insurance or reinsurance companies; and employers.

The information shall be released to PHPNI, PHPNI's legal counsel, or any medical record service PHPNI may use. The purpose of this information is to enable PHPNI to: make eligibility and enrollment decisions; determine underwriting risk; make ratings determinations; and administer claims, benefits and coverage.

The information to be released includes but is not limited to: symptoms; diagnoses; tests; treatments; and prognosis for any health condition. Health conditions include all mental and physical health conditions, including but not limited to: past and present acute or chronic illness; injury; sexually transmitted disease; mental illness; and use of alcohol, drugs or tobacco.

I understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, or to the extent that PHPNI has the legal right to contest a claim under an insurance plan or to contest the plan itself. In order to revoke this authorization, my written notice must be sent by certified mail to: PHPNI, 8101 West Jefferson Blvd., Fort Wayne, IN 46804.

I understand that if I refuse to sign this authorization, or if I revoke this authorization:

- PHPNI may not be able to process my application.
- If coverage has been issued, PHPNI may not be able to make any benefit payments.

I understand that when information is used or disclosed under this authorization, it may be re-disclosed and no longer protected by federal law; however,

- If PHPNI does not approve my enrollment, it may not use or disclose the information it receives for any purpose other than underwriting, except as may be required by law.
- If PHPNI does enroll me, it may use and disclose my information only for purposes described in its Notice of Privacy Practices.

I acknowledge that any prior agreements made to restrict protected health information are superseded by this authorization.

This authorization applies to all persons listed below, **and will remain in force for 30 months**. A copy of this authorization will be valid as an original.

C. Identifying Information and Signatures

Applicant	Date of Birth	Applicant Signature	Date Signed
<i>If signed by a personal representative, please specify relationship/legal authority to sign:</i>			
Spouse	Date of Birth	Spouse Signature	Date Signed
<i>If signed by a personal representative, please specify relationship/legal authority to sign:</i>			
Child	Date of Birth	Child Signature (signature of parent if child is under 18)	Date Signed
<i>If signed by a personal representative, please specify relationship/legal authority to sign:</i>			
Child	Date of Birth	Child Signature (signature of parent if child is under 18)	Date Signed
<i>If signed by a personal representative, please specify relationship/legal authority to sign:</i>			
Child	Date of Birth	Child Signature (signature of parent if child is under 18)	Date Signed
<i>If signed by a personal representative, please specify relationship/legal authority to sign:</i>			

*A representative must have legal authority to sign (e.g., a parent/guardian for a minor child). A spouse and children 18 or over must sign for themselves.