PacifiCare®
UnitedHealthcare Company

Application *Packet*

California

Have you:

- ✓ *Signed all forms necessary for health insurance application?*
- ✓ *Answered all applicable questions?*
- ✓ *Selected a method of payment and enclosed a voided check, if you selected Automatic Bank Draft?*

California Preferred Network

UnitedHealthcare®
PacifiCare®

HOW TO APPLY FOR COVERAGE

Here are the steps to follow to ensure your application is processed as quickly as possible. Be sure to answer all questions completely and provide all the requested information. Incomplete information may result in a processing delay. *Print clearly using black ink.*

1. **Applicant, Dependent Application Information and Eligibility**

   Complete these sections of the application. If the parent or legal guardian is applying for child only coverage, list the child as the applicant.

2. **Coverage Information**

   a) Indicate who is applying for medical coverage and enter your requested effective date. We only allow first of the month or fifteenth of the month effective dates. Actual effective dates are determined by PacifiCare. **Do not cancel any existing coverage until you are notified that your application has been approved.**

   b) Enter the details of the plan you have selected:

   Product Name: Personal Select℠, Personal SDHP℠ or Personal Benefit℠ (HDHP).
   Copay/Deductible: Copay is a fixed fee paid by the insured for specific services. Deductible is the amount of covered expenses an insured pays before benefits are paid under the policy.
   Example: $30/$2500 or $35/$5000.

   Coinsurance: Coinsurance is the insurance plan's level of coverage after the calendar year deductible is satisfied. After the coinsurance limit is met, the insurer pays 100% of covered expenses for the remainder of the calendar year.
   Example: 70% or 80%.

   c) To best answer the statement about your status as a HIPAA - eligible individual, you may refer to questions 1-6 on page 3 of the application.

3. **Medical History**

   Be sure to disclose all health history for the applicant and all dependents listed on the application. Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination or rescission of coverage.

   Include all requested details and explanations. If you need to include additional information, attach an extra sheet of paper. Include your signature and date on the extra sheet.

4. **Prior Coverage and Terms and Conditions of Insurance**

   Complete the questions on page 3 of application.

   Review all Terms and Conditions of the application and the Arbitration Disclosure.

SUBMITTING YOUR COMPLETED APPLICATION

- Review your application to be sure it is complete.
- Sign and date your application. Signatures are also required for your spouse/domestic partner and adult dependent child(ren) age 18 and over, if applying for coverage.
- Sign and date the Authorization to Release Medical Information for Underwriting. Signatures are also required for your spouse/domestic partner and adult dependent child(ren) age 18 and over if applying for coverage.
- Complete the Payment Authorization Form. Be sure to include your first premium payment payable to American Medical Security Life Insurance Company.
- Please submit your completed application to your producer*. Your producer's signature is required on the application. FAX OR E-MAIL SUBMISSIONS MAY ALSO BE AVAILABLE. PLEASE CONTACT US TO REVIEW YOUR OPTIONS at (800) 232-5432 option 2.

Note: Coverage does not become effective under any circumstances until an application has been approved and written notice is provided.

** If no producer, please submit all applicable forms and payments to:*
American Medical Security
P.O. Box 19032
Green Bay, WI 54307-9032

California Individual Application for Health Insurance

PacifiCare®
A UnitedHealthcare Company

❑ 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.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

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.)

1) Digestive Disorder	Yes	No
a. Irritable Bowel, Spastic Colon	❑	❑
b. Colitis, Crohn's Disease	❑	❑
c. Gastric Reflux, Heartburn	❑	❑
d. Gallbladder Disease	❑	❑
e. Hepatitis, Other Liver Disorder	❑	❑
f. Other Digestive or Intestinal Disorder	❑	❑

2) Cardiovascular/Circulatory	Yes	No
a. High Blood Pressure, Hypertension	❑	❑
b. Mitral Valve Prolapse, Heart Murmur	❑	❑
c. Chest Pain, Heart Attack, Arrhythmia, Angina, Palpitations	❑	❑
d. Vascular Abnormality, Poor Circulation	❑	❑
e. Stroke, Transient Ischemic Attack	❑	❑
f. Other Heart Condition or Disease	❑	❑

