

FOR OFFICE USE ONLY

FLORIDA



# Celtic Basic Application

UNDERWRITTEN BY CELTIC INSURANCE COMPANY, CHICAGO, IL

#2048780

Please print in ink

<b>Requested Effective Date:</b> NOTE: the 29, 30 and 31 of the month are not eligible as effective dates. Application is valid within 60 days from the signature date. MO. / DAY / YR.	<b>Authorization Code:</b> (If QuikCoverage was requested)	<b>Please check if this application is for:</b> <input type="checkbox"/> New Applicant <input type="checkbox"/> Add Dependent <input type="checkbox"/> Plan Change <input type="checkbox"/> Reapply
---	---	---

<b>Initial Payment Method:</b> One month/quarter premium required (Complete Section 4): <input type="checkbox"/> Credit card (including Check/Debit cards) <input type="checkbox"/> Check	<b>Subsequent Payment Schedule:</b> <input type="checkbox"/> Monthly Automatic Pay - One month premium required (Complete Section 4) <input type="checkbox"/> Quarterly Billing* - Three months premium required *\$8 billing fee per quarter
--	--

**Total Payment Submitted:**  
 \$ \_\_\_\_\_ /Monthly + \$25.00 One-time, non refundable Application Fee = \$ \_\_\_\_\_ Total Payment submitted  
 \$ \_\_\_\_\_ /Quarterly + \$25.00 One-time, non refundable Application Fee = \$ \_\_\_\_\_ Total Payment submitted

**Have you and/or any dependent to be covered previously applied for insurance with Celtic Insurance Company?**  
 Yes     No

## SECTION 1: GENERAL INFORMATION

*If child-only coverage is being requested, the child is the primary applicant and a separate application must be completed for each child.*

<b>Primary Applicant's Name:</b>				<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
First	Middle	Last			
<b>Birth Date:</b> / /	<b>Age:</b>	<b>Place of Birth:</b> (Country)	<b>Height:</b> ft. in.	<b>Weight:</b> lbs.	
<b>Social Security Number:</b>			<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Home Phone Number:</b> ( ) ( )		<b>Phone Number during regular business hours:</b> ( ) ( )		<b>Occupation:</b> (Position and Type of Business)	
<b>Best Time To Call:</b> a.m. p.m.		<b>Primary Applicant's Home Address:</b>			
Street		City	State	Zip	Country

### GUARDIAN INFORMATION (For Applicants under 18 years of age):

<b>Guardian's Name:</b> (with whom the child resides):		<b>Relationship to Child</b>	<b>Social Security Number:</b>
First	Middle	Last	

### BILLING INFORMATION *If different from Applicant's Home Address (Please send bills to):*

<b>Name and Billing Address:</b>				
Name	Street	City	State	Zip

### CITIZENSHIP INFORMATION

**Are the following Applicants to be insured U.S. citizens?**  
**Primary applicant:**  Yes     No\*    **Spouse:**  Yes     No\*    **Dependent(s):**  Yes     No\*

**\*If anyone answered "No," to the above question, please indicate if he or she has been a permanent legal resident of the U.S. for the last two years?**  
**Primary applicant:**  Yes     No\*\*    **Spouse:**  Yes     No\*\*    **Dependent(s):**  Yes     No\*\*

**\*\* If "No," coverage cannot be granted for that applicant.**

**SECTION 1: GENERAL INFORMATION (continued)**

**PLAN INFORMATION**

Who is to be insured?  Applicant (only)  Applicant/Spouse  Applicant/Child(ren)  Family

**DEPENDENT INFORMATION** (Complete only for dependents to be covered under this plan.)

Spouse's Name: \_\_\_\_\_ Sex:  Male  Female Spouse's Social Security Number: \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Spouse's Occupation: (Position and Type of Business) \_\_\_\_\_

Accurate Readings Required					
Name of Dependent Child(ren):	Social Security Number:	Birth Date:	Sex:	HT. (ft. & in.)	WT. (lbs.)

