P.O. Box 4058, Farmington, CT 06034-4058 ■ www.connecticare.com ■ 1-800-251-7722

APPLICANT INFORMATION: Complete all sections, sign at bottom and read information on reverse side.

Check one: ☐ New Application ☐ Terminate Coverage ☐ Add Dependent ☐ Remove Dependent ☐ Change Physician ☐ Change Ind. Plan Choice (select new choice below) ☐ Other (Name change, address change, etc.) Indicate change ____

Eff. Date (mm/dd/yy) / /

Marital Status: ☐ Single ☐ Widowed ☐ Married (Civil Union) ☐ Divorced ☐ Legally Separated ☐ Domestic Partnership (include "Statement of Domestic Partnership') ☐ Separated

Email Address

First Name | Middle Name | Last Name

Street Address | P.O. Box | Home Telephone Number

City | State | ZIP Code

Work Telephone Number

Billing Address (if different from street address) | City | State | ZIP Code

ConnectiCare, Inc. = HMO Benefit Plans and ConnectiCare Insurance Company, Inc. = POS Benefit Plans

HMO Benefit Plans (Select one) (Deductible=Individual/Family):
- ☐ HMO Hospital Copay $500
- ☐ HMO Hospital Deductible $2,000/$4,000
- ☐ HMO Upfront Plan Deductible $1,500/$3,000
- ☐ HMO Upfront Plan Deductible $2,500/$5,000

Pharmacy Co-Pay (Select one):
☐ $10/$20/$35 ☐ $15/$25/$40

Pharmacy Annual Maximum (Select one):
- ☐ $1,000
- ☐ $2,000
- ☐ $3,000

OR

POS Upfront Plan Deductible Benefit Plans (Select one) (Deductible=Individ./Family):
- ☐ $500/$1,000 In-Network Deductible
- ☐ $1,000/$2,000 In-Network Deductible
- ☐ $2,000/$4,000 In-Network Deductible

Pharmacy Co-Pay (Select one):
☐ $10/$20/$35 ☐ No Pharmacy Option
☐ $15/$25/$40

Pharmacy Maximum (Select one):
☐ $1,000 ☐ $3,000
☐ $2,000 ☐ No Pharmacy Option

OR

HSA Compatible Plans (Select one HMO plan or POS plan) (Deductible=Individual/Family):

HMO HDHP
- ☐ $1,500/$3,000 In-Network Ded.
- ☐ $3,000/$6,000 In-Network Ded.
- ☐ $5,000/$10,000 In-Network Ded.

POS HDHP
- ☐ $1,500/$3,000 In-Network Ded.
- ☐ $3,000/$6,000 In-Network Ded.
- ☐ $5,000/$10,000 In-Network Ded.

MEMBER(S): First Name/Middle Initial/Last Name	Add	Delete	Social Security Number or Current Member Identification Number	Sex	Date of Birth (mm/dd/yy)	Full-Time Student* age 19 & older	Primary Care Physician	Provider ID Number (6 or 8 digits)	Existing Patient
Applicant			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /			_ _ _ _ _ _ _ _	☐ Yes ☐ No
Spouse/Partner			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /			_ _ _ _ _ _ _ _	☐ Yes ☐ No
Dependent 1			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /	☐ Yes* ☐ No		_ _ _ _ _ _ _ _	☐ Yes ☐ No
Dependent 2			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /	☐ Yes* ☐ No		_ _ _ _ _ _ _ _	☐ Yes ☐ No
Dependent 3			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /	☐ Yes* ☐ No		_ _ _ _ _ _ _ _	☐ Yes ☐ No

☐ Check if enrolling a disabled dependent age 19 or over and submit a ConnectiCare proof of disability form. ***Complete student verification form.**

Tell us about your other insurance: Do you have any other health insurance policy or certificate in force? ☐ Yes ☐ No

Name of other insurance company | Type of coverage ☐ Group ☐ Individual | Last date of coverage

Do you intend to replace your current medical or health policy with this policy? ☐ Yes ☐ No

