CAROLINA CARE PLAN®
A MEDICAL MUTUAL OF OHIO COMPANY

CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY

INTERNAL USE ONLY
EFFECTIVE DATE: ____ / ____ / ____
GROUP NUMBER: _____

Individual – Health Application/Change Form

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: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Marriage Date: / /	Divorce Date: / /

Permanent Residence	E-mail Address	City

County	State	Zip Code	Area Code/Phone Number	Occupation

Reason for Application:
☐ Applying for New Coverage ☐ Adding Dependent(s) ☐ Adding Drug Benefit ☐ Deleting Maternity Benefit
☐ Benefit Change ☐ Deleting Dependent(s) ☐ Deleting Drug Benefit ☐ Other_____

LIST BELOW ALL INDIVIDUALS TO BE COVERED

(Dependent children must be under the age of 26.)

	First Name, MI (and Last Name, if different)	SS Number	Birth Date	Sex	Height	Weight	Tobacco User	Physician
Self							**Y N**	
Spouse							**Y N**	
1							**Y N**	
2							**Y N**	
3							**Y N**	

Section II: PRODUCTS

Desired Effective Date _____ / _____ / _____ (when coverage is to begin)

☐ Yes ☐ No As of the requested effective date, will you be a resident of South Carolina? (Only South Carolina residents are eligible for coverage)

Adult Plans:

- ☐ P35-1000 (35-3000 for family)
- ☐ P35-1500 (35-4500 for family)
- ☐ P35-3000 (35-9000 for family)
- ☐ P35-5000 (35-15000 for family)
- ☐ P35-7500 (35-22500 for family)
- ☐ P35-10000 (35-30000 for family)
- ☐ P1000 (3000 for family)
- ☐ P1500 (4500 for family)
- ☐ P3000 (9000 for family)
- ☐ P5000 (15000 for family)
- ☐ P7500 (22500 for family)
- ☐ P10000 (30000 for family)

Select Out of Pocket Max
- ☐ 1500 (3000 for family)
- ☐ 3000 (6000 for family)

Select Coinsurance
- ☐ 80%/60%
- ☐ 70%/50%

Available Riders for Adult Plans
- ☐ Prescription Drug Rider

HDHP Plans:

- ☐ P1500-100 (3000-100 for family) – Plan 1
- ☐ P2000-80 (4000-80 for family) – Plan 2
- ☐ P2600-100 (5150-100 for family) – Plan 3
- ☐ P2600-80 (5150-80 for family) – Plan 4
- ☐ P5000-100 (10000-100 for family) – Plan 5

Order Number: Z7358 R3/11
Dept of Ins. Filing Number: Z7358 R1/11

Section III: Products

Applicant Basic Life Insurance

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Spouse Basic Life Insurance

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000

Dependent Life Insurance

☐ $10,000

Do you, the applicant, own an existing life policy or annuity contract? ☐ Yes ☐ No (answer by checking one)

If you answered "YES" to the above questions, inform the agent who will provide you an "Important Notice: Appendix A, which you must read and complete.

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy or annuity contract?

☐ Yes ☐ No (answer by checking one)

It is understood and agreed that this application shall be made part of the Policies for which application is made, and it is further understood:

(1) Basic Life and Dependent Life are subject to the approval of Consumers Life Insurance Company (CLIC), and nothing contained herein shall be binding upon Consumers Life until this application is approved and accepted at CLIC's home office.

(2) No waiver or change will bind CLIC unless signed by an Executive Officer of CLIC.

Section IV: Applicant Beneficiary Designation

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%.

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary		/ /		%
Primary		/ /		%
Contingent		/ /		%
Contingent		/ /		%

Section V: Spouse Beneficiary Designation

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (If no beneficiary is designated, then the Applicant is the beneficiary of proceeds from spouse or child coverage.)

