CELTIC®

FOR OFFICE USE ONLY

# Celtic Short-Term Health Plan

UNDERWRITTEN BY CELTIC INSURANCE COMPANY, CHICAGO, IL

**Requested effective date:** / / (Note: The 29, 30 and 31 of the month are not eligible effective dates. Cannot be on or before the postmark date.)

**Total Payment Submitted:**

$ _____ Premium for Health Plan + $20 One-time, non refundable Application fee = $ _____ Total Payment Submitted

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

## SECTION 1: GENERAL INFORMATION

FOR DEPENDENT-ONLY COVERAGE THE PARENT/GUARDIAN MUST SIGN APPLICATION AND COMPLETE THE HEALTH INFORMATION FOR THE CHILD.

**Insured's Name:**

**Birthdate:** | **Age:** | **Sex:** ☐ Male ☐ Female

**Resident Address:**

STREET CITY STATE ZIP

**Social Security Number:** | **Telephone Number:**

**Is everyone to be insured a U.S. Citizen or permanent legal resident of the United States?** ☐ Yes ☐ No

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

**Guardian's Name:** (with whom the child resides)

FIRST MIDDLE LAST

☐ Parent ☐ Legal Guardian ☐ Grandparent ☐ Other _____

**DEPENDENT INFORMATION:** LIST SPOUSE AND LEGALLY DEPENDENT CHILDREN ONLY IF THEY ARE TO BE COVERED. (Note: Children must be under age 25.)

| Dependent Name | Relationship to you | Birth Date (Mo/Day/Yr) | Sex (M/F) | Social Security # |
|---|---|---|---|---|
| | spouse | | | |
| | child | | | |
| | child | | | |
| | child | | | |
| | child | | | |
| | child | | | |

**PRODUCT OPTIONS:** (Choose one of the plans listed below)

☐ **Celtic Short-Term Gold:**

**Number of months:** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

**Deductible Options:** ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

**Payment Options:** (Select one)
- ☐ Monthly Automatic Pay Plan/EFT (complete Section 3)
- ☐ One Single Premium Payment by Check or Money Order (include with this application)
- ☐ One Single Premium Payment by Credit Card (complete Section 4)

☐ **Celtic Short-Term Silver:**

**Number of months:** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

**Deductible Options:** ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

**Payment Options:** (Select one)
- ☐ Monthly Automatic Pay Plan/EFT (complete Section 3)
- ☐ One Single Premium Payment by Check or Money Order (include with this application)
- ☐ One Single Premium Payment by Credit Card (complete Section 4)

## SECTION 2: HEALTH QUESTIONS

**IF YOU ANSWER YES TO ANY QUESTION BELOW, COVERAGE CANNOT BE ISSUED.**

☐ YES ☐ NO **1.** Do you or any person applying for coverage have any hospital, major medical, group health, government or medical insurance coverage that will not terminate prior to the effective date of this coverage?

☐ YES ☐ NO **2.** Are you, your spouse, or any dependent, whether to be covered or not, now pregnant or an expectant parent or in the process of adoption or surrogate pregnancy?

**3.** Have you or any person applying for coverage received any medical or surgical consultation, advice, treatment or medication within the last 10 years for: (Y=Yes and N=No)

| | Y | N | | | Y | N | |
|---|---|---|---|---|---|---|---|
| **a.** | ☐ | ☐ | Heart attack, Angina, or other heart or circulatory disorder | **g.** | ☐ | ☐ | Kidney disorders |
| **b.** | ☐ | ☐ | Stroke | **h.** | ☐ | ☐ | Emphysema, COPD |
| **c.** | ☐ | ☐ | Hypertension (high blood pressure) | **i.** | ☐ | ☐ | Excessive use of alcohol or alcoholism |
| **d.** | ☐ | ☐ | Diabetes | **j.** | ☐ | ☐ | Drug abuse, dependence or addiction |
| **e.** | ☐ | ☐ | Cancer or Tumors | **k.** | ☐ | ☐ | Emotional, psychological, psychiatric, or nervous condition or disorder |
| **f.** | ☐ | ☐ | Liver disorders | | | | |

☐ YES ☐ NO **4.** Have you or any person applying for coverage ever been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS or other immune system disorder, or ever tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?