Important: The applicant, spouse/partner and all dependents aged 18 and over must sign this form. By signing here I acknowledge and agree that I have read and understand the information on the front **and back** of this form and Part 2: Health Statement. I also agree that the Member Consent is valid as long as I am enrolled in a ConnectiCare health plan and it is provided under state laws and regulations. I certify that the statements made herein and in Part 2: Health Statement are true and complete to the best of my knowledge and belief. I understand that I have an obligation to notify ConnectiCare of any new conditions or changes in health condition that may occur after this application is signed and before the effective date of coverage, if approved. I acknowledge that I have received a copy of the Outline of Coverage for the Plan I have selected above. I acknowledge and agree that with respect to any dependents under age 18 that I am authorized to make these statements on their behalf. **This plan is issued on an individual basis and is regulated as an individual health insurance plan.**

▶ Applicant Signature | Date

Print name of parent/guardian (if applicable)

▶ Spouse/Partner Signature (if applicable) | Date

▶ Dependent Signature (age 18 years-over) | Date

▶ Dependent Signature (age 18 years-over) | Date

AGENT SECTION:

Agency Name	Phone Number
Agent Name (Print)	▶ Agent Signature

FOR BUSINESS USE ONLY:

Effective Date	
Account #	Other

IMPORTANT: MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Inc., (CCI) or a CCI affiliated, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I understand that CCI's privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CCI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CCI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents' coverage under the Plan. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CCI as long as CCI or others have not taken action relying on this authorization.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment and restitution depending on applicable laws.

Any new conditions or changes occurring after the application is submitted but prior to approval, must be reported to ConnectiCare.

INSTRUCTIONS: DID YOU REMEMBER TO ...

- ☐ **Print clearly, complete all sections on front and sign at the bottom?**
- ☐ **Select your primary care physician and include the 6 or 8 digit Provider ID number? (can be found at www.connecticare.com)**
- ☐ **Attach the ConnectiCare Individual Health Statement?**
- ☐ **Attach the first month's premium payment payable to ConnectiCare?**
- ☐ **Attach EFT form with a check marked "Void" (if applicable), or a savings deposit slip?**
- ☐ **Attach proof of full-time student status for children age 19 and older?**
- ☐ **Attach a HIPAA Certificate of Creditable Coverage (if applicable)?**
- ☐ **Attach Affidavit of Domestic Partnership (if applicable)?**

ConnectiCare, Inc. & Affiliates — Individual Health Statement

Part 2 (page 1 of 2)

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DETAILS MAY BE SUBMITTED VIA SEALED ENVELOPE MARKED "CONFIDENTIAL".

PLEASE PRINT IN INK AND COMPLETE BOTH SIDES OF FORM FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE.

First Name/Middle Initial/Last Name		Height (ft/in)	Weight (lbs.)	Date of Birth (mm/dd/yyyy)	Sex	Social Security #
Applicant				/ /	☐ M ☐ F	___ ___ ___ ___ ___ ___ ___ ___ ___
Spouse/Partner				/ /	☐ M ☐ F	___ ___ ___ ___ ___ ___ ___ ___ ___
Occupation Applicant	Occupation Spouse/Partner					
Dependent 1				/ /	☐ M ☐ F	___ ___ ___ ___ ___ ___ ___ ___ ___
Dependent 2				/ /	☐ M ☐ F	___ ___ ___ ___ ___ ___ ___ ___ ___
Dependent 3				/ /	☐ M ☐ F	___ ___ ___ ___ ___ ___ ___ ___ ___

ANSWER ALL QUESTIONS. For "YES" answers, details must be provided on reverse side under the "Health History" section.

