



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.

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 7.

GENERAL REMINDERS AND ELIGIBILITY

- 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 legal U.S. residents under the age of 24. (*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 health history that occurs 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 8**
- Name Change - **Complete Sections 1 and 8**
- Plan Coverage
 - Upgrade - **Complete Sections 1, 2, 4, 5, 6, 7 and 8**
 - Downgrade - **Complete Sections 1, 2 and 8**

Add Dependents - **Complete Sections 1, 4, 5, 6, 7 and 8**

Remove Dependents - **Complete Sections 1 and 8**

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) _____

Primary Applicant to be Covered

Please print in blue or black ink.

Last Name _____ First Name _____ M.I. _____

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)

City _____ State _____ Zip _____ County _____

Evening Telephone Number () - _____
Daytime Telephone Number () - _____

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	Internal Use
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.

FOR INTERNAL USE ONLY	PF/C	FINAL	EFFECTIVE DATE	BY	DATE
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SECTION 1 APPLICANT INFORMATION (continued)

Does any person applying for coverage live outside the above household? YES NO

If yes, please explain: _____

PRIMARY APPLICANT

Occupation _____

United States Citizen? YES NO *If "NO," a permanent United States residency card will be required.*

SPOUSE

Occupation _____

United States Citizen? YES NO *If "NO," a permanent United States residency card will be required.*

SECTION 2 PLAN COVERAGE *Please refer to our product brochure to make sure you have chosen the benefit plan you want.*

\$30 COPAY PLANS - Select one of the following:

- Copay 1 (\$1000/\$2000 Ded.)
- Copay 2 (\$1500/\$3000 Ded.)
- Copay 3 (\$2500/\$5000 Ded.)
- Copay Choice 3 (\$2500/\$5000 In-Network Ded., \$5000/\$10,000 Out-of-Network Ded.)

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

BUDGET COPAY PLANS - Select one of the following: (Maternity Coverage not available for these plans.)

- Copay Choice Budget Plus (\$3500/\$7000 In-Network Ded., \$7000/\$14,000 Out-of-Network Ded.)
- Copay Choice Budget (\$5000/\$10,000 In-Network Ded., \$10,000/\$20,000 Out-of-Network Ded.)

HSA COMPATIBLE PLAN - Select one of the following: (Maternity Coverage not available for these plans.)

- HSA 1 (\$1500/\$3000 Ded.)
- HSA 2 (\$2500/\$5000 Ded.)
- HSA 3 (\$3000/\$6000 Ded.)
- HSA 4 (\$5000/\$10,000 Ded.)
- HSA Choice 3 (\$3000/\$6000 In-Network Ded., \$6000/\$12,000 Out-of-Network Ded.)
- HSA Choice 4 (\$5000/\$10,000 In-Network Ded., \$10,000/\$20,000 Out-of-Network Ded.)

Embedded Deductible Plans:

- HSA 3E (\$3000/\$6000 Ded.)
- HSA 4E (\$5000/\$10,000 Ded.)
- HSA Choice 3E (\$3000/\$6000 In-Network Ded., \$6000/\$12,000 Out-of-Network Ded.)
- HSA Choice 4E (\$5000/\$10,000 In-Network Ded., \$10,000/\$20,000 Out-of-Network Ded.)

SECTION 3 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 |
|--|-----------|--|

If the Credit Card option was selected above, please complete the following:

Type of Credit Card: Visa Mastercard Discover _____
Credit Card Number Expiration Date

Name and address of credit card account holder _____

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 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.

A. In the last 5 years, has anyone applying for coverage had any condition, diagnosis, consultation, routine follow-up, treatment, or therapy; had treatment recommended; been prescribed any medication; been monitored; or been hospitalized for any of the following?