**DEDUCTIBLE OPTIONS**

**PPO Plan: (Choose one of the following deductibles)**

80/20 of the next \$10,000 \_\_\_\_\_ deductible  
(\$1,500, \$2,500, \$5,000)

**BENEFIT OPTIONS**

**Would you like the Prescription Drug Card Option?**

Yes  No

**OTHER HEALTH COVERAGE**

**Do you or any dependents to be insured have any major medical health insurance coverage currently in force?**

Yes\*  No

**\*If "Yes," will the insurance coverage applied for be used to replace this existing coverage?**  Yes  No

**(If "Yes," a replacement form may be required in your state. Consult your agent. If "No," coverage cannot be issued.)**

**Were you or your dependents covered under any other Health Insurance plan in the last 18 months?**  Yes\*  No

**\*If "Yes," what type of coverage was your or your dependents last plan?**

Employer Based Group  Individual  COBRA  Other

**If you currently have a major medical plan in force or had coverage in the last 18 months complete the following:**

Name of covered individual(s): \_\_\_\_\_

Carrier Name: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Policy Number or Group Number: \_\_\_\_\_

Effective Date of Policy: \_\_\_\_\_

Termination Date of Policy: \_\_\_\_\_

**IMPORTANT: DO NOT cancel any existing health coverage until written notification of your acceptance by Celtic.**

## SECTION 2: HEALTH AND OCCUPATION QUESTIONS

### HEALTH QUESTIONS

For this insurance to be issued, the following health questions must be answered fully and truthfully to the best of your knowledge and belief and all of the health information must be provided, and Celtic Insurance Company must approve this application. No one may change this requirement in any way. If any information on any form is misstated or omitted, coverage may later be rescinded. Rescission voids coverage from the effective date, and any premiums already paid will be refunded, minus any claims already paid. No payments will be made for any claims submitted, whether or not the treatment was related to the condition that was omitted or misstated.

**PLEASE DO NOT MARK OVER OR STRIKE OUT ANY SIGNATURE, DATE OR HEALTH QUESTION INFORMATION.** (Any changes, corrections or alterations must be initialed and dated by the primary applicant.)

#### 1. PREGNANCY

YES\*  NO

Are you, your spouse or any dependent, whether to be covered or not, now pregnant or an expectant parent or have an adoption pending?  
(If "YES," this coverage cannot be provided.)

#### 2. GENERAL HEALTH

YES\*  NO

a. Within the last 10 years, has anyone to be insured been counseled or advised that they have or may have had any disease, disorder, impairment, deformity, familial or congenital abnormality, injury or any chronic or untreatable condition whether active or in remission?

YES\*  NO

b. Does anyone to be insured have a prosthetic device or implant (including breast implants)?

YES  NO

c. Have you or any dependent to be insured used any type of tobacco product in the past 12 months?

If "Yes," check all who apply:  Applicant  Spouse  Dependent(s)

YES\*  NO

d. Have you or any of your dependents been prescribed any medications in the last 12 months?

#### 3. SPECIFIC HEALTH CONDITIONS

Within the last 10 years, have you or any dependent(s) to be insured ever been treated for, had symptoms of, or been advised or counseled that they have or may have had: (Y=Yes and N=No)

##### Y\* N

- Heart condition, (including chest pains or a heart murmur), stroke, high blood pressure or other circulatory disorder
- Blood disorder
- Diabetes
- Cancer, tumor or cyst
- Liver, kidney, genital or urinary tract disorder
- Any disease or disorder of the reproductive system including infertility, complications of pregnancy, sexual dysfunction or sexually transmitted disease(s)
- Elevated Cholesterol
- Neurological disorders or condition

##### Y\* N

- Seizures or other nervous system disorder
- Arthritis, fibromyalgia, gout, back, spine, joint or other musculoskeletal system disorder
- Chronic Fatigue Syndrome
- Digestive system disorder
- Asthma, allergies or other respiratory disorder
- Eye, ear or skin disorders
- Alcohol, substance or drug abuse or dependence. Emotional, psychological, psychiatric or nervous condition or disorder
- Thyroid disorder

