

Consumers Life Insurance Company Cleveland, Ohio

Coverage(s) will be provided by the Company indicated above. Healthcare benefits including dental and vision will be provided by Consumers Life Insurance Company. SaveWell is a discount program and is not an insurance product.



| |
|--------------------------------|
| INTERNAL USE ONLY |
| EFFECTIVE DATE: ____/____/____ |
| GROUP NO.: _____ |

HEALTH APPLICATION/CHANGE FORM – INDIANA

INSTRUCTIONS: All questions must be answered. Incomplete applications will be returned.

SECTION I: CONTRACT HOLDER INFORMATION

| | | | | | | |
|---|--|-------|---------------|----------|----------------------------|--|
| Last Name | | MI | First Name | | SS Number | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed | | | Marriage Date | | Divorce Date | |
| Permanent Residence | | | Email Address | | City | |
| County | | State | | Zip Code | Area Code and Phone Number | |
| Reason for Application: <input type="checkbox"/> Applying for New Coverage <input type="checkbox"/> Applying for Dependent Only Coverage <input type="checkbox"/> Applying for a Change to Current Coverage | | | | | | |

LIST BELOW ALL INDIVIDUALS TO BE COVERED

| | First Name, MI (and Last Name if different) | SS Number | Birth Date | Sex | Height | Weight | Smoker (circle) | Physician | Student |
|--------|--|-----------|------------|-----|--------|--------|--------------------|-----------|---------|
| Self | | | / / | | ' " | | Y N | | |
| Spouse | | | / / | | ' " | | Y N | | |
| 1 | | | / / | | ' " | | Y N | | Y N |
| 2 | | | / / | | ' " | | Y N | | Y N |
| 3 | | | / / | | ' " | | Y N | | Y N |

SECTION II: PRODUCT

| | | | | | | | | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|--|---|--|---|--|--|--|--|---|
| <p>HEALTH INSURANCE</p> <p>Note: Health Insurance products are medically underwritten.</p> <p>Network: <input type="checkbox"/> Private Healthcare Systems (PHCS) <input type="checkbox"/> IHN <input type="checkbox"/> Sagamore <input type="checkbox"/> Encore</p> <p>Desired effective date (when coverage is to begin): ____/____/____</p> <table border="0"> <tr> <td><input type="checkbox"/> \$500/\$1,000 Deductible</td> <td><input type="checkbox"/> Short Term \$500/\$1,000 Deductible</td> </tr> <tr> <td><input type="checkbox"/> \$1,000/\$2,000 Deductible</td> <td><input type="checkbox"/> \$1,200/\$2,400 HSA Compatible</td> </tr> <tr> <td><input type="checkbox"/> \$1,500/\$3,000 Deductible</td> <td><input type="checkbox"/> \$2,000/\$4,000 HSA Compatible</td> </tr> <tr> <td><input type="checkbox"/> \$2,500/\$5,000 Deductible</td> <td><input type="checkbox"/> \$2,500/\$5,000 HSA Compatible</td> </tr> <tr> <td><input type="checkbox"/> \$5,000/\$10,000 Deductible</td> <td><input type="checkbox"/> \$3,000/\$6,000 HSA Compatible</td> </tr> <tr> <td><input type="checkbox"/> Value Plan - \$500/\$1,000 Deductible</td> <td><input type="checkbox"/> \$4,000/\$8,000 HSA Compatible</td> </tr> <tr> <td><input type="checkbox"/> Value Plan - \$1,000/\$2,000 Deductible</td> <td><input type="checkbox"/> \$5,000/\$10,000 HSA Compatible</td> </tr> <tr> <td><input type="checkbox"/> Value Plan - \$1,500/\$3,000 Deductible</td> <td></td> </tr> </table> | <input type="checkbox"/> \$500/\$1,000 Deductible | <input type="checkbox"/> Short Term \$500/\$1,000 Deductible | <input type="checkbox"/> \$1,000/\$2,000 Deductible | <input type="checkbox"/> \$1,200/\$2,400 HSA Compatible | <input type="checkbox"/> \$1,500/\$3,000 Deductible | <input type="checkbox"/> \$2,000/\$4,000 HSA Compatible | <input type="checkbox"/> \$2,500/\$5,000 Deductible | <input type="checkbox"/> \$2,500/\$5,000 HSA Compatible | <input type="checkbox"/> \$5,000/\$10,000 Deductible | <input type="checkbox"/> \$3,000/\$6,000 HSA Compatible | <input type="checkbox"/> Value Plan - \$500/\$1,000 Deductible | <input type="checkbox"/> \$4,000/\$8,000 HSA Compatible | <input type="checkbox"/> Value Plan - \$1,000/\$2,000 Deductible | <input type="checkbox"/> \$5,000/\$10,000 HSA Compatible | <input type="checkbox"/> Value Plan - \$1,500/\$3,000 Deductible | | <p>OPTIONAL RIDERS (Can only be purchased along with health insurance)</p> <p><input type="checkbox"/> \$15 / \$30 / \$45 Prescription Drug Copay</p> <p>OPTIONAL COVERAGE:</p> <p><input type="checkbox"/> Dental¹</p> <p><input type="checkbox"/> Vision¹</p> |
| <input type="checkbox"/> \$500/\$1,000 Deductible | <input type="checkbox"/> Short Term \$500/\$1,000 Deductible | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> \$1,000/\$2,000 Deductible | <input type="checkbox"/> \$1,200/\$2,400 HSA Compatible | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> \$1,500/\$3,000 Deductible | <input type="checkbox"/> \$2,000/\$4,000 HSA Compatible | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> \$2,500/\$5,000 Deductible | <input type="checkbox"/> \$2,500/\$5,000 HSA Compatible | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> \$5,000/\$10,000 Deductible | <input type="checkbox"/> \$3,000/\$6,000 HSA Compatible | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Value Plan - \$500/\$1,000 Deductible | <input type="checkbox"/> \$4,000/\$8,000 HSA Compatible | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Value Plan - \$1,000/\$2,000 Deductible | <input type="checkbox"/> \$5,000/\$10,000 HSA Compatible | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Value Plan - \$1,500/\$3,000 Deductible | | | | | | | | | | | | | | | | | |

