

2. Information About You and Your Family's Health

ANY MISREPRESENTATION MAY BE USED TO DENY A CLAIM OR TO RESCIND AND VOID THE POLICY. Please do not include any AIDS virus antibody tests, except for the FDA-licensed blood tests taken and diagnosed by a member of the medical profession. Any tests performed at anonymous counseling and testing sites or through home test kits are confidential and need not to be revealed on this application.

A. In the past 10 years have you, your spouse or any dependent applying for coverage had symptoms of, been diagnosed, treated (including chiropractic treatment), or sought a medical opinion for any of the following even if you no longer have any current symptoms:

- | | | | |
|---|--|--|--|
| 1. Heart disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 44. Cancer | <input type="radio"/> Yes <input type="radio"/> No |
| 2. Stroke | <input type="radio"/> Yes <input type="radio"/> No | 45. Tumor | <input type="radio"/> Yes <input type="radio"/> No |
| 3. Circulatory disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 46. Cyst | <input type="radio"/> Yes <input type="radio"/> No |
| 4. Chest pain | <input type="radio"/> Yes <input type="radio"/> No | 47. Polyp | <input type="radio"/> Yes <input type="radio"/> No |
| 5. High or low blood pressure | <input type="radio"/> Yes <input type="radio"/> No | 48. Abnormal growth | <input type="radio"/> Yes <input type="radio"/> No |
| 6. Elevated cholesterol and/or triglyceride levels | <input type="radio"/> Yes <input type="radio"/> No | 49. Carcinoma in situ | <input type="radio"/> Yes <input type="radio"/> No |
| 7. Anemia or blood disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 50. Eye disease or disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 8. Ulcers | <input type="radio"/> Yes <input type="radio"/> No | 51. Ear disease or disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 9. Stomach disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 52. Attention deficit disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 10. Liver/pancreas disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 53. Psychological disease or disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 11. Gallbladder disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 54. Depression | <input type="radio"/> Yes <input type="radio"/> No |
| 12. Intestinal disease or disorder (e.g., colitis, Crohn's) | <input type="radio"/> Yes <input type="radio"/> No | 55. Anxiety | <input type="radio"/> Yes <input type="radio"/> No |
| 13. Hernia | <input type="radio"/> Yes <input type="radio"/> No | 56. Nervous, mental or emotional disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 14. Rectal disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 57. Suicide attempt | <input type="radio"/> Yes <input type="radio"/> No |
| 15. Diabetes | <input type="radio"/> Yes <input type="radio"/> No | 58. Eating disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 16. Elevated blood sugar | <input type="radio"/> Yes <input type="radio"/> No | 59. Epilepsy or other seizures | <input type="radio"/> Yes <input type="radio"/> No |
| 17. Sugar albumin or blood in urine | <input type="radio"/> Yes <input type="radio"/> No | 60. Convulsions | <input type="radio"/> Yes <input type="radio"/> No |
| 18. Thyroid disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 61. Headaches | <input type="radio"/> Yes <input type="radio"/> No |
| 19. Adrenal disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 62. Nervous System disease or disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 20. Enlargement of the lymph nodes | <input type="radio"/> Yes <input type="radio"/> No | 63. Organ or other type of transplant | <input type="radio"/> Yes <input type="radio"/> No |
| 21. Connective tissue disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 64. Breast disease or disorder including
fibrocystic breast(s)..... | <input type="radio"/> Yes <input type="radio"/> No |
| 22. Allergy(ies) | <input type="radio"/> Yes <input type="radio"/> No | 65. Sleep Disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 23. Asthma | <input type="radio"/> Yes <input type="radio"/> No | 66. Sleep Apnea | <input type="radio"/> Yes <input type="radio"/> No |
| 24. Hayfever | <input type="radio"/> Yes <input type="radio"/> No | 67. Lupus | <input type="radio"/> Yes <input type="radio"/> No |
| 25. Emphysema | <input type="radio"/> Yes <input type="radio"/> No | 68. Arthritis | <input type="radio"/> Yes <input type="radio"/> No |
| 26. Sinus or nasal disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 69. Fibromyalgia | <input type="radio"/> Yes <input type="radio"/> No |
| 27. Lung disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 70. Back disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 28. Shortness of breath | <input type="radio"/> Yes <input type="radio"/> No | 71. Joint disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 29. Pneumonia | <input type="radio"/> Yes <input type="radio"/> No | 72. Musculoskeletal disease or disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 30. Menstrual disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 73. Skin disease or disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 31. Genital disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 74. Acne | <input type="radio"/> Yes <input type="radio"/> No |
| 32. Sexual dysfunction | <input type="radio"/> Yes <input type="radio"/> No | 75. Throat disease or disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 33. Infertility | <input type="radio"/> Yes <input type="radio"/> No | 76. Paralysis | <input type="radio"/> Yes <input type="radio"/> No |
| 34. Urinary tract disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 77. Spinal Cord disorder | <input type="radio"/> Yes <input type="radio"/> No |
| 35. Kidney disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 78. Chronic fatigue syndrome | <input type="radio"/> Yes <input type="radio"/> No |
| 36. Bladder disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 79. Hepatitis | <input type="radio"/> Yes <input type="radio"/> No |
| 37. Prostate disease or disorder | <input type="radio"/> Yes <input type="radio"/> No | 80. Multiple sclerosis | <input type="radio"/> Yes <input type="radio"/> No |
| 38. Abnormal Prostate Specific Antigen (PSA) results | <input type="radio"/> Yes <input type="radio"/> No | 81. Disease or disorder of brain..... | <input type="radio"/> Yes <input type="radio"/> No |
| 39. Disease or disorder of male or female sex organs ... | <input type="radio"/> Yes <input type="radio"/> No | 82. Any type of implant..... | <input type="radio"/> Yes <input type="radio"/> No |
| 40. Abnormal Pap smear results..... | <input type="radio"/> Yes <input type="radio"/> No | | |
| 41. Abnormal mammogram results..... | <input type="radio"/> Yes <input type="radio"/> No | | |
| 42. Sexually transmitted disease or disorder..... | <input type="radio"/> Yes <input type="radio"/> No | | |
| 43. Pregnancy complications (e.g., premature birth, miscarriage, c-section) | <input type="radio"/> Yes <input type="radio"/> No | | |

