

California Individual Application for Health Insurance

New Business Change in Benefits (specify requested date below in Coverage Information section) Dependent Add
This application is to be completed by the applicant applying for coverage. For child only, application is to be completed by the child's parent or legal guardian if child is not of legal age.

Applicant's Social Security Number _____ Group No. (Home Office to assign) _____

APPLICANT/PERSON TO BE COVERED FOR CHILD ONLY

Last Name _____ First Name _____ Initial _____

Home Address _____ City _____ State _____ Zip _____ County _____
(PO Box, not acceptable)

Billing Address _____ City _____ State _____ Zip _____

Home Phone No. () _____ Best time to Call _____ Alternate Phone No. (if applicable) () _____

Gender M F Date of Birth _____ Height _____ Weight _____ Primary Care Physician's Name _____

Single Married Domestic Partner
Language (Optional) English Spanish Other _____

Ethnicity (Optional) Caucasian or White Hispanic or Latino American Indian or Alaskan Native
 Black or African-American Asian, Native Hawaiian, other Pacific Islander Not Provided

Applicant's Occupation: _____ Spouse/Domestic Partner's Occupation: _____

Yes No Are you a U.S. citizen? If no, list how long in the U.S.: _____ (Attach copy of valid permanent resident card)

DEPENDENT ENROLLMENT INFORMATION

(If more space is needed, attach an additional sheet of paper, sign and date it.)

Spouse/Domestic Partner (First Name & M.I., last name if different): _____ Soc. Sec. No. _____

Gender M F Date of Birth _____ Height _____ Weight _____ Primary Care Physician's Name _____

Child (First Name & M.I., last name if different): _____ Soc. Sec. No. _____

Gender M F Date of Birth _____ Height _____ Weight _____ Primary Care Physician's Name _____

Child (First Name & M.I., last name if different): _____ Soc. Sec. No. _____

Gender M F Date of Birth _____ Height _____ Weight _____ Primary Care Physician's Name _____

Child (First Name & M.I., last name if different): _____ Soc. Sec. No. _____

Gender M F Date of Birth _____ Height _____ Weight _____ Primary Care Physician's Name _____

Dependents (age 19 through 23) attending school full-time, include name of dependent, name/address of school, and number of credits: _____

ELIGIBILITY

Yes No Are you or any family members covered by Medicare/Medicaid? If yes, list family members and their effective date: _____

Yes No Are you, any family member, or significant other pregnant or in the process of adoption or surrogacy (including those not applying for coverage)? _____

Yes No Are you or any eligible dependent disabled, receiving disability payments, or hospital confined? _____

COVERAGE INFORMATION

Medical: Applicant Applicant/Family Applicant/Spouse or Domestic Partner
 Applicant/Child(ren) Child only

Requested effective date ____ / ____ / ____ (Effective date may not be guaranteed)

Network Name _____ Product Name _____

Copay/Deductible _____ Coinsurance _____

Upon signature of this application, I am indicating that I have selected the plan design within this Coverage Information section and that I fully understand the benefit levels of this plan.

I am a HIPAA Eligible Individual as defined in the Prior Coverage section on page 3 of this application and I choose to apply for (HIPAA Eligible medical plan selected): _____

I am a HIPAA Eligible Individual as defined in the Prior Coverage section on page 3 of this application but I choose to apply for the Non-HIPAA Eligible medical plan selected. I understand there is no guarantee of policy issuance and that the pre-existing condition limitations of the selected plan will apply regardless of my status as a HIPAA Eligible Individual.

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Home Office Use Only

Depending upon state law, this information may be used in determining whether your application is approved for coverage.

MEDICAL HISTORY

A. Within the past five years, has any person to be insured ever had any conditions, diagnosis, consultation, routine follow-up, treatment, or therapy; been prescribed any medication; been monitored; or received counseling for any of the following?...(Provide details to "Yes" answers below.)