¹ Can be purchased as a stand alone product. If purchased as stand alone product, one year of premium is due with payment of first bill.

SECTION III: OTHER COVERAGE INFORMATION

1. Do **YOU**, your **SPOUSE** or any listed **DEPENDENT** have any other type of (Accident, Medicare, Medicaid, etc.) or are you currently applying for any other health insurance? Yes No If yes, please complete the following:

| | |
|-----------------|---|
| Name of Company | Name of Family Member with or applying for coverage |
|-----------------|---|

2. If you were covered by another health plan within the last 63 days you may be eligible for credit of pre-existing condition limitation, except for Consumers Life Insurance Company Short Term. To qualify for credit, please complete the following.

| | |
|------------------------------|---------------------|
| Name of Insurance Company | Date of Coverage |
| Policy # (If Medical Mutual) | From _____ To _____ |

SECTION V: BILLING INFORMATION

CHOOSE ONE:

- HOME – Receive monthly premium billings**
- FINANCIAL INSTITUTION – Have monthly automatic premium withdrawals**

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Consumers Life Insurance Company to initiate premium deductions from my account. The authorization will remain in effect until Consumers Life and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from: Checking Savings

(Please note: Not all Financial Institutions allow deductions from a savings account. Please verify this information with your financial institution.)

| | | | |
|---|-------|----------|-------------------------|
| Name and branch of bank/financial institution | | | Account Number |
| Address | | | Account Holder's Name |
| City | State | Zip Code | Transit Routing Number: |
| Account Holder's Signature | | | Date |

Please attach a voided check for checking account or a deposit slip for savings account in order for our office to verify the bank information.

- CREDIT CARD – Have monthly premium billed to credit card**

If you wish to be billed through your credit card, please complete the following authorization: MasterCard Visa

| | |
|----------------------------|-----------------|
| Card Holder Name | Card Number |
| Bank Name (If applicable) | Expiration Date |
| Account Holder's Signature | Date |

- LIST BILLING THROUGH EMPLOYER – is available only to employees of a common employer who has agreed to collect the premiums on a monthly basis through payroll deduction and where the employer is not paying any portion of the premium.**

| | | |
|------------------|----------------------------|----------|
| Name of Employer | Occupation | |
| Address | Area Code and Phone Number | |
| City | State | Zip Code |