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary		/ /		%
Primary		/ /		%
Contingent		/ /		%
Contingent		/ /		%

Section VI: OTHER COVERAGE INFORMATION

1. ☐ Yes ☐ No Have **YOU,** your **SPOUSE,** or any **listed DEPENDENT** previously had coverage with CCP? If yes, please provide the following information:

NAME	SOCIAL SECURITY NUMBER

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

NAME	TYPE	NAME OF INSURANCE COMPANY

3. ☐ Yes ☐ No Were **YOU,** your **SPOUSE,** or any **listed DEPENDENT COVERED** by another health plan within the last 63 days? If yes, please complete the following:

NAME	NAME OF INSURANCE COMPANY	DATES OF COVERAGE	
		From:	To:
		From:	To:
		From:	To:
		From:	To:
		From:	To:

Section VII: MEDICAL ELIGIBILITY

A. ☐ Yes ☐ No Are **YOU,** your **SPOUSE** or any **DEPENDENT** currently pregnant or an expectant parent?

Name	Due Date

B. ☐ Yes ☐ No Are **YOU,** your **SPOUSE** or any listed **DEPENDENT** currently taking any prescription medication?

NAME	MEDICATION	DOSAGE	MEDICAL CONDITION

C. ☐ Yes ☐ No Has any insurance company refused, restricted or charged more for health coverage on any person listed on this Application?

NAME	REFUSAL OR RESTRICTION	MEDICAL CONDITION

D. ☐ Yes ☐ No DO **YOU,** your **SPOUSE** or any listed **DEPENDENT** have a condition covered by Workers' Compensation?

NAME	WORKERS' COMPENSATION NUMBER	MEDICAL CONDITION

E. ☐ Yes ☐ No In the past five years, have **YOU,** your **SPOUSE** or any listed **DEPENDENT** engaged in sports or hobbies such a scuba diving, automobile or motorcycle racing, skydiving or aero sports on a regular/routine basis? If YES, please complete the following"

NAME	SPECIFIC ACTIVITY

F. When was the last time **YOU,** your **SPOUSE** or any listed **DEPENDENT** saw a physician? Please complete the following:

NAME	DATE	REASON	RESULTS

Section VII: MEDICAL ELIGIBILITY (continued)

G. ☐ Yes ☐ No Have **YOU,** your **SPOUSE,** or any listed **DEPENDENT** ever been diagnosed and/or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS or other immune system disorders?

H. Have **YOU,** your **SPOUSE,** or any listed **DEPENDENT** ever been treated for, diagnosed as having, hospitalized, had surgery, been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advice for any of the following conditions? Each condition must be checked (√) yes or no.

CONDITION	YES	NO
1. Abnormal Pap Smears	☐	☐
2. AIDS, ARC, or HIV	☐	☐
3. Allergies	☐	☐
4. Alzheimer's Disease	☐	☐
5. Aneurysm	☐	☐
6. Anorexia/Bulimia	☐	☐
7. Arthritis (Type: _____)	☐	☐
8. Asthma	☐	☐
9. Back Sprains/Strains	☐	☐
10. Bronchitis	☐	☐
11. Bursitis	☐	☐
12. Cancer (Type: _____)	☐	☐
13. Cardiomyopathy	☐	☐
14. Carotid Artery Disease	☐	☐
15. Carpel Tunnel Syndrome	☐	☐
16. Cataracts	☐	☐
17. Cerebral Palsy	☐	☐
18. Cholesterol (High)	☐	☐
19. COPD or Emphysema	☐	☐
20. Cirrhosis of the Liver	☐	☐
21. Colitis (Including Ulcerative)	☐	☐
22. Colon Polyps	☐	☐
23. Congenital Disorders	☐	☐
24. Congestive Heart Failure	☐	☐
25. Coronary Artery Disease (Including Angina and Angioplasty)	☐	☐
26. Coronary Insufficiency	☐	☐
27. Crohns Disease	☐	☐
28. Cystic Fibrosis	☐	☐
29. Cystitis (Chronic or interstitial)	☐	☐
30. Cysts, Tumors or Growths	☐	☐
31. Diabetes/Blood Sugar Disorder Last 3 Blood Sugars & Dates: 1) _____ 2) _____ 3) _____	☐	☐