#### 4. RECENT MEDICAL TREATMENT

a. Within the past 24 months, have you or any dependent(s) to be insured undergone or been advised or recommended for: (Y=Yes and N=No)

##### Y\* N

- Lab work or tests
- Hospitalization
- Surgery or surgical consultation
- Treatment for any condition(s)

##### Y\* N

- Psychological or marital counseling
- Physical, occupational, or disability therapy
- Second opinion from another physician

\*QuikCoverage cannot be granted over the phone. Please mail in your application for processing.

**SECTION 2: HEALTH AND OCCUPATION QUESTIONS (continued)**

YES\*  NO      b. Are you or any dependent(s) to be insured scheduled for or awaiting the results of any tests, biopsies, procedures or lab work?

YES\*  NO      **5a. HUMAN IMMUNODEFICIENCY VIRUS, ACQUIRED IMMUNE DEFICIENCY SYNDROME AND IMMUNODEFICIENCY SYNDROME**  
Have you or any dependent(s) tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immunodeficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?

YES\*  NO      **5b. OTHER IMMUNE SYSTEM DISORDERS**  
Have you or any dependent(s) to be insured ever been diagnosed as having an immune system disorder or other disease associated with an immune system disorder?

YES\*  NO      **6. OCCUPATION/AVOCATION QUESTION**  
Do you or any dependent(s) to be insured participate in or work in any of the following occupations/avocations?

- |                      |                          |                                  |
|----------------------|--------------------------|----------------------------------|
| Bartenders           | Modeling                 | Professional fire fighting       |
| Crop dusting         | Motorized vehicle racing | Professional sports or athletics |
| Hazardous materials  | Musician                 | Roofing                          |
| Inter-state trucking | Off-shore drilling       |                                  |
| Mining               | Police                   |                                  |

If "Yes," please provide the name(s) of each person and their occupation/avocation.

Name: \_\_\_\_\_ Occupation/Avocation: \_\_\_\_\_

Name: \_\_\_\_\_ Occupation/Avocation: \_\_\_\_\_

**7. FOR APPLICANTS AGE 50 OR OLDER**

YES\*  NO      **a. General**  
Have you or any dependent over 50 had a physical within the last 24 months?

**b. Male Applicants Only - PSA Results:**  
What was the date of your most recent PSA (Prostate Specific Antigen) test? \_\_\_\_\_ MM / DD / YYYY  
What was the exact level/reading? \_\_\_\_\_

**c. Female Applicants Only - PAP/Mammogram Results:**  
What was the date of your most recent mammogram? \_\_\_\_\_ MM / DD / YYYY  
Results normal?  Yes  No

What was the date of your most recent pap smear? \_\_\_\_\_ MM / DD / YYYY  
Results normal?  Yes  No

\*QuikCoverage cannot be granted over the phone. Please mail in your application for processing.

**SECTION 3: ADDITIONAL HEALTH QUESTION INFORMATION**

To be completed if the applicant or any dependent(s) answered "Yes" to any questions in Section 2. If more space is needed attach a separate sheet, each separate sheet must be signed and dated by the primary applicant.

Please give month and year when providing dates. Also, please give specifics when listing conditions, (Ex. Broken left leg.)