CONDITION (check YES or NO)	YES	NO	CONDITION (check YES or NO)	YES	NO
1. Heart Conditions			g. Deviated nasal septum, nasal polyps	<input type="checkbox"/>	<input type="checkbox"/>
a. High blood pressure/hypertension (If yes, provide 3 blood pressure readings in Section 5)	<input type="checkbox"/>	<input type="checkbox"/>	h. Excessive snoring, sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
b. Mitral valve prolapse (MVP)	<input type="checkbox"/>	<input type="checkbox"/>	i. Sinusitis, tonsillitis, adenoiditis	<input type="checkbox"/>	<input type="checkbox"/>
c. Chest pain, heart attack, angina, coronary artery disease, arterio/athero-sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	j. TMJ or jaw disorder	<input type="checkbox"/>	<input type="checkbox"/>
d. Arrhythmia, palpitations, pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	k. Leukoplakia, oral thrush, tongue condition	<input type="checkbox"/>	<input type="checkbox"/>
e. Valve disorder or replacement	<input type="checkbox"/>	<input type="checkbox"/>	l. Other ear, eye, nose, throat, mouth condition	<input type="checkbox"/>	<input type="checkbox"/>
f. Other heart, cardiovascular condition	<input type="checkbox"/>	<input type="checkbox"/>	6. Digestive/Gastrointestinal Conditions		
2. Blood/Circulatory Conditions			a. Gastric reflux, GERD, heartburn, hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>
a. Anemia (specify type in Section 5)	<input type="checkbox"/>	<input type="checkbox"/>	b. Irritable bowel (IBS), spastic colon	<input type="checkbox"/>	<input type="checkbox"/>
b. Bleeding/clotting disorders	<input type="checkbox"/>	<input type="checkbox"/>	c. Colitis, Crohn's disease, ileitis, proctitis, IBD	<input type="checkbox"/>	<input type="checkbox"/>
c. Thrombocytopenia, Idiopathic Thrombocytopenia Purpura	<input type="checkbox"/>	<input type="checkbox"/>	d. Diverticulosis, diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
d. Varicose Veins, Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	e. Rectal bleeding, anal fissure, hemorrhoids,	<input type="checkbox"/>	<input type="checkbox"/>
e. Enlarged lymph nodes, abnormal red or white blood cells	<input type="checkbox"/>	<input type="checkbox"/>	f. Rectal or colon polyps	<input type="checkbox"/>	<input type="checkbox"/>
f. Blood Clots, Aneurysm, impaired circulation	<input type="checkbox"/>	<input type="checkbox"/>	g. Ulcers, chronic abdominal pain, gallbladder condition	<input type="checkbox"/>	<input type="checkbox"/>
g. Raynaud's disease or phenomenon	<input type="checkbox"/>	<input type="checkbox"/>	h. Hepatitis (indicate type), cirrhosis, other liver disorder/condition	<input type="checkbox"/>	<input type="checkbox"/>
h. Other blood, spleen, circulatory condition	<input type="checkbox"/>	<input type="checkbox"/>	i. Obesity, bariatric surgery, gastric bypass/banding	<input type="checkbox"/>	<input type="checkbox"/>
3. Neurological/Central Nervous System			j. Other hernias, digestive, intestinal, stomach condition	<input type="checkbox"/>	<input type="checkbox"/>
a. Epilepsy, seizures, convulsions	<input type="checkbox"/>	<input type="checkbox"/>	7. Kidney/Bladder Conditions		
b. Headaches, migraines	<input type="checkbox"/>	<input type="checkbox"/>	a. Urinary tract/bladder infections, incontinence, blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
c. Tremors, Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>	b. Kidney stones, kidney infection	<input type="checkbox"/>	<input type="checkbox"/>