CONDITION	YES	NO
32. Diverticulitis/Diverticulosis	☐	☐
33. Down's Syndrome	☐	☐
34. Drug/Alcohol Abuse (Including DUI's)	☐	☐
35. Endometriosis	☐	☐
36. Fibrocystic Breast Disease	☐	☐
37. Fibromyalgia	☐	☐
38. Gallbladder Disease	☐	☐
39. Gastric Reflux (GERD)	☐	☐
40. Gout	☐	☐
41. Graves Disease	☐	☐
42. Growth Deficiency	☐	☐
43. Guillain Barre Syndrome	☐	☐
44. Heart Attack	☐	☐
45. Heart Bypass Grafting	☐	☐
46. Heart Murmur	☐	☐
47. Heart Palpitations/Arrhythmia	☐	☐
48. Heart Valve Disorders	☐	☐
49. Hemorrhoids	☐	☐
50. Hemophilia	☐	☐
51. Hydrocephalus/Shunt	☐	☐
52. Hypertension (High Blood Pressure) Last 3 Pressures & Dates: 1) _____ 2) _____ 3) _____	☐	☐
53. Ileostomy/Colostomy	☐	☐
54. Infertility	☐	☐
55. Kidney Failure	☐	☐
56. Kidney Stones	☐	☐
57. Liver Disorders/Hepatitis	☐	☐
58. Lou Gehrig's Disease (ALS)	☐	☐
59. Meningitis	☐	☐
60. Menstrual Disorders (including Abnormal Cycles/Uterine Bleeding)	☐	☐

CONDITION	YES	NO
61. Mental Health Disorders (Including Depression, Anxiety, ADD/ADHD and counseling)	☐	☐
62. Migraines	☐	☐
63. Multiple Sclerosis	☐	☐
64. Muscular Dystrophy	☐	☐
65. Organ Transplant/Failure	☐	☐
66. Osteoporosis	☐	☐
67. Otitis Media (ear infections)	☐	☐
68. Ovarian Cyst/Polycystic Ovarian Disease	☐	☐
69. Pacemaker Implantation	☐	☐
70. Pancreatitis	☐	☐
71. Paralysis	☐	☐
72. Parkinson's Disease	☐	☐
73. Peptic/Gastric Ulcer	☐	☐
74. Peripheral Vascular Disease	☐	☐
75. Phlebitis/Blood Clot	☐	☐
76. Polycystic Kidney Disease	☐	☐
77. Prostate Disorders	☐	☐
78. Schizophrenia/Bipolar	☐	☐
79. Scleroderma	☐	☐
80. Seizure Disorder/Epilepsy	☐	☐
81. Sexually Transmitted Disease	☐	☐
82. Sleep Apnea	☐	☐
83. Spina Bifida Cystica/Occulta	☐	☐
84. Spinal Disorders/Disc Disease	☐	☐
85. Stroke	☐	☐
86. Suicide Attempts/Psych Admits	☐	☐
87. Systemic Lupus	☐	☐
88. Tendonitis	☐	☐
89. Thyroid Disorder	☐	☐
90. TMJ	☐	☐
91. Tonsillitis	☐	☐
92. Transient Ischemic Attacks (TIA)	☐	☐
93. Varicose Veins	☐	☐
94. Other condition(s) not listed	☐	☐

I. If any questions A through H or conditions 1 through 94 are checked "YES", please explain below, (use additional paper, if necessary). Indicate all details of the injury, ailment or condition. Include items such as specific location of condition (example: right knee), diagnosis, type of treatment and hospitalization.

QUESTION/ CONDITION	PATIENT'S NAME	DETAILS OF INJURY, AILMENT OR CONDITION	START DATE(S) OF TREATMENT(S)	END DATE(S) OF TREATMENT(S)	PHYSICIAN

Section VIII: BILLING INFORMATION

CHOOSE ONE:

☐ **FINANCIAL INSTITUTION — Have monthly automatic premium withdrawls**

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

I authorize Carolina Care Plan® to initiate premium deductions from my account. The authorization will remain in effect until Carolina Care Plan 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 (deducted on 1st business day of the month)
(*Please note: Not all Financial Institutions allow deductions from a savings account. Please verify this information with your financial institution.)*

In case of insufficient funds, a $20 returned check fee will be applied.

