Application

Signature HMO and PPO Health Benefit Plans for Individuals and Families

HealthPlus HMO Signature plans are provided through HealthPlus of Michigan

HealthPlus PPO Signature plans are provided through HealthPlus Insurance Company

Last Updated 10/15/2013

HealthPlus™

The Right Plan for a Healthier You™

Thank you for your interest in HealthPlus Signature HMO and PPO health benefit plans.

HealthPlus Signature is a package of affordable, comprehensive HMO and PPO plans designed for individuals and families who are looking for health coverage options. Members must live in the areas HealthPlus Signature is offered and cannot have health insurance through an employer or government-sponsored program.

The first step to becoming a HealthPlus member is to complete this application by answering all questions, signing both the application and payment authorization, including a voided check if paying the first month premium by check and sending it to HealthPlus of Michigan, ATTN: Individual Sales, 2050 S. Linden Rd., Flint, MI 48532. If submitted electronically, you will receive notification from HealthPlus within two days. Otherwise, you will receive notification within one week as to the status of your application.

Paper applications must be received by the 10th of the month to be eligible for coverage on the first of the following month. Please complete the accompanying application for individual health insurance coverage with either HealthPlus of Michigan for the HMO plan or HealthPlus Insurance Company for the PPO plan. It is used to determine acceptability for health care coverage. This form is a legal document and must be completed in its entirety so that you and your family will receive proper and timely coverage. An incomplete application will delay the application process and access to medical benefits. Please complete this form per the following instructions:

Applicant Information – Primary Applicant
This section is to be completed for the primary applicant. Complete all applicable blank spaces.

Applicant Information – List all individuals applying for coverage
In the spaces provided, indicate name, gender, birth date, smoker/non-smoker status and social security number of all applicants. If you are requesting coverage for more than four dependent children, please include their information on a separate page.

Plan Coverage Selection
Please indicate your choice of benefit plan by checking the appropriate box.

Other Insurance Information
Please indicate yes or no to all of the questions in this section. For any “yes” response, please fill in the requested information in the space provided.

Payment Options
Please indicate initial payment method, ongoing payments method and desired payment frequency. Then complete the applicable payment authorization section (credit card or electronic funds transfer). If paying by EFT, please include a voided check with your application.

Terms, Conditions and Authorization
Please read this section carefully before signing the application. The application must be signed and dated by the applicant, spouse, any dependent children age 18 or older.

Agent/Agency Information This section is to be completed by the Agent or General Agent if applicable.

If you have any questions about this application or the process, please call us at 1-877-562-0907. You may also contact your insurance agent.

HealthPlus of Michigan and HealthPlus Insurance Company Individual Insurance Policy Application

HealthPlus
The Right Plan for a Healthier You™

Mail completed application to: HealthPlus of Michigan
ATTN: Individual Sales
2050 S. Linden Rd., Flint, MI 48532

Questions? Call 1-877-562-0907
Fax (810) 600-8057

Please complete this application in black or blue ink.

As used in this Application, "HealthPlus" means HealthPlus of Michigan if applying for a HMO Signature health benefit plan, or HealthPlus Insurance Company if applying for a PPO Signature health benefit plan, as indicated in the Plan Coverage Selection section.

Applicant Information – Primary Applicant

Street address	City	State	Zip code	County

Home phone number	Work phone number	Mobile phone number
( )	( )	( )

Marital status
❑ Single ❑ Married ❑ Divorced
❑ Widowed

Do you reside in Michigan nine or more months each year? ❑ Yes ❑ No*
*An applicant must reside in the HealthPlus service area nine or more months each year to qualify.