Ques. No.:

Applicant's Name:

Diagnosis/Condition:

Onset Date:

Date Last Treated:

Length of Treatment:

Medication(s), including over the counter (please list med/dosage and date last taken):

Name of Test/Surgery/Date/Results:

Is the condition still present? If not, date of recovery:

Details of Treatment/Treatment pending or scheduled:

Doctor's name, Address and Phone Number:

Ques. No.:

Applicant's Name:

Diagnosis/Condition:

Onset Date:

Date Last Treated:

Length of Treatment:

Medication(s), including over the counter (please list med/dosage and date last taken):

Name of Test/Surgery/Date/Results:

Is the condition still present? If not, date of recovery:

Details of Treatment/Treatment pending or scheduled:

Doctor's name, Address and Phone Number:

**SECTION 4: PREMIUM PAYMENT METHOD AND AUTHORIZATION AGREEMENT**

**Initial Payment (Credit Card or Check): PRODUCER PAYMENTS ARE NOT ACCEPTED.**

1. For Initial Payment Only: I authorize Celtic Health Plan Trust to bill my account for the initial payment and I agree to pay the initial payment billed in accordance to my payment selection on this application by checking the following credit card box:

VISA® (including Check/Debit cards\*)  Mastercard® (including Check/Debit cards\*)  Discover®

\* Debit cards must have a Visa or Mastercard logo on the front of the Debit Card.

Card No.:           Expiration Date (MO/YR):   /

Cardholder's Name: \_\_\_\_\_

2. Or, attach your check below for total payment submitted.

**MONTHLY AUTOMATIC PAY PLAN**

<b>Payor Name or Depositor if different (Please print):</b>	<b>Relationship to Applicant:</b>
First _____ Middle _____ Last _____	

<b>Signature of Primary Payor:</b>	<b>Date:</b> /        /
------------------------------------	-------------------------

<b>Name of Financial Institution:</b>	<b>Address:</b> CITY _____ STATE _____ ZIP _____
---------------------------------------	---

<b>Specify type of account:</b> <input type="checkbox"/> Checking or <input type="checkbox"/> Savings	<b>Checking/Savings Account Number:</b>
---	---

**ABA 9 Digit Routing Number (See below or please call your Financial Institution for assistance):**

Celtic Insurance Company is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month, until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Certificate is not issued.

I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by Celtic Insurance Company, and I agree that the bank named shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Celtic Insurance Company in writing.

<p><b>MONTHLY AUTOMATIC PAY PLAN APPLICANTS ONLY</b></p> <p><b>Voided Check</b></p> <p><i>(Deposit Slips are not acceptable)</i></p>	<p style="text-align: right;"><b>ATTACH YOUR INITIAL CHECK OR MONEY ORDER FOR PREMIUM PAYMENT</b></p> <p style="text-align: right;">1117</p> <p>Joe Smith 123 Main Street Anytown, IL 12345</p> <p>Pay to the order of _____ \$ _____</p> <p>Date _____</p> <p style="text-align: center;">Routing Number</p> <p>For <u>123456789</u> 1234567891011 1117</p>
<p><b>DO NOT STAPLE CHECKS TO FORM.</b></p>	