2. Information About You and Your Family's Health (cont'd.)

The following questions must be answered either "Yes" or "No." Please provide full details on page 6 for each "Yes" answer.

- B.** Are you, your spouse or any dependent pregnant or an expectant mother or father (even if dependent coverage is not being requested)? Yes No
- C.** Have you, your spouse or any dependent applying for coverage smoked cigarettes or used tobacco or nicotine in any form including smokeless tobacco within the past 12 months? Yes No
- D.** Have you, your spouse or any dependent applying for coverage been diagnosed or been treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS, or other immune system disorders, or ever tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? Yes No
- E.** Have you, your spouse or any dependent applying for coverage ever had symptoms of or been treated for alcohol, substance or drug abuse or dependence; ever been advised to limit or reduce the use of alcohol, chemicals, or other drugs; had any alcohol or drug-related arrest, or been a member of Alcoholics Anonymous? Yes No
- F.** In the past 10 years have you, your spouse or any dependent, when applying for medical, disability or life insurance with any company, ever been declined for coverage; had coverage postponed or ridered, whether or not a policy was issued; or had the premium increased due to health history? Yes No
- G.** Is anyone named in this application now disabled or unable to perform normal work- or age-related activities? Yes No
If yes, please identify names, conditions, dates of disability, and name and address of physician.
- H. In the past 5 years**, have you, your spouse or any dependent applying for coverage:
 - 1. Been hospitalized or scheduled for hospitalization; had surgery or surgery scheduled; had a test or test scheduled (e.g., x-rays, lab services, diagnostic services) for any reason not already mentioned? Yes No
 - 2. Had an injury, accident, illness, medical attention, diagnosis, or treatment for any reason not already mentioned (except AIDS, HIV and genetic testing results)? Yes No
 - 3. Consulted with or been treated by any physicians or other health care professionals (including chiropractors, podiatrists and osteopathic physicians) for any reason including routine care, other than stated above? Yes No
- I.** Are you, your spouse or any dependent applying for coverage currently taking any medications recommended or prescribed by a physician or other health care practitioner? Yes No
If Yes, please list all medications and their dosage in the space provided on page 6.
- J.** Have you, your spouse or any dependent applying for coverage had a medication recommended or prescribed by a physician or other health care practitioner within the past 12 months? Yes No
If Yes, please list all medications and their dosage in the space provided on page 6.