Name and branch of bank/financial institution			Account Number
Address			Account Holder's Name
City	State	Zip	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** (Charged on 1st business day of the month)

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

☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

Cardholder Name	Card Number
Bank Name (if applicable)	Expiration Date
Account Holder's Signature	Date

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

☐ **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	Phone Number	
City	State	Zip Code

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Sold – Account Executive and Code
Service – Account Executive and Code

or

Broker Name/Agent of Record	Tax ID
Broker Signature	Date
Broker Email Address	Broker's Fax Number
General Agent	Commission Indicator

Section IX: TERMS AND CONDITIONS

I hereby apply to Carolina Care Plan Inc. (CCP) for the health coverage indicated on this Application and to Consumers Life Insurance Company (CLIC) for the life coverage indicated on this application.

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau Inc. (MIB), prescription history database supplier, government agency or person to CCP, CLIC and/or any affiliates or division of CCP or 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 and/or; (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 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. By signing below, I represent as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true; and (d) I did not sign a blank or partially completed Application. I agree that CCP and/or CLIC, in its sole discretion, may rescind my policy at any time, subject to the time limit on certain defenses provision, on the basis of any untrue, inaccurate or incomplete answer to any question in this Application, or any misrepresentation, omission or concealment on this Application, whether intentional or otherwise. I further agree that if a policy is issued, it will be issued by CCP and/or CLIC in full reliance and in consideration of the information, answers and statements contained herein. I understand that the policy for which I am applying will be medically underwritten, and that I must notify CCP and/or CLIC if there is a change in the health history of any Applicant between the time I sign this Application and the effective date of coverage, if approved.
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 policy for which I am applying have been explained to my satisfaction.
5. No issuance, waiver, modification or change of policy or any of CCP and/or CLIC rules or amendments shall be binding upon CCP and/or CLIC unless it is in writing and signed by an authorized officer of CCP and/or CLIC, as applicable.
6. Notice for health coverage: Certain Pre-Existing Condition limitations will apply: A Pre-Existing Condition is a Condition not revealed or misrepresented in the Application and for which an ordinarily prudent person would seek medical advice, diagnosis, care or treatment; or for which the covered person incurred medical expense, received medical treatment, used prescription drugs or was advised by a physician or other professional provider to receive treatment prior to the covered person's effective date. If a Pre-Existing Condition existed at any time during the twelve (12) month period immediately preceding the covered person's effective date, the Pre-Existing Condition will be covered no later than twelve (12) months without medical care, treatment, or supplies ending after the effective date of the covered person's coverage or twelve (12) months after the effective date of the covered person's coverage, whichever occurs first.
7. I represent that neither I nor my spouse are receiving any form of reimbursement or compensation for this coverage from any employer.
8. 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.
9. I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application. I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority: (a) to waive any answer or any portion of any answer to any question on this Application or any information CCP and/or CLIC requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning health benefits that are inconsistent with, or different from, any written information provided by CCP and/or CLIC; (d) to bind CCP and/or CLIC in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage.
10. I understand and agree that I am responsible for disclosing all information required by this Application, including but not limited to, all health conditions and diagnoses of which I am aware. I understand and agree that CCP and/or CLIC has the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this Application and that I am obligated to disclose even those conditions or diagnoses that I do not believe are significant or important.
11. My dependents and I understand and agree that any information obtained will not be released by CCP and/or CLIC to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any Application, claim or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photocopy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to CCP and/or CLIC's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by CCP and/or CLIC's Privacy Office.
12. I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information.

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. I understand that I should not cancel any current insurance coverage until I receive an approval letter and policy from CCP and/or CLIC.

Contract Holder's or Guardian's Signature	Date		
Spouse's Signature	Date	Dependent's Signature if 18 or older	Date
Dependent's Signature if 18 or older	Date	Dependent's Signature if 18 or older	Date

Section X: HOW DID YOU HEAR ABOUT PERSONAL HEALTH PLAN? (CHECK ONE)

☐ 1. Friend/Family Member	☐ 4. Advertisement in newspaper, magazine, etc.	☐ 7. Radio	☐ 10. Other _____
☐ 2. Yellow Pages	☐ 5. Newspaper Article	☐ 8. Mail	
☐ 3. Insurance Agent	☐ 6. Internet/Web site	☐ 9. Through current employer	

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 may have violated state law.