**SECTION 5: AGREEMENT AND SIGNATURE**

1. **TRUE AND COMPLETE:** My answers to the questions on this application and any additional information I have provided are true and complete and accurately recorded. I understand that under no circumstances is a producer or company representative allowed to permit me to answer any question inaccurately or untruthfully and I represent that such did not occur. The producer is not authorized to alter any terms of the Certificate. I understand that I may not pay cash or make checks payable to the agent or broker, or leave the payee blank.
2. **PRE-EXISTING CONDITIONS:** I understand that eligible expenses for pre-existing conditions may be limited.
3. **EFFECTIVE DATE:** Except as provided in the Conditional Receipt, I understand that insurance, if approved, will become effective the day after the confirmed receipt date the application and all required medical and other information is received by Celtic and the initial premium is paid in full. Application is valid within 60 days from the signature date.
4. **HEALTH CARE CERTIFICATION:** I understand that a Health Care Certification Program is a part of the Health Plan. This program requires me to have all hospital confinements, outpatient surgeries, and major diagnostic tests Certified. I understand that failure to do so will result in a reduction of my health plan benefits or no benefits paid at all. The Health Care Certification Program number is 1-800-477-7870.
5. **OTHER COVERAGE:** I understand that in order to be eligible for this coverage, neither I, nor any dependents to be insured can be covered under any other major medical plan. I hereby attest that no one applying for coverage under the Health Plan will be covered under any other coverage.
6. **PREFERRED PROVIDER ORGANIZATION:** I understand if I have selected one of the PPO plan options as part of my Health Plan, then I agree to participate and comply with all requirements of the PPO plan. I understand that I will maximize my benefits when treatment is received from a participating hospital and physician and that it is my responsibility to ensure that a PPO hospital and physician is near me. I understand this applies not only to myself, but to any dependent to be insured under this health plan.
7. **APPLICATION:** I understand that I am applying for membership in the Celtic Health Plan Trust and am responsible for ensuring that all premium payments are met. I understand that Celtic will individually underwrite my application and that if my application is accepted by Celtic, a Certificate will be issued to me. I understand that the plan applied for is not an employer-sponsored group health plan, that it will in no way be related to any employer/employee relationship, and it is not offered pursuant to and does not comply with state or federal small employer laws. If premium will be paid from a business/employer account, I hereby certify that no person to be insured under this plan will receive favorable tax treatment under sections 162, 125 or 106 of the United States Revenue Code, unless such favorable tax treatment would not make the plan subject to any state or federal small employer laws.
8. **AUTHORIZATION TO RELEASE INFORMATION:** I authorize any physician, medical or health care practitioner, hospital, clinic, other medically related facility, insurance company, third party administrator, employer or consumer reporting agency having information regarding me and all eligible dependents, including information concerning advice, diagnosis, treatment or care of physical, psychiatric, mental or emotional conditions, drug, substance, or alcohol abuse, illness, and copies of all hospital or medical records, or non-medical information, to give to Celtic Insurance Company, its reinsurers, or its legal representatives, and its affiliates, any and all such information. Such information may be used by Celtic Insurance Company to determine eligibility for insurance and make claim determinations. This authorization shall remain valid for two years from the date shown below. Anyone who knowingly misrepresents or falsifies such requested information may, upon conviction, be subject to a fine or imprisonment. I acknowledge having received and read the Notice of Information Practice.

**This policy is primarily governed by the laws of Illinois. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

SIGNATURE: PRIMARY APPLICANT: \_\_\_\_\_ SPOUSE: \_\_\_\_\_  
(Parent or Guardian if under 18 years of age)

DATED AND SIGNED AT: \_\_\_\_\_ on \_\_\_\_/\_\_\_\_/\_\_\_\_  
City State Date

## SECTION 6: PRODUCER INFORMATION

NOTE: If you have written business with Celtic *in this state* during this calendar year, just complete your name, Social Security number and sign below. There is no need to submit a copy of your license with every case.

Writing Producer's Name: <b>Tony Novak</b>	Social Security Number or Agent Number <b>2048780</b>
--	---

Are you licensed in the state where the application was completed?  YES  NO

Are you currently appointed with Celtic in the state where the application was completed?  YES  NO\*

\*If NO, please submit appointment materials with this application. Some states require pre-appointment, check with Celtic to verify pre-appointment states.

Florida Agent's License Identification Number: <b>D016619</b>	Commissions paid to:
---	----------------------

Address:

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number: **800-609-0683**  
( )

Fax Number:  
( )

## CERTIFICATE INFORMATION

Please check this box if you would like the Certificate Booklet to be sent directly to the insured. If this box is not checked, the Certificate Booklet will be sent to your attention at the above address.

PRODUCER'S STATEMENT: I certify that the answers given to the questions in this application were provided by the primary applicant and the applicant was instructed that all information must be accurate and complete. I understand that commissions cannot be paid unless I am appointed with Celtic.