d. Downs Syndrome, mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	c. Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>
e. Multiple Sclerosis, paralysis	<input type="checkbox"/>	<input type="checkbox"/>	d. Other urinary, bladder, kidney condition	<input type="checkbox"/>	<input type="checkbox"/>
f. Autism, Pervasive Development Disorder	<input type="checkbox"/>	<input type="checkbox"/>	8. Reproductive System Conditions		
g. Memory loss, dementia, Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	a. Abnormal pap smear, cervical dysplasia	<input type="checkbox"/>	<input type="checkbox"/>
h. Dizziness, fainting, head injury, loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	b. Irregular or excessive menstruation/bleeding	<input type="checkbox"/>	<input type="checkbox"/>
i. Stroke, TIA, numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	c. Endometriosis, uterine fibroids, pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>
j. Other neurological, central nervous condition	<input type="checkbox"/>	<input type="checkbox"/>	d. Ovarian cysts or disorder	<input type="checkbox"/>	<input type="checkbox"/>
4. Respiratory/Lung Conditions			e. Infertility testing or treatment	<input type="checkbox"/>	<input type="checkbox"/>
a. Allergies, asthma, Reactive Airway Disease	<input type="checkbox"/>	<input type="checkbox"/>	f. Prostate gland disorder, BPH, abnormal PSA test	<input type="checkbox"/>	<input type="checkbox"/>
b. Emphysema, COPD, Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	g. Penile/scrotal implant or other condition	<input type="checkbox"/>	<input type="checkbox"/>
c. Pneumonia, bronchitis, respiratory/ lung infection	<input type="checkbox"/>	<input type="checkbox"/>	h. Herpes, HPV, or other sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
d. Other respiratory, lung condition	<input type="checkbox"/>	<input type="checkbox"/>	i. Breast cyst, implants, fibrocystic breast disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Eye/Ear/Nose/Throat Conditions			j. Gynecomastia, abnormal mammogram, or other breast condition	<input type="checkbox"/>	<input type="checkbox"/>
a. Cataract, glaucoma, strabismus	<input type="checkbox"/>	<input type="checkbox"/>	k. Other reproductive, breast condition	<input type="checkbox"/>	<input type="checkbox"/>
b. Retinal/macular: degeneration, detachment	<input type="checkbox"/>	<input type="checkbox"/>	9. Psychological Conditions		
c. Blindness, optic neuritis, other eye condition	<input type="checkbox"/>	<input type="checkbox"/>	a. Anxiety, panic disorder, adjustment reaction	<input type="checkbox"/>	<input type="checkbox"/>
d. Otitis Media/ear infections (indicate number of infections in past 12 months)	<input type="checkbox"/>	<input type="checkbox"/>	b. Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
e. Meniere's disease, tinnitus (ringing in the ears)	<input type="checkbox"/>	<input type="checkbox"/>	c. Depression, bipolar disorder, psychosis	<input type="checkbox"/>	<input type="checkbox"/>
f. Deafness, cochlear implant	<input type="checkbox"/>	<input type="checkbox"/>	d. Eating disorder (anorexia/bulimia), obsessive-compulsive disorder	<input type="checkbox"/>	<input type="checkbox"/>
			e. Attention deficit, hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>
			f. Other nervous, mental, emotional condition	<input type="checkbox"/>	<input type="checkbox"/>

