

ARISE HEALTH PLAN BRIDGE65 INDIVIDUAL POLICY NEW APPLICATION

Mail This Application To:
Arise Health Plan
P.O. Box 11625 – Green Bay, WI 54307-1625



We care for Wisconsin.
UNDERWRITTEN BY WPS HEALTH PLAN, INC.

INSTRUCTIONS: PLEASE COMPLETE THE ENTIRE APPLICATION. PLEASE PRINT USING BLACK INK. ARISE HEALTH PLAN DOES NOT GUARANTEE APPROVAL OF THIS APPLICATION FOR ANY PERSON, OR ISSUANCE OF A POLICY.

1. Information About You (Applicant)

Your Name		<i>Last</i>		<i>First</i>		<i>Middle Initial</i>	
Social Security Number	Birth Date	Sex <input type="radio"/> Male <input type="radio"/> Female	Height	Weight	()	Evening Phone Number	
Address						Daytime Phone Number	
<i>Number & Street</i>		<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>	()	
Marital Status						Email Address	
<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Widowed							
Occupation: _____ Primary Care Practitioner (PCP) _____							
How did you hear about this Policy? _____							
Where would you like your policy delivered?			May we contact you with any questions regarding the application using the daytime phone listed?				
<input type="radio"/> Applicant <input type="radio"/> Agent			<input type="radio"/> Yes <input type="radio"/> No				

2. Information About Your Dependent Children (Please complete this section only if enrolling dependents – NOTE: Spouses are not eligible)

Last Name	First Name	MI	Birth Date	Sex	Height	Weight	Primary Care Practitioner	Relationship to Applicant

3. Information About Your Family Residency

- A. Are you and every named dependent child a citizen of the United States or a resident legal alien? Yes No
 - B. Do you and your dependent children reside in the geographical service area 12 months per year? Yes No
- If you answer "No" to question A. or B. above, you are not eligible for the coverage and benefit plan you're requesting. Arise Health Plan won't approve this application. Do not proceed further and do not submit this application to Arise Health Plan.

4. Information About Other Medical Coverage

- A. Does any person applying for coverage currently have other individual or group health coverage?..... Yes No
If yes, answer question B. below.
 - B. If approved for the coverage and benefit plan you're requesting, do you wish to cancel your other individual or group health coverage and replace it with the requested coverage and benefit plan?..... Yes No
- If you answered "Yes" to question B. above, please complete Section 10 (part A) of this application.**
- If you answered "No" to question B. above, you are not eligible for the coverage and benefit plan you're requesting. Arise Health Plan won't approve this application. Do not proceed further and do not submit this application to Arise Health Plan.**

4. Information About Other Medical Coverage (continued)

C. Are you or any of your dependent children eligible for Medicare? Yes No
Name(s) _____

Persons who are eligible for Medicare are not eligible for the coverage and benefit plan you’re requesting. Arise Health Plan won’t approve these persons for coverage. If the applicant is such a person, do not proceed further and do not submit this application to Arise Health Plan.

5. Type of Coverage and Benefits Plan

A. Choose Type of Coverage:

- Applicant Applicant & Child(ren)

B. Choose your Benefit Plan:

Individual Policy

HMO

Deductible Amount: _____
Coinsurance Level: _____
Coinsurance Maximum: _____

POS

In-Network Deductible Amount: _____
In-Network Coinsurance Level: _____
In-Network Coinsurance Maximum: _____

Buy-Up Option (Doctor Office Visit Copay and Drug Deductible Waiver): Yes No

HSA High Deductible Health Plan

HMO

Deductible Amount: _____
Coinsurance Level: _____
Coinsurance Maximum: _____

POS

In-Network Deductible Amount: _____
In-Network Coinsurance Level: _____
In-Network Coinsurance Maximum: _____

6. 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 be revealed on this application.

The following questions must be answered either “Yes” or “No.” Please provide full details on page 4 for each “Yes” answer.

- A. Are you or any dependent pregnant or an expectant mother or father (even if dependent coverage is not being requested)? Yes No
- B. Have you 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
- C. Have you 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
- D. Have you or any dependent applying for coverage ever had symptoms of or been treated for alcohol, substance, or drug abuse or dependence; been advised to limit or reduce the use of alcohol, chemicals, or other drugs; had any alcohol or drug-related arrest whether or not it resulted in a conviction; or been a member of Alcoholics Anonymous? Yes No
- E. In the past 10 years, have you 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
- F. 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.

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

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

H. In the past 5 years, have you 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

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

- I.** Are you 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 below.
- J.** Have you 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 below.