PRODUCER'S SIGNATURE:                     Tony Novak                     DATE:       /      /      

Mail this application and the initial premium payment check made out to Celtic Health Plan Trust to:

Celtic Health Plan Trust  
P.O. Box 33640  
Indianapolis, IN 46203-0640

[www.celticenrollment.com](http://www.celticenrollment.com)

PLEASE KEEP THE FOLLOWING SECTIONS FOR YOUR RECORDS

NOTICE OF INFORMATION PRACTICES

In order to properly underwrite and administer your insurance coverage, we must collect personal information concerning your insurability. You are our most important source of information, but we may also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see (and copy if you wish) items of personal information about you which appear in our files, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment, or deletion of information you believe to be inaccurate.

If you have questions or desire additional information about the items disclosed above, please write to us at Celtic Insurance Company, Underwriting Department, 233 South Wacker Drive, Suite 700, Chicago, IL 60606.

Requests for medical information will only be disclosed to your attending physician.

CONDITIONAL RECEIPT FOR HEALTHPLAN

ALWAYS COLLECT THE INITIAL PREMIUM AND GIVE THE APPLICANT THIS CONDITIONAL RECEIPT.

No insurance will become effective prior to the approval of your application by Celtic. No producer or broker is authorized to alter or waive any of the following provisions of the receipt:

Applicant's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Amount Received: \_\_\_\_\_

Date: \_\_\_\_\_

- (A) If QuikCoverage has been granted over the phone (please indicate **Authorization Code:** \_\_\_\_\_), coverage is effective at the moment approval was given over the phone, provided that all the following conditions are met: (1) The answers on the completed and signed Celtic Basic Health Plan Application Form agree with those answers that were given to QuikQuote. (2) The completed application and the initial premium are mailed to Celtic, and postmarked no later than the next business day and received within 10 working days after QuikCoverage was granted.
- (B) If the conditions in (A) are not met, or if QuikCoverage was not applied for, coverage will become effective on the "Effective Date" (as defined below) if all of the following conditions are met: (1) On the Date of Application, the applicant and all proposed insureds must be a risk acceptable to Celtic, for the exact coverage and premium applied for without any modification. (2) If Celtic cannot determine the acceptability of the applicant(s) as defined in (B) (1) above, due to the nonreceipt (within 60 days of the date of application), of medical or other material information that Celtic has requested from the applicant or other sources; then this condition has not been fulfilled and no coverage will be provided under the terms of this Conditional Receipt. (3) The initial premium, equal to one month/quarter of the first yearly premium, has been paid on or prior to the Effective Date, and the check or credit card is honored on the first presentation for payment.

"Effective Date" as used herein means 12:01 a.m. on the later of: (A) the Requested Effective Date; (B) the day following the postmarked date on the application envelope addressed to Celtic, if no effective date is requested; (C) if no postmarked date, the effective date is the day after the confirmed receipt date of the application and all required medical and other information is received by Celtic. **Note: Metered mail is not an acceptable postmark.**



**Insured by Celtic Insurance Company**

---

Celtic Group Company

**CELTIC INSURANCE COMPANY**

**HIPAA**

**Authorization to Release Information**

I authorize any physician, medical or health care practitioner, hospital, clinic, other medically related facility, insurance company, third party administrator, employer or consumer reporting agency having information regarding me and all eligible dependents, including information concerning advice, diagnosis, treatment or care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness or injury, and copies of all hospital records, medical records, pharmaceutical records or non-medical information, to give to Celtic Insurance Company, its reinsurers, or its legal representatives, and its affiliates, any and all such information. Such information will be used by Celtic to determine eligibility for insurance and make claim determinations. I understand that there is a possibility of redisclosure of any information pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand that I can revoke this authorization at any time by giving written notice to Celtic and my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. I know that I may request to receive a copy of this authorization. This authorization shall remain valid for two years from the date shown below. A copy of this authorization shall be considered as valid as the original.

\_\_\_\_\_  
Signature of Primary Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse

\_\_\_\_\_  
Date

**Dependent signatures only required in North Carolina:**

\_\_\_\_\_  
Dependent Child (age 18 years or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dependent Child (age 18 years or older)

\_\_\_\_\_  
Date