Are all applicants United States citizens or have a valid social security number? ❑ Yes ❑ No

Employer	Occupation

Applicant Information – List all individuals applying for coverage (up to age 26)

Name (Last, First, MI)	Gender	Birthdate (mm/dd/yyyy)	Height (optional)	Weight (optional)	Smoker	Social Security Number (You must supply this unless a child is less than 90 days old)
Primary	❑ M ❑ F				❑ Yes ❑ No	
Spouse	❑ M ❑ F				❑ Yes ❑ No	
❑ Dependent Child ❑ Stepchild ❑ Disabled Dependent*	❑ M ❑ F				❑ Yes ❑ No	
❑ Dependent Child ❑ Stepchild ❑ Disabled Dependent*	❑ M ❑ F				❑ Yes ❑ No	
❑ Dependent Child ❑ Stepchild ❑ Disabled Dependent*	❑ M ❑ F				❑ Yes ❑ No	
❑ Dependent Child ❑ Stepchild ❑ Disabled Dependent*	❑ M ❑ F				❑ Yes ❑ No	

Dependent address if over age 18

* Disabled dependent: Requires physician certification

Applicant Name:

Plan Coverage Selection

Coinsurance: A fixed percentage of the cost of covered services you will pay after your deductible has been met.

Deductible: A fixed dollar amount you must pay each benefit year before certain services are covered by the plan. Some services are not subject to deductible.

Health Savings Account (HSA): A tax-advantaged spending and savings account that can be used to pay for qualified medical expenses.

High-Deductible Health Plan (HDHP): A health insurance plan with lower premiums and higher deductibles than a traditional health plan.

SIGNATURE GOLD Deductible/Coinsurance	SIGNATURE SILVER Deductible/Coinsurance	SIGNATURE BRONZE Deductible/Coinsurance	SIGNATURE CATASTROPIC Deductible/Coinsurance
❑ $750/20% HMO	❑ $1,500/30% HMO	❑ $2,000/30% HMO	❑ $6,350/0% PPO
❑ $1,750/0% HMO	❑ $2,500/20% HMO	❑ $3,000/30% HSA PPO	
❑ $1,750/0% HDHP PPO	❑ $2,550/20% PPO	❑ $5,000/30% HSA PPO	
	❑ $1,500/30% PPO		
	❑ $2,500/30% PPO		
	❑ $2,500/20% HSA PPO		
	❑ $5,000/20% PPO		

Other Insurance Information

Have any of the applicants had health care coverage, standalone dental and/or vision plan within the past six months?
❑ Yes ❑ No
If yes, please complete the table below.

Applicant name	Insurance company	Coverage type *(Group, Individual, Medicaid, Medicare, Other)*	Policy ID#	Coverage start date	Coverage end date

Have any of the applicants previously been covered by HealthPlus? ❑ Yes ❑ No
If yes, please provide member name(s) and ID number(s).

Are any applicants currently disabled? ❑ Yes ❑ No
If yes, please attach physician certification.

Applicant Name:

Payment Options		
Initial payment method: ❑ Credit card ❑ Voided personal check for Electronic Funds Transfer (EFT)* ❑ Voided business check EFT* ❑ EFT Savings * Please include a voided check with your application.	**Ongoing payment method:** ❑ Credit card ❑ EFT from personal checking, savings or business account ❑ Bill me	**Ongoing payment frequency:** ❑ Monthly ❑ Annually

Credit Card Payment Authorization

Type of credit card: ❑ Visa ❑ MasterCard ❑ American Express	Cardholder's name (as printed on card)	
Account number __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __	Card expiration date __ __ / __ __ __ __ Month/Year	Verification code – last three digits found on back of the signature panel (four digits for American Express) __ __ __ __

I authorize HealthPlus to bill my Visa/MasterCard/American Express for initial/ongoing payments.

✓ _____ ✓ _____

Signature Date

Electronic Funds Transfer (EFT) Authorization

Account type: ❑ Personal checking ❑ Personal savings ❑ Business	Name(s) on account

Employer forms are required when an employer is forwarding premiums on behalf of the applicant