3) Respiratory/Lung	Yes	No
a. Allergies, Asthma	❑	❑
b. Bronchitis, COPD, Emphysema	❑	❑
c. Sleep Apnea, Tuberculosis	❑	❑
d. Other Respiratory or Lung Disorder	❑	❑

4) Musculoskeletal/Nerve	Yes	No
a. Arthritis or Rheumatism, Carpal Tunnel	❑	❑
b. Neck, Back, Spinal Condition	❑	❑
c. Bone, Muscles, Joint Condition	❑	❑
d. Fracture, Dislocation, Internal Fixation	❑	❑
e. Lupus, Connective Tissue Disease	❑	❑
f. Osteoporosis, Osteopenia	❑	❑

5) Cyst/Tumor/Polyp/Malignancy	Yes	No
a. Cancer, Leukemia	❑	❑
b. Cyst, Growth, Lump, Tumor, Polyp	❑	❑
c. Hodgkin's or Non-Hodgkin's Lymphoma	❑	❑

6) Genitourinary	Yes	No
a. Fibrocystic Breast, Implants, Other Breast Condition	❑	❑
b. Ovarian Cyst, Uterine Fibroid	❑	❑
c. Infertility Testing or Treatment	❑	❑
d. Menstrual, Reproductive Organ Disorder	❑	❑
e. Abnormal Pap Smear	❑	❑
f. Prostate Gland Disorder, Abnormal PSA Test	❑	❑
g. Sexually Transmitted Disease	❑	❑
h. Urinary Tract, Bladder, Kidney Disorder	❑	❑

7) Eyes/Ears/Nose/Throat/Skin	Yes	No
a. Acne, Skin Disorder	❑	❑
b. Ear, Nose, Sinus, Throat, Mouth	❑	❑
c. Eye, Cataracts, Glaucoma, Other	❑	❑
d. Loss of Hearing, Deafness	❑	❑
e. Jaw Condition or TMJ	❑	❑
f. Vision Impairment, Blindness	❑	❑

8) Endocrine/Gland/Lymph/Blood	Yes	No
a. Blood Abnormality, Anemia (except for HIV)	❑	❑
b. Elevated Cholesterol/Triglycerides	❑	❑
c. Diabetes, Pancreas, Elevated Glucose	❑	❑
d. Hormonal Disorder, Adrenal	❑	❑
e. Lymph Gland Disorder, Immune System (except for HIV)	❑	❑
f. Thyroid, Goiter	❑	❑

9) Alcohol/Drug	Yes	No
a. Alcoholism, Alcohol Use (3+ drinks/day)	❑	❑
b. Drug or Substance Abuse, Illicit Use	❑	❑

10) Psychological	Yes	No
a. Anxiety, Panic Disorder	❑	❑
b. Depression, Major Depressive Disorder	❑	❑
c. Bipolar Disorder	❑	❑
d. Obsessive Compulsive Disorder	❑	❑
e. Schizophrenia, Schizoaffective Disorder	❑	❑
f. Anorexia, Bulimia Nervosa	❑	❑
g. Other Psychological Condition	❑	❑

11) Neurological	Yes	No
a. Cerebral Palsy, Muscular Dystrophy	❑	❑
b. Epilepsy, Seizures, Convulsions	❑	❑
c. Headaches, Migraines	❑	❑
d. Mental Retardation, Down's Syndrome	❑	❑
e. Multiple Sclerosis, Paralysis	❑	❑
f. Other Neurological Disease or Disorder	❑	❑
g. Alzheimer's Disease, Dementia	❑	❑
h. Parkinson's Disease	❑	❑
i. Autism, Pervasive Develop. Disorder	❑	❑

12) General	Yes	No
a. Abnormal Test Results (except for HIV)	❑	❑
b. Burns	❑	❑
c. Congenital Abnormality, Loss of Limb	❑	❑
d. Edema	❑	❑
e. Fibromyalgia, Chronic Fatigue	❑	❑
f. Hernia	❑	❑
g. Organ or Tissue Transplant	❑	❑
h. Pain Disorder	❑	❑
i. Surgical Implants	❑	❑
j. Chronic Infection	❑	❑
k. Ulcer	❑	❑

13) Other	Yes	No
a. Health disorders not listed above (except for HIV)	❑	❑

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 (individual, employer group, short term, COBRA, Medicare, other)	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.

