PERSONAL HEALTH PLANS
from CONSUMERS LIFE INSURANCE COMPANY®

CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO® Company
health plans for life

INTERNAL USE ONLY
EFFECTIVE DATE: ____/____/____
GROUP NO.: ______________

HEALTH APPLICATION/CHANGE FORM - WISCONSIN

INSTRUCTIONS: All questions must be answered. Incomplete applications will be returned.

SECTION I: CONTRACT HOLDER INFORMATION

Last Name	MI	First Name	SS Number

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Marriage Date	Divorce Date
	/ /	/ /

Permanent Residence	Email Address	City

County	State	Zip Code	Area Code and Phone Number	Occupation

Reason for Application: ☐ Applying for New Coverage ☐ Applying for Dependent Only Coverage ☐ Applying for a Change to Current Coverage

LIST BELOW ALL INDIVIDUALS TO BE COVERED

	First Name, MI (and Last Name if different)	SS Number	Birth Date	Sex	Height	Weight	Tobacco User	Physician	Student
Self			/ /		' "		Y N		
Spouse			/ /		' "		Y N		
1			/ /		' "		Y N		Y N
2			/ /		' "		Y N		Y N
3			/ /		' "		Y N		Y N

SECTION II: PRODUCT

HEALTH INSURANCE

Note: Health Insurance products are medically underwritten.

Network: ☒ Health EOS ☐ First Health

Desired effective date (when coverage is to begin): _____/_____/_____

- ☐ $500/$1,000 Deductible
- ☐ $500/$1,000 Deductible – 25
- ☐ $1,000/$2,000 Deductible
- ☐ $1,000/$2,000 Deductible – 25
- ☐ $1,500/$3,000 Deductible
- ☐ $1,500/$3,000 Deductible – 25
- ☐ $2,500/$5,000 Deductible
- ☐ $5,000/$10,000 Deductible

- ☐ Short Term $500/$1,000 Deductible

- ☐ Value Plan - $500/$1,000 Deductible
- ☐ Value Plan - $1,000/$2,000 Deductible
- ☐ Value Plan - $1,500/$3,000 Deductible

- ☐ $1,200/$2,400 HSA Compatible
- ☐ $2,000/$4,000 HSA Compatible
- ☐ $2,500/$5,000 HSA Compatible
- ☐ $3,000/$6,000 HSA Compatible
- ☐ $4,000/$8,000 HSA Compatible
- ☐ $5,000/$10,000 HSA Compatible

OPTIONAL RIDERS: (Can only be purchased along with health insurance)

- ☒ $15/$30/$45 Prescription Drug Copay
- ☐ Maternity Services

OPTIONAL COVERAGE:

- ☐ Dental
- ☐ Vision

SECTION III: OTHER COVERAGE INFORMATION

1. ☐ Yes ☐ No Do **YOU**, your **SPOUSE** or any listed **DEPENDENT** have any other type of (Accident, Medicare, Medicaid, etc.) or are you currently applying for any other health insurance? If yes, please complete the following:

NAME	TYPE	NAME OF INSURANCE COMPANY

2. ☐ Yes ☐ No Were **YOU**, your **SPOUSE** or any listed **DEPENDENT** covered by another health plan within the last 63 days? If yes, please complete the following:

NAME	NAME OF INSURANCE COMPANY	DATE OF COVERAGE
		From To
		From To
		From To
		From To
		From To

SECTION IV: MEDICAL ELIGIBILITY

A. ☐ Yes ☐ No Are **YOU**, your **SPOUSE** or any listed **DEPENDENT** currently pregnant or an expectant parent?

Name	Due Date

B. ☐ Yes ☐ No Are **YOU**, your **SPOUSE** or any listed **DEPENDENT** currently taking any prescription medications?

NAME	MEDICATION AND DOSAGE	MEDICAL CONDITION

C. ☐ Yes ☐ No Has any insurance company refused, restricted or charged more for health coverage on any person listed on this Application?