_____

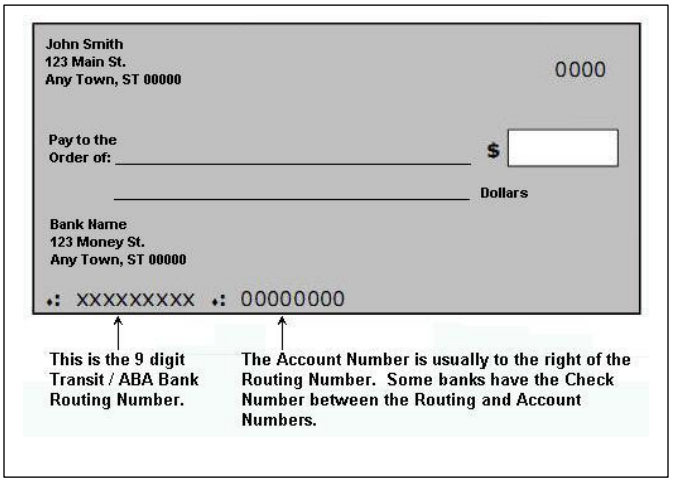
Account number

_____

Routing number

_____

Name of Financial Institution



I authorize HealthPlus to instruct my financial institution to deduct my premium payments from the account designated above. Payments will be deducted from the above designated account on the premium due date each month until I tell HealthPlus Insurance Company to stop the deductions. I also understand that my policy certificate may lapse if my account does not have sufficient funds at the time of deduction. Attach a voided check or personal bank deposit ticket that displays the financial institution name and account number.

✓ _____ ✓ _____

Signature Date

Note: Your bank account, credit or debit card will be charged for insurance premiums when you have been approved for coverage by HealthPlus. Your initial premium will be charged against your bank account, credit or debit card depending on the payment option you select when applying for coverage. Regardless of which ongoing payment option you select, payments are due on the 15th of the month for next month's coverage. If you choose to have subsequent payments automatically made from your bank account, credit or debit card, payments will be processed against the account you designated on the 15th of the month for the next month's coverage. If you choose to have a paper bill sent to you for subsequent payments, those bills will be sent on or around the first of each month, with payment due on the 15th of the month for the next month's coverage.

Applicant Name:

Terms, Conditions and Authorizations

By completing and signing this application for individual health insurance coverage, I agree to the following:

1. All information I have provided on this form is true to the best of my knowledge and belief and correctly recorded by me.
2. Any material misstatement in this application may result in denial of a claim and/or rescission of coverage. Once the application is submitted, I may be contacted by phone or e-mail by HealthPlus or its representative to complete the application process.
3. The effective date of coverage will be on the 1st of the month following approval by HealthPlus. Evidence of approval will be based upon the issuance of ID Cards and policy certificate. Coverage is contingent upon the timely and accurate premiums due and will be terminated if this condition is not met.
4. I Certify that I meet all requirements for eligibility stated within this application including but not limited to:
    a. Michigan residency for nine or more months during the year
    b. United States Citizen or have a valid social security number
    c. No other health insurance coverage currently in place, except Medicaid.
5. You may sign up to receive text message alerts sent directly to your mobile phone device, and emails to your computer, iPad, mobile phone device, etc. Receiving text messages and/or emails is completely voluntary and you may discontinue receipt of the messages at any time.

    AUTHORIZATION TO SEND A TEXT MESSAGE
    I authorize HealthPlus to send text messages to provide information alerts/notifications for HealthPlus Health Alerts, and administrative reminders to me on my provided cellular phone number. I will receive approximately five messages per month. I understand that text message charges from my cell phone provider may apply and that HealthPlus is in no way responsible for any fees charged to me by my cellular provider. If the provided cellular number changes without notification, I realize that HealthPlus cannot be responsible for texting my previous number with my information. If at any time I wish to discontinue receiving text messages from HealthPlus I must text "STOP" to HPLUS (47587). I will receive a text message confirmation that I have been signed up for this program.

    Cell Phone Number(s) including Area Code:_____

    Cellular Provider (i.e., Verizon, AT&T, Sprint): _____

    Applicant's Signature: _____

    AUTHORIZATION TO SEND EMAIL MESSAGES
    Periodically HealthPlus sends out emails to our members providing them a newsletter, or to send information alerts/notifications, or administrative reminders. HealthPlus will not sell or give away your email.

    I authorize HealthPlus to send periodic emails and reminder emails to me at the email address I have provided. I understand that I may open emails on my cell phone and that charges from my cell phone provider may apply. HealthPlus is in no way responsible for any fees charged to me by my cellular provider. I understand email is not a secure form of communication. If after receiving such emails, I wish not to receive them in the future, I may opt out of this program.