SECTION 4 QUESTIONS ABOUT YOUR HEALTH (continued)

CONDITION (check YES or NO)	YES	NO	CONDITION (check YES or NO)	YES	NO
10. Immune System Conditions			12. Endocrine/Glandular or Hormonal		
a. AIDS, HIV	<input type="checkbox"/>	<input type="checkbox"/>	a. Diabetes, abnormal glucose (high/low), insulin resistance	<input type="checkbox"/>	<input type="checkbox"/>
b. Lupus, Scleroderma, Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>	b. Thyroid: Hypo/hyper, goiter, nodule	<input type="checkbox"/>	<input type="checkbox"/>
c. Rheumatoid Arthritis, CREST or Sjogren's syndrome	<input type="checkbox"/>	<input type="checkbox"/>	c. Elevated cholesterol, triglycerides (If yes, provide last lab results in Section 5)	<input type="checkbox"/>	<input type="checkbox"/>
d. Other immune or connective tissue condition	<input type="checkbox"/>	<input type="checkbox"/>	d. Adrenal, pituitary, pancreas condition	<input type="checkbox"/>	<input type="checkbox"/>
11. Bone/Joint/Muscle Conditions			13. Skin, Cyst, Tumor		
a. Back/neck pain, strain, low back pain	<input type="checkbox"/>	<input type="checkbox"/>	a. Acne, keratosis, eczema, rosacea, fungal infections	<input type="checkbox"/>	<input type="checkbox"/>
b. Herniated disc, Scoliosis, or other disc problems	<input type="checkbox"/>	<input type="checkbox"/>	b. Warts, birthmarks, lesions, burns	<input type="checkbox"/>	<input type="checkbox"/>
c. Arthritis, Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	c. Skin cancer (basal cell, squamous cell, melanoma)	<input type="checkbox"/>	<input type="checkbox"/>
d. Fibromyalgia, Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	d. Benign (non-cancerous) cyst/tumor	<input type="checkbox"/>	<input type="checkbox"/>
e. Carpal Tunnel Syndrome, tendonitis, bursitis	<input type="checkbox"/>	<input type="checkbox"/>	14. Congenital		
f. Fracture, dislocation	<input type="checkbox"/>	<input type="checkbox"/>	a. Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>
g. Joint disorders - knee, hip, shoulder, ankle	<input type="checkbox"/>	<input type="checkbox"/>	b. Cleft lip/palate	<input type="checkbox"/>	<input type="checkbox"/>
h. Joint replacement, prosthesis, internal fixation/device (pins, plates, screws, rods, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	c. Skull/facial deformities	<input type="checkbox"/>	<input type="checkbox"/>
i. Bunions or other foot disorders	<input type="checkbox"/>	<input type="checkbox"/>	d. Other birth/congenital defects	<input type="checkbox"/>	<input type="checkbox"/>
j. Muscular dystrophy, post-polio residuals	<input type="checkbox"/>	<input type="checkbox"/>			
k. Other neck, back, joint, muscle, ligament, tendon, foot condition	<input type="checkbox"/>	<input type="checkbox"/>			

B. Is any person applying for coverage expecting a child or in the process of adoption, whether or not the mother is listed on the application?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
C. Has any person applying for coverage ever been declined, postponed, had specific conditions excluded from coverage, or charged extra premium for life, disability, critical illness, long term care, or health insurance? If yes, please explain: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
D. In the last 10 years, has any person applying for coverage had any type of malignant tumor/growth/cyst, leukemia, lymphoma, sarcoma, Hodgkin's disease, or any other type of malignancy or cancer?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
E. In the last 5 years, has any person applying for coverage had any abnormal blood tests, MRI or CT scans, electrocardiogram, echocardiogram, or any other diagnostic tests or labs?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
F. In the last 5 years, has any applicant consulted a provider for any condition, not elsewhere listed on this application, for which a diagnosis has not been established or a condition for which future consultation, treatment, or work up is contemplated or advised?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
G. In the last 5 years, has any applicant seen, received treatment from, or consulted a doctor or any healthcare service provider for any other condition not elsewhere listed on this application?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
H. Has any applicant been a recipient of or a candidate for organ or bone marrow transplant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I. Has any person applying for coverage ever received treatment or had treatment recommended for alcohol or substance (drug) abuse?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
J. Has any person applying for coverage ever used illicit drugs by IV injection?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
K. In the last 10 years, has any person applying for coverage been advised to reduce alcohol intake?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
L. In the last 12 months, has any person applying for coverage taken any prescription medication, over-the-counter medication, or alternative remedies or therapies?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
M. In the last 5 years, has any applicant been hospitalized, visited an emergency room, or had a surgery performed?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
N. Has anyone applying for coverage smoked or used tobacco products within the past 5 years? If yes, Name: _____ Type of product: _____ Date discontinued: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
O. Does anyone applying for coverage consume alcohol? If yes, Name: _____ Drinks per day: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Medical conditions which occur after the signature date and before the approval date may be considered in the final underwriting decision.