NAME	REFUSAL OR RESTRICTION	MEDICAL CONDITION

D. ☐ Yes ☐ No Do **YOU**, your **SPOUSE** or any listed **DEPENDENT** has a condition covered by Workers' Compensation?

NAME	WORKERS' COMPENSATION NUMBER	MEDICAL CONDITION

E. ☐ Yes ☐ No In the past five years, have **YOU**, your **SPOUSE**, or any listed **DEPENDENT** engaged in sports or hobbies such as scuba diving, automobile or motorcycle racing, skydiving or aero sports on a regular/routine basis? If YES, please complete the following:

NAME	SPECIFIC ACTIVITY

F. When was the last time **YOU**, your **SPOUSE**, or any listed **DEPENDENT** saw a physician? Please complete the following:

NAME	DATE	REASON	RESULTS

SECTION V: MEDICAL ELIGIBILITY

G. ☐ Yes ☐ No Have **YOU**, your **SPOUSE**, or any listed **DEPENDENT** ever been diagnosed and/or treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS or other immune system disorders?

H. Have **YOU**, your **SPOUSE**, or any listed **DEPENDENT** within the past five years been treated for, diagnosed as having, hospitalized, had surgery, been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advise for any of the following conditions? Each condition must be checked (✓) Yes or No

CONDITION	YES	NO
1. Abnormal Pap Smears	☐	☐
2. AIDS, ARC, or HIV	☐	☐
3. Allergies	☐	☐
4. Alzheimer's Disease	☐	☐
5. Aneurysm	☐	☐
6. Anorexia/Bulimia	☐	☐
7. Arthritis (Type: ____________)	☐	☐
8. Asthma	☐	☐
9. Back Sprains/Strains	☐	☐
10. Bronchitis	☐	☐
11. Bursitis	☐	☐
12. Cancer (Type: ____________)	☐	☐
13. Cardiomyopathy	☐	☐
14. Carotid Artery Disease	☐	☐
15. Carpel Tunnel Syndrome	☐	☐
16. Cataracts	☐	☐
17. Cerebral Palsy	☐	☐
18. Cholesterol (High)	☐	☐
19. COPD or Emphysema	☐	☐
20. Cirrhosis of the Liver	☐	☐
21. Colitis (Including Ulcerative)	☐	☐
22. Colon Polyps	☐	☐
23. Congenital Disorders	☐	☐
24. Congestive Heart Failure	☐	☐
25. Coronary Artery Disease (Including Angina and Angioplasty)	☐	☐
26. Coronary Insufficiency	☐	☐
27. Crohns Disease	☐	☐
28. Cystic Fibrosis	☐	☐
29. Cystitis (Chronic or interstitial	☐	☐
30. Cysts, Tumors or Growths	☐	☐
31. Diabetes/Blood Sugar Disorder Last 3 Blood Sugars & Dates: 1) ____________________ 2) ____________________ 3) ____________________	☐	☐

CONDITION	YES	NO
32. Diverticulitis/Diverticulosis	☐	☐
33. Down's Syndrome	☐	☐
34. Drug/Alcohol Abuse (Including DUIs)	☐	☐
35. Endometriosis	☐	☐
36. Fibrocystic Breast Disease	☐	☐
37. Fibromyalgia	☐	☐
38. Gallbladder Disease	☐	☐
39. Gastric Reflux (GERD)	☐	☐
40. Gout	☐	☐
41. Graves Disease	☐	☐
42. Growth Deficiency	☐	☐
43. Guillian Barr Syndrome	☐	☐
44. Heart Attack	☐	☐
45. Heart Bypass Grafting	☐	☐
46. Heart Murmur	☐	☐
47. Heart Palpitations/Arrhythmia	☐	☐
48. Heart Valve Disorders	☐	☐
49. Hemorrhoids	☐	☐
50. Hemophilia	☐	☐
51. Hydrocephalus/Shunt	☐	☐
52. Hypertension (High Blood Pressure) Last 3 Pressures & Dates: 1) ____________________ 2) ____________________ 3) ____________________	☐	☐
53. Ileostomy/Colostomy	☐	☐
54. Infertility	☐	☐
55. Kidney Failure	☐	☐
56. Kidney Stones	☐	☐
57. Liver Disorders/Hepatitis	☐	☐
58. Lou Gehrig's Disease (ALS)	☐	☐
59. Meningitis	☐	☐
60. Menstrual Disorders (including Abnormal Cycles/Uterine Bleeding)	☐	☐