- DIFFERENT BILLING ADDRESS – Have home billing sent to a different address**

If your mailing address is different than your permanent address, complete the following:

| | | |
|-----------------|------------|----------|
| Last Name (C/O) | First Name | MI |
| Address | | |
| City | State | Zip Code |

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

FOR OFFICE USE ONLY

| |
|--------------------------------------|
| Sold - Account Executive and Code |
| Service - Account Executive and Code |

or

| | |
|------------------------|--------------------------------------|
| Agent of Record | Tax ID |
| Royal Advantage Broker | Commission Indicator 96.15 |

SECTION VI: TERMS AND CONDITIONS

I hereby apply to Consumers Life Insurance Company (CLIC) for the coverage indicated on this application. I agree to be bound by the relevant terms of the health insurance Policy.

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, government agency or person to Consumers Life Insurance Company (CLIC), and/or any affiliates or division of CLIC: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities; (d) for credentialing purposes. I authorize the applicable carrier to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this application.
2. I agree that a medical examination of me may be required in connection with this Health Application. I further agree that I, as the Applicant, will be responsible to pay for the medical examination and/or the release of any and all records on behalf of myself, my spouse, and/or the listed dependents.
3. I represent and warrant that I have read this Health Application, and understand each of the questions and the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any misrepresentation or concealment on this Application will void my policy at the discretion of CLIC. I further agree that if a policy is issued, it will be issued by CLIC (if applicable) in full reliance and in consideration of the information, answers, and statements contained herein. I understand that this policy will be medically underwritten.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of the health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction.
5. No issuance, waiver, modification or change of policy or any of CLIC rules or amendments shall be binding upon CLIC unless it is in writing and signed by an authorized officer of CLIC, as applicable.
6. Notice: Certain Pre-Existing Condition limitations will apply: A Pre-existing Condition is a Condition for which an ordinarily prudent person would seek medical advice, diagnosis, care or treatment; or for which you incurred medical expense, received medical treatment, used Prescription Drugs or were advised by a Physician or Other Professional Provider to receive treatment prior to your Enrollment Date. Your Enrollment Date is your Effective Date. If a Pre-existing Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, CLIC will provide benefits for the Pre-existing Condition for Covered Services incurred after twelve (12) months following your Enrollment Date.
7. I represent and warrant that neither I nor my spouse are receiving any form of reimbursement or compensation for this coverage from any employer.
8. I understand that upon completion of this application CLIC will issue to me a temporary identification card. I also understand that information submitted with this application may require further medical underwriting. If that underwriting discloses additional medical risk I understand that there may be a significant change in the rate charged for this coverage or in certain cases, the coverage may be rescinded. A permanent ID card will be issued following the final review and acceptance of the application. Any premium payment will be deposited immediately upon CLIC's receipt of this application. Should CLIC not approve my application, my payment will be refunded in full.
9. I understand and agree that no agent or broker has the authority: (i) to bind CLIC by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information CLIC requests; (iii) approve coverage; (iv) make or alter any contract on behalf of CLIC; or (v) waive or alter any of CLIC's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of CLIC to be binding on CLIC.

I am signing this Health Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original.

Policyholder Signature

Date

Spouse's Signature

Date

The policyholder hereby appoints the Secretary of CLIC as its proxy, with power of substitution, to act for and on its behalf at any and every annual meeting or any special meeting of the members of CLIC. The policyholder authorizes its proxy to vote and act for and on behalf of the policyholder at such meeting as fully and to the same extent as the policyholder could do if present thereat. This proxy shall continue in force until ten years from the date hereof unless sooner revoked by a notice, in writing, signed by the policyholder and delivered to CLIC.

Signature

Date

SECTION VIII: HOW DID YOU HEAR ABOUT PERSONAL HEALTH PLANS?

- | | | |
|--|---|--|
| <input type="checkbox"/> 1. Friend / Family Member | <input type="checkbox"/> 5. Newspaper Article | <input type="checkbox"/> 9. Through current employer |
| <input type="checkbox"/> 2. Yellow Pages | <input type="checkbox"/> 6. Internet / Web site | <input type="checkbox"/> 10. Other _____ |
| <input type="checkbox"/> 3. Insurance Agent | <input type="checkbox"/> 7. Radio | |
| <input type="checkbox"/> 4. Advertisement in Newspaper, Magazine, etc. | <input type="checkbox"/> 8. Mail | |

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.