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.) _____ Date of last/most recent treatment _____

Medication/dosage prescribed _____ Frequency medication is taken _____

Frequency of condition: One episode now resolved Reoccurs periodically Currently being treated

Name of physician/hospital/facility _____ Phone # _____ Fax # _____

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.) _____ Date of last/most recent treatment _____

Medication/dosage prescribed _____ Frequency medication is taken _____

Frequency of condition: One episode now resolved Reoccurs periodically Currently being treated

Name of physician/hospital/facility _____ Phone # _____ Fax # _____

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.) _____ Date of last/most recent treatment _____

Medication/dosage prescribed _____ Frequency medication is taken _____

Frequency of condition: One episode now resolved Reoccurs periodically Currently being treated

Name of physician/hospital/facility _____ Phone # _____ Fax # _____

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.) _____ Date of last/most recent treatment _____

Medication/dosage prescribed _____ Frequency medication is taken _____

Frequency of condition: One episode now resolved Reoccurs periodically Currently being treated

Name of physician/hospital/facility _____ Phone # _____ Fax # _____

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 OTHER HEALTHCARE COVERAGE

1. Is anyone applying covered by or eligible for Medicare benefits Part A and/or Part B? If yes, give name(s) _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
2. Has anyone applying for coverage filed a claim and/or received benefits from Social Security disability, private disability insurance, or Workers' Compensation? If yes, give name(s)/details _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
3. Is anyone applying for coverage covered by another health insurance program, or covered in the past 63 days? If yes, provide: Member Name _____ Name of Carrier _____ Date coverage began _____ Date coverage ends(ed) _____ Type: <input type="checkbox"/> Employer Group <input type="checkbox"/> Individual	<input type="checkbox"/> YES	<input type="checkbox"/> NO
4. If yes to Question 3, will you cancel your other insurance coverage if you are approved for this coverage?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
5. Has anyone applying for coverage ever had PHPNI insurance either as a primary insured or as a dependent? If yes, provide member's name, ID number, and dates covered _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
6. Is anyone applying for coverage currently covered, or eligible for group coverage with PHPNI? If yes, give name(s)/details _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SECTION 8 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 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 that no agent or PHPNI representative is allowed to permit me to answer any question: 1) inaccurately; 2) untruthfully; or 3) incompletely. I represent that such did not occur. 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.

Notice to applicant regarding replacement of accident and sickness insurance. You may intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a 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 include all medical information on the Application may provide a basis for PHPNI to deny any future claims and to 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.

SECTION 8 STATEMENT OF UNDERSTANDING (continued)

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.

B. Signatures

All persons age 18 or over who are applying for coverage must personally read, agree to, and sign this application. If any applicant does not speak or read English, the translator must sign and submit the Statement of Accountability in Section 9.

Applicant/Parent or Legal Guardian _____ **Date** _____

Applicant's Spouse _____ **Date** _____
(Required if applying for coverage)

Child (Age 18 or over) _____ **Date** _____
(Required if 18 or over and applying for coverage)

Child (Age 18 or over) _____ **Date** _____
(Required if 18 or over and applying for coverage)

Child (Age 18 or over) _____ **Date** _____
(Required if 18 or over and applying for coverage)

C. 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.
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** _____

Coverage is not in force until your application is approved and effective date is determined by PHPNI.

SECTION 9 STATEMENT OF ACCOUNTABILITY

This is to be used when the Applicant cannot complete the application because of the reason(s) indicated below.

I, _____, personally read and completed this Individual Enrollment Application for the applicant named below because:
(Translator's Name)

- Applicant does not read English Applicant does not speak English Applicant does not write English

Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____
(Applicant Name)

I also translated and fully explained Section 8 of the Application titled "Statement of Understanding" and the attached form titled "Authorization for Use and Disclosure of Health Information."

Translator's Signature _____ **Date** _____



AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE: By signing this form, 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.

AUTHORIZATION

I hereby authorize the following to release any information that is requested about me: PHPNI; all healthcare providers; pharmacies 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.

IDENTIFYING INFORMATION/SIGNATURES FOR THE APPLICANT AND DEPENDENTS

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.