CONDITION	YES	NO
61. Mental Health Disorders (Including Depression, Anxiety, ADD/ADHD and counseling)	☐	☐
62. Migraines	☐	☐
63. Multiple Sclerosis	☐	☐
64. Muscular Dystrophy	☐	☐
65. Organ Transplant/Failure	☐	☐
66. Osteoporosis	☐	☐
67. Otitis Media (ear infections)	☐	☐
68. Ovarian Cyst/Polycystic Ovarian Disease	☐	☐
69. Pacemaker Implantation	☐	☐
70. Pancreatitis	☐	☐
71. Paralysis	☐	☐
72. Parkinson's Disease	☐	☐
73. Peptic/Gastric Ulcer	☐	☐
74. Peripheral Vascular Disease	☐	☐
75. Phlebitis/Blood Clot	☐	☐
76. Polycystic Kidney Disease	☐	☐
77. Prostate Disorders	☐	☐
78. Schizophrenia/Bipolar	☐	☐
79. Scleroderma	☐	☐
80. Seizure Disorder/Epilepsy	☐	☐
81. Sexually Transmitted Disease	☐	☐
82. Sleep Apnea	☐	☐
83. Spina Bifida Cystica/Occulta	☐	☐
84. Spinal Disorders/Disc Disease	☐	☐
85. Stroke	☐	☐
86. Suicide Attempts/Psych Admits	☐	☐
87. Systemic Lupus	☐	☐
88. Tendonitis	☐	☐
89. Thyroid Disorder	☐	☐
90. TMJ	☐	☐
91. Tonsillitis	☐	☐
92. Transient Ischemic Attacks (TIA)	☐	☐
93. Varicose Veins	☐	☐
94. Other condition(s) not listed	☐	☐

I. If any questions A through H or conditions 1 through 94 are checked "YES", please explain below, (use additional paper, if necessary). Indicate all details of the injury, ailment or condition. Include items such as specific location of condition (example: right knee), diagnosis, type of treatment and hospitalization.

Question/ Condition	Patient's Name	Details of Injury, Ailment or Condition	Start and End Date(s) of Treatment(s)	Physician

SECTION VI: BILLING INFORMATION

CHOOSE ONE:

☐ **HOME – Receive monthly premium billings**

☐ **FINANCIAL INSTITUTION – Have monthly automatic premium withdrawals**

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Consumers Life to initiate premium deductions from my account. The authorization will remain in effect until Consumers Life and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from: ☐ Checking ☐ Savings
(Please note: Not all Financial Institutions allow deductions from a savings account. Please verify this information with your financial institution.)

Name and branch of bank/financial institution			Account Number
Address			Account Holder's Name
City	State	Zip Code	Transit Routing Number:
Account Holder's Signature			Date

Please attach a voided check for checking account or a deposit slip for savings account in order for our office to verify the bank information.

☐ **CREDIT CARD – Have monthly premium billed to credit card**

If you wish to be billed through your credit card, please complete the following authorization: ☐ MasterCard ☐ Visa

Card Holder Name	Card Number
Bank Name (If applicable)	Expiration Date
Account Holder's Signature	Date

☐ **LIST BILLING THROUGH EMPLOYER** – is available only to employees of a common employer who has agreed to collect the premiums on a monthly basis through payroll deduction and where the employer is not paying any portion of the premium.

Name of Employer	Occupation	
Address	Area Code and Phone Number	
City	State	Zip Code

☐ **DIFFERENT BILLING ADDRESS – Have home billing sent to a different address**

If your mailing address is different than your permanent address, complete the following:

Last Name (C/O)	First Name	MI
Address		
City	State	Zip Code

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

FOR OFFICE USE ONLY

Sold - Account Executive and Code
Service - Account Executive and Code

or

Agent of Record	Tax ID
Truth Benefits, LLC	74-3190025
Royal Advantage Broker	Commission Indicator **96.15**

SECTION VII: TERMS AND CONDITIONS

I hereby apply under Consumers Life Insurance Company Group Trust for the coverage indicated on this application. I further agree to participate in such trust and agree to be bound to the relevent terms of the Master Group Contract(s) and the Trust Agreement.