<p>1) Digestive Disorder Yes No</p> <p>a. Irritable Bowel, Spastic Colon <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Colitis, Crohn's Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Gastric Reflux, Heartburn <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Gallbladder Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Hepatitis, Other Liver Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Other Digestive or Intestinal Disorder <input type="checkbox"/> <input type="checkbox"/></p>	<p>6) Genitourinary Yes No</p> <p>a. Fibrocystic Breast, Implants, <input type="checkbox"/> <input type="checkbox"/></p> <p> Other Breast Condition <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Ovarian Cyst, Uterine Fibroid <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Infertility Testing or Treatment <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Menstrual, Reproductive Organ Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Abnormal Pap Smear <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Prostate Gland Disorder, <input type="checkbox"/> <input type="checkbox"/></p> <p> Abnormal PSA Test <input type="checkbox"/> <input type="checkbox"/></p> <p>g. Sexually Transmitted Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>h. Urinary Tract, Bladder, <input type="checkbox"/> <input type="checkbox"/></p> <p> Kidney Disorder</p>	<p>10) Psychological Yes No</p> <p>a. Anxiety, Panic Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Depression, Major Depressive Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Bipolar Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Obsessive Compulsive Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Schizophrenia, Schizoaffective Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Anorexia, Bulimia Nervosa <input type="checkbox"/> <input type="checkbox"/></p> <p>g. Other Psychological Condition <input type="checkbox"/> <input type="checkbox"/></p>	<p>11) Neurological Yes No</p> <p>a. Cerebral Palsy, Muscular Dystrophy <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Epilepsy, Seizures, Convulsions <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Headaches, Migraines <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Mental Retardation, Down's Syndrome <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Multiple Sclerosis, Paralysis <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Other Neurological Disease or Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>g. Alzheimer's Disease, Dementia <input type="checkbox"/> <input type="checkbox"/></p> <p>h. Parkinson's Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>i. Autism, Pervasive Develop. Disorder <input type="checkbox"/> <input type="checkbox"/></p>
<p>2) Cardiovascular/Circulatory Yes No</p> <p>a. High Blood Pressure, Hypertension <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Mitral Valve Prolapse, Heart Murmur <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Chest Pain, Heart Attack, Arrhythmia, <input type="checkbox"/> <input type="checkbox"/></p> <p> Angina, Palpitations</p> <p>d. Vascular Abnormality, Poor Circulation <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Stroke, Transient Ischemic Attack <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Other Heart Condition or Disease <input type="checkbox"/> <input type="checkbox"/></p>	<p>7) Eyes/Ears/Nose/Throat/Skin Yes No</p> <p>a. Acne, Skin Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Ear, Nose, Sinus, Throat, Mouth <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Eye, Cataracts, Glaucoma, Other <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Loss of Hearing, Deafness <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Jaw Condition or TMJ <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Vision Impairment, Blindness <input type="checkbox"/> <input type="checkbox"/></p>	<p>12) General Yes No</p> <p>a. Abnormal Test Results (except for HIV) <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Burns <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Congenital Abnormality, Loss of Limb <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Edema <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Fibromyalgia, Chronic Fatigue <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Hernia <input type="checkbox"/> <input type="checkbox"/></p> <p>g. Organ or Tissue Transplant <input type="checkbox"/> <input type="checkbox"/></p> <p>h. Pain Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>i. Surgical Implants <input type="checkbox"/> <input type="checkbox"/></p> <p>j. Chronic Infection <input type="checkbox"/> <input type="checkbox"/></p> <p>k. Ulcer <input type="checkbox"/> <input type="checkbox"/></p>	<p>13) Other Yes No</p> <p>a. Health disorders not listed above <input type="checkbox"/> <input type="checkbox"/></p> <p> (except for HIV)</p>
<p>3) Respiratory/Lung Yes No</p> <p>a. Allergies, Asthma <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Bronchitis, COPD, Emphysema <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Sleep Apnea, Tuberculosis <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Other Respiratory or Lung Disorder <input type="checkbox"/> <input type="checkbox"/></p>	<p>8) Endocrine/Gland/Lymph/Blood Yes No</p> <p>a. Blood Abnormality, Anemia (except for HIV) <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Elevated Cholesterol/Triglycerides <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Diabetes, Pancreas, Elevated Glucose <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Hormonal Disorder, Adrenal <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Lymph Gland Disorder, <input type="checkbox"/> <input type="checkbox"/></p> <p> Immune System (except for HIV)</p> <p>f. Thyroid, Goiter <input type="checkbox"/> <input type="checkbox"/></p>	<p>9) Alcohol/Drug Yes No</p> <p>a. Alcoholism, Alcohol Use (3+ drinks/day) <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Drug or Substance Abuse, Illicit Use <input type="checkbox"/> <input type="checkbox"/></p>	
<p>4) Musculoskeletal/Nerve Yes No</p> <p>a. Arthritis or Rheumatism, Carpal Tunnel <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Neck, Back, Spinal Condition <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Bone, Muscles, Joint Condition <input type="checkbox"/> <input type="checkbox"/></p> <p>d. Fracture, Dislocation, Internal Fixation <input type="checkbox"/> <input type="checkbox"/></p> <p>e. Lupus, Connective Tissue Disease <input type="checkbox"/> <input type="checkbox"/></p> <p>f. Osteoporosis, Osteopenia <input type="checkbox"/> <input type="checkbox"/></p>	<p>5) Cyst/Tumor/Polyp/Malignancy Yes No</p> <p>a. Cancer, Leukemia <input type="checkbox"/> <input type="checkbox"/></p> <p>b. Cyst, Growth, Lump, Tumor, Polyp <input type="checkbox"/> <input type="checkbox"/></p> <p>c. Hodgkin's or Non-Hodgkin's Lymphoma <input type="checkbox"/> <input type="checkbox"/></p>		