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

7. Agent Statement

I asked the applicant, 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) _____ Agent's phone # _____
Writing Agent's Signature _____ Agent's fax # _____
Address _____ Date Signed by Agent ____/____/____
City _____ State/Zip _____ Agent's License Number _____
Arise Health Plan 10 digit Agent ID Number _____ Agency Name _____

8. 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.)

9. Your Premium Payment Options *(Business checks and/or accounts cannot be used for premium payment. Remit One Month Advance Premium Deposit)*

Please note: In an effort to comply with Small Employer Health Insurance laws, we are unable to accept business checks for payment of premium. Please check the mode of payment you're requesting in either A. or B. below.

- A. **AUTOMATIC WITHDRAWAL.** We electronically transfer your premium directly from your bank account at the frequency you request. (If you select this option, please complete Automatic Withdrawal Payment Authorization Form.)
 - Monthly
 - Quarterly
 - Semiannually
 - Annually

With this option, your first premium payment can be drafted from your bank account.

- B. **DIRECT BILL.** We send a premium notice directly to your home at the frequency you request. You return payment to Arise Health Plan by the premium due date.
 - Quarterly
 - Semiannually
 - Annually

With this option you must submit at least one month's premium with your application.

10. Notice/Certification/Understanding

A. NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE IF YOU ARE REPLACING OTHER INDIVIDUAL OR GROUP HEALTH COVERAGE, PLEASE READ THIS SECTION

According to your application or the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Arise Health Plan. For your own information and protection, certain facts shown below should be pointed out to you. If Arise Health Plan approves your application for coverage and issues a policy, you should consider these facts before you lapse or terminate your present policy.

- Your new policy provides a time limit within which you may decide, without cost to you, whether you desire to keep the policy. The time limit is 10 days from the date of receipt of this policy.
- Health conditions which you presently may have might not be covered under the new policy. This change in coverage could result in a claim for benefits being denied under the new policy even though they are payable under your present policy.
- Although some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
- Questions in the application for the new policy must be answered truthfully and completely; if not, the validity of the policy and the payment of any benefits thereunder may be rescinded and voided.
- The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.
- The renewal provisions of the new policy should be reviewed to ensure your rights to periodically renew the policy.
- It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

Cancel date of coverage being replaced _____

Name, address, and telephone number of insurance company: _____

Policyholder name: _____ Policy number: _____


B. 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 or my dependent(s). Furthermore, I understand that Arise Health Plan is not liable for any statement, representation, or other information provided to myself 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 Notice/Certification/ Understanding section above.

Sign Here  X	_____
	Applicant's Signature

	Child over Age 18's Signature

Date

Date

11. 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, Medical Information Bureau, 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 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
	_____	_____
	Child over Age 18's Signature	Date

12. Important Notice to Persons on Medicare

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most of all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

More information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company upon request.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

13. Conditional Receipt

No insurance agent or broker has the authority to waive or modify any term, condition, or provision of this conditional receipt or of the application. An insurance agent or broker can not approve or bind coverage, cannot guarantee Arise Health Plan's approval or issuance of a policy, and cannot waive or alter any of Arise Health Plan's other rights and requirements.

This conditional receipt is issued on the condition that any check, draft, or other order for the premium payment by you to Arise Health Plan be good and collectable, as determined by Arise Health Plan.

NOTE: If you have not received an Arise Health Plan policy or your premium payment is not returned within six weeks from the date shown above, please notify our Arise Health Plan Member Services Department at the address shown on page 1. Please give us your name, the amount paid, the date of your payment and your application, the name of the person who received your payment, and the name of the writing agent who took your application.

Date: ____/____/____

Received from _____ the sum of \$ _____ paid as an advance premium deposit at the time of signing the application, dated the date shown above for an Arise Health Plan health insurance policy. In such application, _____ is named as the applicant. Arise Health Plan acknowledges receipt of this payment subject to the following conditions:

- If Arise Health Plan determines, in accordance with its established underwriting rules and practices in effect on the date shown above, that one or more of the persons named in the application and proposed for coverage are insurable on such date for the policy and coverage applied for, Arise Health Plan will issue a policy, contingent upon such coverage for such person(s) is approved by Arise Health Plan, to the extent permitted by such rules and practices, with such policy's premiums determined accordingly by Arise Health Plan.
- The effective date of any policy so issued will be the date determined by Arise Health Plan. If, however, an issued policy is not accepted by the applicant upon delivery, such policy shall be deemed void from the beginning and no coverage shall be in effect at any time for any person.
- Arise Health Plan will credit a future bill the excess, if any, of the sum shown above over the sum of the correct initial premium amount for any policy issued and accepted by the applicant.

Writing Agent (*Print Name*)

Signature of Agent

Agency Name

Agent ID No.

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

Date