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, government agency or person to Consumers Life Insurance Company (CLIC) and/or any affiliates or division of CLIC: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities; (d) for credentialing purposes. I authorize the applicable carrier to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this application.
2. I agree that a medical examination of me may be required in connection with this Health Application. I further agree that I, as the Applicant, will be responsible to pay for the medical examination and/or the release of any and all records on behalf of myself, my spouse, and/or the listed dependents.
3. I represent that I have read this Health Application, and understand each of the questions and the answers to each of the questions I have given are complete and true to the best of my knowledge. I agree that any intentional misrepresentation or concealment on this Application will void my policy at the discretion of CLIC. I further agree that if a policy is issued, it will be issued by CLIC in full reliance and in consideration of the information, answers, and statements contained herein. I understand that this policy will be medically underwritten.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of this health insurance policy (such as the preferred provider organization network) have been explained to my satisfaction. I also understand that I may review a copy of the Master Group Contract(s) and Trust Agreement upon making such a written request to CLIC.
5. No issuance, waiver, modification or change of policy or any of CLIC rules or amendments shall be binding upon CLIC unless it is in writing and signed by an authorized officer of CLIC, as applicable.
6. Notice: Certain Pre-Existing Condition limitations will apply: A Pre-existing Condition is a Condition for which an ordinarily prudent person would seek medical advice, diagnosis, care or treatment; or for which you incurred medical expense, received medical treatment, used Prescription Drugs or were advised by a Physician or Other Professional Provider to receive treatment prior to your Enrollment Date. Your Enrollment Date is your Effective Date. If a Pre-existing Condition existed at any time during the six (6) month period immediately preceding your Enrollment Date, CLIC will provide benefits for the Pre-existing Condition for Covered Services incurred after twelve (12) months following your Enrollment Date.
7. I represent that neither I nor my spouse are receiving any form of reimbursement or compensation for this coverage from any employer.
8. I also understand that information submitted with this application may require further medical underwriting. If that underwriting discloses additional medical risk I understand that there may be a significant change in the rate charged for this coverage or in certain cases, the coverage may be rescinded. A permanent ID card will be issued following the final review and acceptance of the application.
9. I understand and agree that I am solely and exclusively responsible for all of the answers contained in this application. I understand and agree that no agent or broker who may be assisting in the completion of this application has any authority (a) to waive any answer or any portion of any answer to any question on this application or any information CLIC requests, (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the application, (c) to make any representation concerning health benefits that are inconsistent with, or different from, any written information provided by CLIC or (d) to bind CLIC in any way by making any statement, promise or representation that is not set out in writing in this application or regarding eligibility, benefits or issuance of a policy or (e) to approve coverage.
10. 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 am signing this Health Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. Do not cancel any current health insurance coverage until you receive an approval letter and insurance policy from Consumers Life.

Contract Holder's or Guardian's Signature	Date	Guardian's Social Security Number if child only policy	
Spouse's Signature	Date	Dependent's Signature (Only if 18 or older)	Date
Dependent's Signature (Only if 18 or older)	Date	Dependent's Signature (Only if 18 or older)	Date

SECTION VIII: HOW DID YOU HEAR ABOUT PERSONAL HEALTH PLAN?

Please check how you heard about Personal Health Plan

- ☐ 1. Friend / Family Member
- ☐ 2. Yellow Pages
- ☐ 3. Insurance Agent
- ☐ 4. Advertisement in Newspaper, Magazine, etc.
- ☐ 5. Newspaper Article
- ☐ 6. Internet / Web site
- ☐ 7. Radio
- ☐ 8. Mail
- ☐ 9. Through current employer
- ☐ 10. Other ____________________

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.