- B. Yes No Have you or any eligible dependent ever been declined, postponed, ridered, rescinded, or rated up for medical, disability, critical illness, life insurance, or long term care with another insurance carrier? If yes, explain: _____
- C. Yes No In the past five years, have you or any person to be insured received treatment, received therapy, taken medication, or consulted a health care provider for any reason? If yes, explain: _____
- D. Yes No Are you or any person to be insured currently taking any prescription medication, over-the-counter medication, vitamin therapy or alternative remedies (including herbs)? Please indicate the reason for use: _____
- E. Yes No In the past five years, have you or any person to be insured been advised to have a test or treatment, been advised to obtain equipment or service, been advised of a condition that may require attention or treatment, or are you awaiting the results of any medical tests or investigation? Explain: _____
- F. Yes No Within the past five years, has any person to be insured been advised to seek treatment for or been advised to limit alcohol or drug use, been a member of any alcohol or drug abuse support group or used any controlled drug not prescribed by a doctor? If yes, explain: _____
- G. Yes No Has any person to be insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or had a T-cell abnormality? If yes, list names: _____
- H. Yes No Has anyone to be insured used tobacco products during the previous 12 months? If yes, list names: _____

Provide details to "YES" answers (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question No./Letter	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Physician's Name & Address

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PRIOR COVERAGE

- Yes No Are you or any dependents replacing health coverage that was in effect within the last 63 days?
- Yes No Do you or any dependents to be insured have or intend to keep any health insurance coverage, including COBRA and/or state continuation currently in force?
- Yes No Have you or any dependents ever been previously covered by PacifiCare? If yes, list PacifiCare ID #: _____

If you answered "Yes" to any of the above questions, please complete the following section. If you answered "No" to all questions, please proceed to the Terms and Conditions of Insurance section.

Name(s) of covered individual	Insurance Company Name, Address and Phone	Policy or Group Number	Type of Coverage <small>(individual, employer group, short term, COBRA, Medicare, other)</small>	Effective Date	Termination Date

HIPAA Eligible Individual Determination - Please indicate yes or no to the following:

Yes No

- 1. As of the date on which you are applying for coverage, have you been insured under creditable coverage for at least 18 months with no more than a 63 day lapse in coverage?
- 2. Was your most recent period of coverage under a group health plan (employer-sponsored), a governmental plan, or a church plan?
- 3. If you were offered the option of continuation of coverage under COBRA, Cal-COBRA or a similar state continuation program, did you complete the allowable period of coverage?
- 4. Are you eligible for any of the following: a group health plan (employer-sponsored plan); Part A or Part B of Medicare; or a state plan under Medicaid, Medi-Cal, or any successor program?
- 5. Do you have other health insurance?
- 6. Was your most recent health insurance terminated for fraud, intentional misrepresentation of material fact, or individual nonpayment of premium?

If you answered YES to questions 1 through 3 and NO to questions 4 through 6, you or your dependents may qualify as a HIPAA Eligible Individual, and we may waive the pre-existing limitation for you and your dependents on selected plans. If qualifying as a HIPAA Eligible Individual, please attach a certificate of creditable coverage from the prior plan, or any other documents to prove that you or your dependents had prior coverage.

TERMS AND CONDITIONS OF INSURANCE

You, the Applicant, shall furnish to PacifiCare Life and Health Insurance Company (PLHIC) or American Medical Security Life Insurance Company (hereinafter collectively PacifiCare) any information required for PacifiCare to underwrite and administer the insurance. You shall have records available for PacifiCare to inspect at any time while insurance is in force, and for up to the earlier of three years after the termination date or the final adjustment and settlement of claims is made. PLHIC reserves the right to waive or change any of the above requirements at any time.

PLHIC compensates producers for the sale of certain products. You may contact your producer for information regarding the amount or type of compensation paid by PLHIC.

PACIFICARE UNDERWRITING REQUIREMENTS

You are required to submit this Individual Application for Health Insurance (Application) for yourself and/or for all eligible dependents to be insured. **Insurance for any person is not effective until the date specified by PLHIC.** Depending upon the law, PLHIC may have the right to decline insurance for any person for whom information has been submitted in this Application.