2. Information About You and Your Family's Health (cont'd.)

GIVE DETAILS BELOW OF ANY "YES" ANSWERS TO QUESTIONS A.-H. (IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER; PLEASE SIGN AND DATE THE ADDITIONAL SHEET.)

Question	Name of Person	Illness or Health Condition <i>(Include diagnosis and prognosis)</i>	Dates Treated		Complete Name and Address of Physician Clinic, Hospital or Other Provider
			Beginning	Ending <i>(Indicate if ongoing)</i>	

GIVE DETAILS BELOW OF ANY "YES" ANSWERS TO QUESTIONS I. & J. (IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER; PLEASE SIGN AND DATE THE ADDITIONAL SHEET.)

Question	Name of Person	Name, Dosage and Frequency of Medication <i>(Include illness or health condition for which medication was prescribed)</i>	Dates Medication Taken <i>(Indicate if ongoing)</i>	Complete Name and Address of Prescribing Physician and Pharmacy

3. Policy Effective Date (If this application is approved by Arise Health Plan, the policy effective date is determined only by Arise Health Plan..)

The policy effective date shall be, as determined by Arise Health Plan, **the later of:**

- A. If the application is received by the Arise Health Plan, Underwriting Department in Green Bay, Wisconsin, on the 1st through the 25th day of the calendar month, the policy effective date will be the first day of the following calendar month (for example, an application received on January 4th will receive a February 1st effective date).
- B. If the application is received by the Arise Health Plan, Underwriting Department in Green Bay, Wisconsin, on the 26th through the last day of the calendar month, the policy effective date will be the first day of the second calendar month following the calendar month in which the application is received (for example, an application received on January 26th will receive a March 1st effective date).
- C. The policy effective date requested by the applicant, provided the requested effective date is later than the dates stated in A. and B. above, but not more than 60 days following the date of application. **Requested Policy Effective Date:** ____/01/ ____
(Insert month and year.)

4. Certification/Understanding

CERTIFICATION: I represent and certify all of the following: • I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application; • I entered each and every answer myself in response to each request for information and/or question; • no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); • such representations are true, accurate, and complete to the best of my knowledge.

UNDERSTANDING: I understand: the representations I make, together with any supplemental representations that I make, shall be the basis for Arise Health Plan to issue any coverage; • that no agent has the authority to waive an answer to any question, pass on insurability, make or alter any contract, or waive or alter any of Arise Health Plan's other rights or requirements; • that no coverage will be effective unless and until the date specified by Arise Health Plan after this application has been approved by Arise Health Plan, • any misrepresentation contained herein may be used to reduce or deny a claim, or to rescind and void coverage and the policy within the contestable period, if such misrepresentation materially affects Arise Health Plan's acceptance of the risk, including approving any person for coverage.

I understand that Arise Health Plan has no liability for anything the agent said or failed to say before, during or after the application process, that's not subsequently confirmed in writing by an authorized officer of Arise Health Plan, including, but not limited to, answers given by the agent in response to questions asked by myself, my spouse or my dependent(s). Furthermore, I understand that Arise Health Plan is not liable for any statement, representation, or other information provided to myself, my spouse or my dependent(s) that isn't expressly contained in a written document provided to them and signed by an authorized officer of Arise Health Plan.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

To the best of my knowledge and belief, I represent that all statements and answers I made in this application, and on the attached sheet (if any) are complete and true. I have read and understand this application, including the Certification/Understanding/Notice section above.