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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 **X** _____ 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 **X** _____ Date _____
(If spouse/domestic partner is to be covered)

Dependent's Signature (age 18 or older) **X** _____ 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 **X** _____ 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 No. _____

B. INITIAL METHOD OF PAYMENT

❑ Automatic Bank Draft (Complete Bank Draft Authorization below.) ❑ Credit Card (Complete Credit Card Authorization below.) ❑ Check Enclosed

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 _____ Expiration Date _____
(16 digits required) (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 1 1/2 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 ❑ Semiannual ❑ Annual ❑ Monthly Direct Bill (available in CA only)

❑ List Bill*
* Additional forms are required. Not available in some states.

BANK DRAFT AUTHORIZATION

Type of Account: ❑ Checking ❑ Savings

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

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

I hereby authorize 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.

If payment is submitted by my employer, I will need to complete a payment disclaimer form, when required and/or permitted by state law.

Signature of Primary Applicant/Parent or Legal Guardian **X** _____ Date _____

Signature Account Holder **X** _____ Date _____
(If other than Primary Applicant/Parent or Legal Guardian)

NOTICE OF INFORMATION PRACTICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any personal information that is created or received by a health care provider or health plan that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our Web sites listed at the bottom of this page.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative);
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected; and
- Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **For Payment** of premiums due us and to process claims for health care services you receive.
- **For Treatment.** We may disclose health information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and for the protective services for the President and others.
- **For Workers' Compensation** including disclosures required by state workers compensation laws of job-related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking, or transplantation of organs, eyes, or tissue.

If none of the above reasons apply, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. In many states, your authorization may be required in order for us to disclose your highly confidential health information. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address).
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- **You have the right to ask to amend** information we maintain about you if you believe the health information about you is wrong or incomplete. We will notify you within 30 days if we deny your request and provide a reason for our decision. If we deny your request, you may have a statement of your disagreement added to your health information. We will notify you in writing of any amendments we make at your request. We will provide updates to all parties that have received information from us within the past two years (seven years for support organizations).
- **You have the right to receive an accounting** of disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) other disclosures that federal law does not require use to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. In addition, you may obtain a copy of this notice at our Web sites, *www.eAMS.com* or *www.goldenrule.com*.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address: Golden Rule Insurance Company, Privacy Officer, 7440 Woodland Drive, Indianapolis, IN 47278-1719.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. **We will not take any action against you for filing a complaint.**

Fair Credit Reporting Act Notice

In some cases, we may ask a consumer-reporting agency to compile an investigative consumer report about you. If we request such a report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the federal Fair Credit Reporting Act.

We may disclose information solely about our transactions or experiences with you or our affiliates.

Medical Information Bureau

In conjunction with our membership in the Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a nonprofit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance company, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, (866) 692-6901, *www.mib.com* or (TTY) (866) 346-3642.

FINANCIAL INFORMATION PRIVACY NOTICE

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms such as name, address, age and social security number, and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees, affiliates, and service providers who are involved in administering your health care coverage or providing services to you. We maintain physical, electronic, and procedural safeguards that comply with federal standards to guard your personal financial information.

We may disclose personal financial information to financial institutions which perform services for us. These services may include marketing our products or services or joint marketing of financial products or services.

The Notice of Information Practices, effective January 2007, is provided on behalf of American Medical Security Life Insurance Company, Golden Rule Insurance Company, PacifiCare Life and Health Insurance Company, PacifiCare Life Assurance Company, All Savers Insurance Company, and UnitedHealthcare, Inc.

To obtain an authorization to release your personal information to another party, please go to the appropriate Web site listed at the bottom of the page.

NO-0537-00-1-00 1/07 230D-P-0108

PacifiCare®

A UnitedHealthcare Company

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

230D-P-0108