ADMINISTRATIVE FEE

A \$25.00 service fee will be applied to any payment returned as non-negotiable.

TERMINATION OF INSURANCE

You may terminate insurance at any time by providing PacifiCare written notice prior to the requested termination date. The termination date will be the first of the month following receipt of the request. Insurance will terminate at 12:01 a.m. Central Standard Time on the termination date. PLHIC will terminate insurance if you fail to pay premium on the due date, except that coverage continues for a grace period of 31 days after the premium due date. You will be responsible to pay premium for the grace period coverage unless, before any premium due date, you provide written notice to PacifiCare of request to cancel. In addition to reasons for termination that are specified in the insurance policy, PLHIC may also reform or rescind coverage for fraud or material misrepresentation. When PLHIC terminates insurance, PacifiCare will provide you with a minimum of 31 days advance written notice of the termination date unless termination is due to nonpayment of premium, fraud or misrepresentation. Termination will not prejudice a valid claim existing on the termination date, unless termination is due to nonpayment of premium, fraud or misrepresentation.

Upon termination, you may request reinstatement of coverage by paying all applicable premium. A nonrefundable reinstatement fee may apply, where allowed by state law. Your payment will be deposited during review of your request. Depositing your check does not mean acceptance and does not guarantee reinstatement. PacifiCare can approve or decline reinstatement requests and will notify you in writing of its decision.

Benefits are not effective until you receive written approval from PLHIC. No action is taken on this Application until all required information is submitted. The deposit amount will be returned to you if this Application is declined.

To be a valid application, your signature and the date you sign it are required. Signature Required-Applicant Agreement

I understand that all answers will be relied upon by PacifiCare in the issuance of a certificate of insurance. I declare all statements contained in this entire Application about me and my dependents to be insured are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand and agree that PacifiCare is not bound by any statement made by or to any producer unless written herein. I understand that no person other than an officer of PacifiCare has the authority to bind or alter benefits and that any such attempt by any producer is void and is not effective. **I agree that no coverage will be effective until written notification has been provided by PLHIC and that the actual effective date may not be the requested effective date.**

To assist with determining my creditable coverage, I authorize any insurance company, third-party administrator, plan administrator, pharmacy benefit manager, pharmacy, or other carrier or provider of health benefits to release to PacifiCare certificates of creditable coverage and all such information.

State law may require a group health plan to follow rules for use of medical history, rating, renewability, and replacement of prior coverage when the plan is issued to a self-employed individual, a sole proprietor, an independent contractor, a partner, or a sole employee of a Subchapter S or Chapter C corporation. I have been made aware of regulations that may apply in my state. The producer, if applicable, has advised me about the law and I hereby certify that I do not qualify for such group health plan.

Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be found guilty of insurance fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

- I hereby acknowledge receipt of the Notice of Information Practices. I understand that I may request an additional copy of this Notice at any time.

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Arbitration Disclosure - By signing below, I acknowledge that I have read, understand and agree to the Arbitration Disclosure and the Terms and Conditions on all the pages of this Application.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN ME AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE LIFE AND HEALTH INSURANCE COMPANY OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

SIGNATURES

- I understand that the policy for medical coverage will not pay benefits during the first 6 months after the effective date for a pre-existing disease or physical condition. However, the length of the exclusionary period for pre-existing conditions will be reduced by the number of days of my creditable coverage, as applicable, if I have not experienced a break in coverage of at least 63 days.

Applicant's Signature _____ Date ____ / ____ / ____

(If for child only, signature must be the child's parent or legal guardian if the child is not of legal age.) _____
(Parent or Legal Guardian Name)

If signed by a representative of Applicant, please indicate the representative's authority to act on behalf of Applicant. _____

Spouse/Domestic Partner's Signature _____ Date _____
(If spouse/domestic partner is to be covered)

Dependent's Signature (age 18 or older) _____ Date _____

PRODUCER INFORMATION

- I certify that I have delivered the Notice of Information Practices to the applicant, as required by law.

Producer Name (if applicable) _____ Producer ID _____
(Only last 4 digits required)

Producer Address _____

Phone (____) _____ Fax (____) _____

General Agent Name/Number _____

Licensed Producer Signature _____ Date _____

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SIGNATURE REQUIRED/AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR UNDERWRITING

Please clearly print all information.