    Email address: _____

    Applicant's Signature: _____

6. No contract, waiver, modification or change of contract shall be binding upon HealthPlus Insurance Company unless it is in writing and signed by an authorized officer of HealthPlus.
7. I represent that neither I, my spouse, nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer.
8. I understand and agree that no agent, producer or broker has the authority: (i) to bind HealthPlus by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information HealthPlus requests; (iii) approve coverage; (iv) make or alter any contract on behalf of HealthPlus; or (v) waive or alter any of HealthPlus' other rights or requirements.
9. I understand that, unless required by law, the completion of this application and submission of any estimated initial premium does not provide interim coverage.

Applicant Name:

Do not cancel any current health insurance coverage until you receive an ID card and a policy certificate from HealthPlus. You will be notified of the effective date of your policy certificate.

I have personally read, understand and agree to the terms, conditions and authorization listed throughout this application.

✓ _____ ✓ _____
Applicant's Signature Date Signed

✓ _____ ✓ _____
Spouse's Signature Date Signed

✓ _____ ✓ _____
Signature of child age 18 years or older Date Signed

✓ _____ ✓ _____
Signature of parent/legal guardian for child (ren) Date Signed

Agent/Agency Verification

All questions on this application have been completed by the applicant and the responses are true and accurate to the best of my knowledge.

Signature of Agent	Date	Signature of General Agent (if applicable)	Date
Name of Agent (print name) Lani Corriveau		Name of General Agent (print name)	
Agent/Agency number KM01		Agency number	
Street address or mailing address 324 E Main St, Northville MI 48167		Street address or mailing address	
Phone number 734-335-0084	Fax number 248-374-3239	Phone number	Fax number
E-mail address bluesky@northvilleinsurance.com		E-mail address	

Authorization for Release of Protected Health Information

Applicant's Name	Date of Birth
Spouse's Name	Date of Birth
Dependent's Name	Date of Birth
Dependent's Name	Date of Birth

- I authorize HealthPlus of Michigan, Inc. and/or HealthPlus Insurance Company ("HealthPlus") to receive, use and disclose as necessary my protected health information for the purposes case or disease management, benefit administration or eligibility and rate determination. Protected health information may be written, oral, or electronic.
- This authorization includes the release of any medical, psychological, and prescription drug information from any current or past health care provider, medical professional, hospital, clinic, laboratory, pharmacy, medical care institute or other medical care giver, a health plan, insurance or reinsurance company, consumer reporting agency, Medical Information Bureau, or any other health care clearinghouse that has treated me or provided medical services or supplies to me or any of my dependents applying for coverage.
- The protected health information (excluding psychotherapy notes) that may be used and disclosed include, but are not limited to, hospital records, physician records, claim or benefit records, lab results, mental health records, as well as information regarding the use and treatment of drug, alcohol, HIV/AIDS, sexually transmitted disease, reproductive health services, or any other information concerning my current or past health status or treatment received from my medical care providers, any medical care institute, health plan, or health care clearinghouse.
- I understand that I may revoke it at any time, but I must do so in writing to HealthPlus at the following address: HealthPlus of Michigan, Inc., Customer Service Department, 2050 South Linden Road, P. O. Box 1700, Flint, MI 48501-1700. I also understand that my revocation will not affect any action taken by HealthPlus before my written revocation notice is received. If this authorization is needed as a condition to obtain health care coverage and I revoke it, then I understand that HealthPlus may have the right to contest health care coverage claims.
- I understand that authorizing the disclosure of this protected health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or eligibility for benefits unless the information is necessary to demonstrate that I meet eligibility or enrollment criteria.
- By signing this authorization, I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules. I further understand I may request a copy of this signed authorization. This authorization is valid for 30 months from the signature date on the authorization unless revoked prior to that date.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

✓ _____ ✓ _____
Applicant's Signature Date Signed

✓ _____ ✓ _____
Spouse's Signature Date Signed

✓ _____ ✓ _____
Dependent's Signature (18 years or older)* Date Signed

✓ _____ ✓ _____
Dependent's Signature (18 years or older)* Date Signed

*If under the age of 18, the parent or legal guardian must sign on the child's behalf and indicate their relationship next to their signature. If you are the individual's legal representative and are not the parent of a minor, you must attach documentary evidence of your authority to act as the individual legal representative for this authorization to be valid.