1. Is any person seeking coverage currently covered by Medicare? ☐ Yes ☐ No
2. Has anyone seeking coverage had health or life insurance **modified,** postponed or rated? If yes, please provide details on the reverse side of this form. ☐ Yes ☐ No
3. Are you or your spouse or any dependent seeking coverage, currently disabled or unable to perform their normal activities,or require the use of assistive devices? ☐ Yes ☐ No
4. Within the past 5 years, have you, your spouse, or any dependent seeking coverage been hospitalized, had surgery or been advised to have surgery for any reason? ☐ Yes ☐ No
5. Is any applicant, male or female, expecting a child, or in the process of adoption or surrogacy with anyone, whether or not that person is applying for coverage on this application? **If yes, please provide applicant name:** ______________ Expected delivery date: ______________ ☐ Yes ☐ No
   A. All females seeking coverage must complete the Box "5a" on the reverse side of this form. Is box 5a completed? ☐ Yes ☐ No
6. Has any applicant taken, or been advised to take, either currently or in the past 2 years any medications on a long-term basis? **If yes, please provide details on the reverse side of this form, including the name of the medication(s) and the reason it was prescribed.** ☐ Yes ☐ No
7. Have you, your spouse, or any dependent seeking coverage ever smoked cigarettes? If yes, who? ______________ If yes, for how long? ______________ If no longer smoking, when was the date of the last cigarette? ______________ ☐ Yes ☐ No
8. Have you, your spouse, or any dependent seeking coverage or renewing this policy been counseled by a doctor to have surgical procedures, biopsies, medication, testing, consultations or other treatments which you have not yet had? **If yes, please provide details on the reverse side of this form.** ☐ Yes ☐ No
9. Has any person seeking coverage, had medical expenses in excess of $5,000.00 in the last 12 months? ☐ Yes ☐ No
10. Have you, your spouse, or any dependent seeking coverage, ever had, or been told they had, or been medically counseled, consulted or treated for any of the following? **If yes, details must be provided on reverse side under the "Health History" section.**
    - A. Chest pain, heart attack, heart murmur, heart trouble, irregular heartbeat, any implanted devices (such as pacemaker or defibrillator) or any other diseases of the heart, circulatory system or blood vessels? ☐ Yes ☐ No
      - 1. Is there a family history of ischemic heart disease? ☐ Yes ☐ No
    - B. Any cancer, tumor or lymph node enlargement? **If yes, indicate type and location of cancer.** ______________ ☐ Yes ☐ No
      - 1. Any family history of colon, breast or ovarian cancer? **If yes, please specify relationship.** ______________ ☐ Yes ☐ No
    - C. Have you been tested for, consulted for, or diagnosed with, sleep apnea? ☐ Yes ☐ No
    - D. High Blood Pressure or high cholesterol. **If yes, please provide most recent reading/value.** ☐ Yes ☐ No
    - E. Diabetes, endocrine system or glands? **If yes, provide date of diagnosis, type and amount of medication, if any.** ☐ Yes ☐ No
    - F. Sexually transmitted disease? ☐ Yes ☐ No
    - G. Medical diagnosis of HIV positive, HIV/AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)? ☐ Yes ☐ No
    - H. Major depression, psychosis, anxiety, attention deficit, chemical imbalance; bi-polar, obsessive-compulsive, panic disorders or schizophrenia, substance use/abuse, eating disorders (anorexia/bulimia, etc.); alcohol use/abuse or chemical use/dependence? ☐ Yes ☐ No
    - I. Brain disorder, neurological disorder, seizure disorder, stroke or paralysis or any other disorder of the central nervous system? ☐ Yes ☐ No
    - J. Any disorder of the stomach, intestines, gallbladder or esophagus? ☐ Yes ☐ No
    - K. Any disorder of the lungs or respiratory system or Tuberculosis? ☐ Yes ☐ No
    - L. Any disorder of the kidneys, bladder or urinary tract? ☐ Yes ☐ No
    - M. Any disorder of the liver or pancreas? ☐ Yes ☐ No
    - N. Any back, neck, bone, joint problems, or artificial joints; Lupus, arthritis or autoimmune disorder? ☐ Yes ☐ No
    - O. Anemia, hemophilia or any other disorders of the blood? ☐ Yes ☐ No
    - P. Are you a recipient of, or a candidate for, an organ transplant? ☐ Yes ☐ No
    - Q. Any disorder of the female/male reproductive organs? ☐ Yes ☐ No
    - R. Does any female seeking coverage currently have or ever had breast implants? ☐ Yes ☐ No
    - S. Has any applicant seeking coverage been treated for or had a surgery related to morbid obesity? ☐ Yes ☐ No
    - T. Any skin conditions, past or present, including skin cancers, psoriasis, acne or eczema? ☐ Yes ☐ No

(Additional questions on back of this page.)

PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.

DETAILS MAY BE SUBMITTED VIA SEALED ENVELOPE MARKED "CONFIDENTIAL".

APPLICANT NAME: ______________________ **APPLICANT SOCIAL SECURITY #** ______________________

QUESTIONS, CONTINUED FROM PAGE 1. For "YES" answers, details must be provided below under the "Health History" section.

11. Are you, your spouse or any dependent (including those not seeking coverage) currently receiving treatment for infertility or ever received treatment for infertility in the past and/or had any previous recommendation or evaluation for future infertility treatment? ☐ Yes ☐ No
12. Other Conditions: Has any person seeking coverage consulted with, or received treatment from, any doctor or other health care provider for any other conditions or symptom(s) not listed on this application? **If yes, please provide details below.** ☐ Yes ☐ No

BOX 5a FEMALE APPLICANTS: Date of last menstrual period for each female listed on the front of this application: Enter date or N/A (as "not applicable" for child under 10)

Name: ____________ / / ____ Name ____________ / / ____ Name: ____________ / / ____

A detailed explanation must be provided below if you answered "YES" to any question. NOTE: Simply listing the name of a primary physician or referring to a physician's name will not be considered a substitute for listing fully detailed answers to the questions. If additional space is needed you may attach a separate page which must be signed and dated.

HEALTH HISTORY:

Question Number/Ltr.	Person Affected	Condition/Diagnosis	Treatment (surgeries/medication)	Date Treatment Began	Date of Full Recovery	Physician Name, Address & Phone Number

*** By my signature on Part 1, I certify that the statements made herein and in Part 1 are true and complete to the best of my knowledge and belief. Any health conditions that change after the application is submitted but prior to approval, must be reported to ConnectiCare and will be considered in the final underwriting decision.**

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Note: You and any dependents aged 18 or over must sign this form along with the completed **Individual** application form. If we do not receive this signed form, the **application will be considered incomplete** and could be delayed.

NAMES OF APPLICANT(S):

Primary Applicant	Applicant Social Security Number
Spouse/Partner	Dependent Applicant Aged 18 or over
Dependent Applicant Aged 18 or over	Dependent Applicant Aged 18 or over

AUTHORIZATION:

I hereby authorize any health care provider, medical facility, pharmacy, pharmacy benefits company or pharmacy related facility, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested by ConnectiCare. As part of our medical underwriting, ConnectiCare may need access to medical records and other medical information. It is your responsibility to provide us access to that medical information and to pay for any costs your physician's office may charge to copy and send us those records. If we do not have complete medical information, your application will be incomplete and may be denied if you do not arrange to have the medical records provided to us within sixty days.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment (but not psychotherapy notes), pharmacy, prescriptions, HIV testing and treatment, STD testing and treatment, lab data and EKGs. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by ConnectiCare pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable ConnectiCare to make eligibility determinations relating to me and/or my minor children and for ConnectiCare's underwriting or risk rating determinations. If I refuse to sign or chose to revoke this authorization, ConnectiCare may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying ConnectiCare in writing of my desire to revoke. Such revocation must be sent to the following address: ConnectiCare, Inc., Underwriting Department, 175 Scott Swamp Road, Farmington, CT 06032. Such revocation will not be valid if ConnectiCare has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, or, if insured, when I am no longer an insured of ConnectiCare.

Any health conditions that change after the application is submitted but prior to approval, should be reported to ConnectiCare.

▶ ______________________________
Signature of Primary Applicant or Representative* Date

▶ ______________________________
Signature of Spouse/Partner or Representative* Date

▶ ______________________________
Signature of Other Dependent Applicants aged 18 or over or Representative* Date

▶ ______________________________
Signature of Other Dependent Applicants aged 18 or over or Representative* Date

▶ ______________________________
Signature of Other Dependent Applicants aged 18 or over or Representative* Date

* If you are the individual's representative and are not the parent or legal guardian of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

PLEASE RETAIN A SIGNED COPY FOR YOUR RECORDS.