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, medical information services, such as, but not limited to, Ingenix, Inc. (Ingenix), urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, pharmacy data, laboratory tests and results, diagnoses, treatment, and prognoses, to PacifiCare Life and Health Insurance Company, American Medical Security Life Insurance Company, or either company's designee (hereinafter collectively PacifiCare). I further authorize PacifiCare to disclose such protected health information to medical information services, such as, but not limited to, Ingenix. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under an existing policy for me and my dependents. This authorization is not applicable to psychotherapy notes.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by PacifiCare and may no longer be protected by state or federal privacy law.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 30 months from the latest signature date below. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining coverage, my revocation will not prevent PacifiCare from the right to contest a claim under the policy if another law so allows. Should my dependents or I refuse to sign this authorization, I understand it may affect my enrollment in the health plan. I understand that all pages must be attached and complete, including this authorization, for this Application to be considered complete and that incomplete applications may be rejected.

Applicant's Signature **X** _____ Social Security Number _____ Date ____ / ____ / ____
(If for child only, signature must be the child's parent or legal guardian if the child is not of legal age.)

If signed by a representative of Applicant, please indicate the representative's authority to act on behalf of Applicant.

Spouse/Domestic Partner's Signature **X** _____ Date _____
(If spouse/domestic partner is covered)

Signature of each covered dependent age 18 and over:

X _____ Date _____ **X** _____ Date _____
X _____ Date _____ **X** _____ Date _____

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Insurance Products are underwritten by PacifiCare Life and Health Insurance Company. American Medical Security Life Insurance Company provides administrative services for insurance products underwritten by PacifiCare Life and Health Insurance Company.

Payment Authorization Form

A. APPLICANT INFORMATION

Last Name _____ First Name _____ SS# _____

B. INITIAL METHOD OF PAYMENT

- Automatic Bank Draft (Complete Bank Draft Authorization below) Credit Card (Complete Credit Card Authorization below)

CREDIT CARD AUTHORIZATION (AVAILABLE FOR FIRST MONTH PAYMENT ONLY)

- VISA MasterCard

Cardholder's First Name _____ Middle Initial _____ Last Name _____
(As it appears on credit card)

Cardholder's Address _____ Cardholder's Phone Number _____

Credit Card Number: _____ Verification Code _____ Expiration Date: _____
(16 digits required) (3 digits required from back of credit card) (MM/YYYY)

As a convenience, I request and authorize American Medical Security Life Insurance Company (AMS) to charge the credit card account, identified above, for the payment of the health plan premium and any fees for the payment option(s) designated. In submitting this payment authorization with the application, I understand that the initial premium for the health plan may be adjusted based on the applicant's medical history (or that of any dependent to be covered) and agree that the additional amount(s) required may be charged to this account. I further agree that should this card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, AMS will attempt to contact me, but shall be under no liability whatsoever, including any fees imposed by the card issuer, even though such dishonor may ultimately result in forfeiture of coverage.

Signature of Cardholder X _____ Date _____
(As it appears on credit card)

If the VISA/Mastercard request for payment is declined, a \$25 nonrefundable service fee may be applied when allowed by state law.

Note: If effective date of coverage is the 15th of the month, you may be charged for 1½ months of premium for the initial payment.

C. ONGOING METHOD OF PAYMENT

- Automatic Monthly Bank Draft (Complete Bank Draft Authorization below)
- Direct Bill Choose One: (Fees may apply)
- Quarterly Semi-Annual Annual Monthly Direct Bill (Available in CA Only)

BANK DRAFT AUTHORIZATION

Type of Account: Checking Savings

Account Holder Name _____ Financial Institution _____
(As it appears on financial institution records)

Routing/Transit # (9 digits required) _____ Account Number (9 digits required) _____

I hereby authorize American Medical Security Life Insurance Company (AMS) to initiate debit entries to the account and the financial institution named above. AMS will not be held responsible for policy lapse or cancellation due to nonpayment of premium if the withdrawal is presented and not honored for any reason and the amount due is not paid. AMS is not responsible for charges I may incur from my bank due to late notification of the termination or change. This authorization is to remain in full force and effect until AMS has received written notice of my intention to terminate this authorization. I understand that I must give at least 30 days advance notice to terminate or change this authorization.

If the automatic bank draft or direct payment by check transaction is returned for any reason, a \$25 nonrefundable service fee will be applied when allowed by state law.

Signature of Primary Applicant and Account Holder X _____ Date _____

American Medical Security Life Insurance Company (AMS) 3100 AMS Blvd., P.O. Box 19032, Green Bay, WI 54304-9032, 800-232-5432 underwrites fully insured products and provides administrative services for PacifiCare Life and Health Insurance Company and PacifiCare Life Assurance Company.