☐ YES ☐ NO **5.** Have you or any person applying for coverage seen any healthcare provider for any condition, signs or symptom(s) which have not yet been diagnosed?

☐ YES ☐ NO **6.** In the past 12 months, have you or any person applying for coverage been recommended by a physician or health care professional to have or to be scheduled for testing, treatment or surgery that has not been completed?

☐ YES ☐ NO **7.** Are you or any person applying for coverage enrolled in training for or engaged in college-level, semi-pro or professional athletics?

☐ YES ☐ NO **8.** Have you or any person applying for coverage been denied insurance due to any health reasons that are still present?

☐ YES ☐ NO **9.** Are you or any person applying for coverage over 300 pounds if male or over 250 pounds if female?

## SECTION 3: MONTHLY EFT PAYMENT AND AUTHORIZATION AGREEMENT

REQUIRED IF MONTHLY EFT PAYMENT WAS SELECTED

**Payor Name or Depositor:** (Please print)

FIRST MIDDLE LAST

**Signature of Primary Payor:** **Date:**

**Name of Financial Institution:**

**Specify type of account:** ☐ Checking or ☐ Savings **Checking/Savings Account Number:**

**Payor Relationship to Applicant:** ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other _____

**ABA 9 Digit Routing Number:** (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 Health Plan 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.

## SECTION 4: CREDIT CARD PAYMENT AND AUTHORIZATION AGREEMENT

REQUIRED IF FULL PAYMENT BY CREDIT CARD WAS SELECTED - **PRODUCER PAYMENTS ARE NOT ACCEPTED**
THE PLAN APPLIED FOR IS NOT AN EMPLOYER SPONSORED GROUP HEALTH PLAN.

☐ **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.

I authorize Celtic Insurance Company to bill my account for the Total Premium Payment and I agree to pay the Total Premium Payment billed in accordance to my payment method selected above on this application:

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

Authorized Signature: _____

Cardholder's Name: (Please print) _____

## SECTION 5: AGREEMENT AND SIGNATURE

**PLEASE READ, SIGN AND DATE:**

1. **TRUE AND COMPLETE:** My answers to the questions on this application 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 Health Plan.
2. **PRE-EXISTING CONDITIONS:** I understand that the Certificate or Policy applied for will not pay benefits for any expense incurred on account of any pre-existing conditions, in accordance with the terms of the contract.
3. **EFFECTIVE DATE:** I understand that I/we must be in the U.S. at the time the application is signed in order for overseas claims to be considered eligible expenses. I understand that the insurance will become effective the later of (A) 12:01 a.m. on the day following the postmark date stamped on the application envelope addressed to Celtic, OR (B) 12:01 a.m. on the requested effective date. I also understand that the coverage may be rescinded, meaning that coverage will be void and no claims paid, for any false or misleading information on this application. I understand that no premium will be refunded if I do not need the full benefit period selected. Note: Application is valid within 30 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. **PREFERRED PROVIDER ORGANIZATION:** I understand if I have selected a PPO plan 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.
6. **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. However, such information does not include psychotherapy notes (as defined by 45 C.F.R. §164.501). This information will be used by Celtic to determine eligibility for insurance and make benefit 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 failure to sign this authorization may result in the denial of my application for coverage or eligibility for benefits.

   I understand that I can revoke this authorization, as described in Celtic's HIPAA Notice of Privacy Practices for Protected Health Information (PHI), 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 photocopy of this authorization shall be considered as valid as the original.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalty.**

Signature of APPLICANT: _____

Signature of SPOUSE: _____

Date: _____

## SECTION 6: PRODUCER INFORMATION

**You must be currently licensed and appointed with Celtic in the state where the application was completed.**

**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:** Tony Novak NAIC #2048780 | **Producer Number:** |
|---|---|
| **Address:** | |
| CITY | TATE ZIP |
| **Telephone Number:** (Including Area Code) | **Fax Number:** (Including Area Code) |
| **Email:** | |

**Mail this application to: Celtic Insurance Co., P.O. Box 26110, Little Rock, AR 72221**
(Note: metered mail is not an acceptable postmark)

CELTIC®

**Insured by Celtic Insurance Company**

Celtic Group Company