Sign Here	X	_____ Applicant's Signature _____ Spouse's Signature _____ Child over Age 18's Signature	_____ Date _____ Date _____ Date
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Parent or Guardian Information – Please complete this section if Primary Applicant is under 18 years of age. If child-only coverage is being requested, the youngest child is the Primary Applicant.

Sign Here	X	_____ Parent or Guardian Full Legal Name _____ Parent or Guardian's Signature _____ Relationship to Child (ren) Social Security Number	_____ Date
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5. Agent Statement

I asked the applicant, spouse and all child(ren) over age 18 all questions contained in this application and recorded their answers exactly as given to me. I also represent that no other person provided any of their answers, or influenced any of their answers; if any of their answers were influenced by another person, I have attached a written explanation thereof to this application..... Yes No

Writing Agent's Name (Print) _____
 Writing Agent's Signature _____ Agent's phone # _____
 Address _____ Agent's fax # _____
 City _____ Date Signed by Agent ____/____/____
 State/Zip _____ Agent's Social Security Number _____
 Arise Health Plan 9 digit Agency ID Number _____ Agency Name _____


6. Authorization Notice

Authorization to release medical records: I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, ("MIB, Inc."), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to Arise Health Plan or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulation promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended "HIPAA Privacy Regulation", but excluding psychotherapy notes, if any) in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by Arise Health Plan to determine eligibility for coverage under this policy and that my failure to authorize the release of said information might result in a refusal to issue or provide coverage. I agree that Arise Health Plan may release said information to MIB or to Arise Health Plan's reinsuring companies, representative(s) or other person(s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand that I may revoke this authorization by providing advance written notice of termination to Arise Health Plan at its office in Green Bay, Wisconsin, and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. In such case, Arise Health Plan, its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 30 months from the date I execute this authorization unless revoked by me in writing prior to the end of that 30-month period.

I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA Privacy Regulation and could be re-disclosed by the person or entity that receives it.

Sign Here  X	_____	Applicant's Signature	_____	Date
	_____	Spouse's Signature	_____	Date
	_____	Child over Age 18's Signature	_____	Date

Parent or Guardian Information – Please complete this section if Primary Applicant is under 18 years of age. If child-only coverage is being requested, the youngest child is the Primary Applicant.

Sign Here  X	_____	Parent or Guardian Full Legal Name	_____	Date
	_____	Parent or Guardian's Signature	_____	
	_____	Relationship to Child (ren)	_____	Social Security Number

AUTOMATIC WITHDRAWAL PAYMENT AUTHORIZATION FORM

By my signature below, I authorize Arise Health Plan to instruct my financial institution to deduct my premium payments from the account designated below. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify Arise Health Plan in writing of its termination. My notification must afford Arise Health Plan and my financial institution reasonable opportunity to act on it.

A. ACCOUNT HOLDER INFORMATION

Name _____

Social Security Number _____

Address _____

City _____ State _____ ZIP _____

Payment mode

Select One: Monthly Quarterly Semiannually Annually

B. FINANCIAL INSTITUTION INFORMATION

Institution Name _____

Branch/Location _____

Address _____

City _____ State _____ ZIP _____

Select One: Checking Account* Savings Account*

Arise Health Plan will withdraw the premium amount on the 1st of the month. If the 1st of the month falls on a weekend or holiday the withdrawal will be on the next business day.

Transit Number _____ Account Number _____

***IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK WITH "VOID" WRITTEN ACROSS IT.**


***IF USING A SAVINGS ACCOUNT, PLEASE ATTACH A DEPOSIT SLIP WITH "VOID" WRITTEN ACROSS IT.**

FINANCIAL INFORMATION

Sign Here  X _____ Applicant's Signature
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_____ Date

Parent or Guardian Information – Please complete this section if Primary Applicant is under 18 years of age. If child-only coverage is being requested, the youngest child is the Primary Applicant.

Sign Here  X	_____ Parent or Guardian Full Legal Name
	_____ Parent or Guardian's Signature
	_____ Relationship to Child (ren)
	_____ Social Security Number

_____ Date
