

SECTION 2: HEALTH QUESTIONS

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

<input type="checkbox"/> YES	<input type="checkbox"/> 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?																																																																																																											
<input type="checkbox"/> YES	<input type="checkbox"/> 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)																																																																																																											
		<table border="0"> <tr> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td></td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> </tr> <tr> <td>a.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>g.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Heart attack, Angina, or other heart or circulatory disorder</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>h.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Stroke</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>i.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Hypertension (high blood pressure)</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>j.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Diabetes</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>e.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>k.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Cancer or Tumors</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>f.</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td></td> <td>Liver disorders</td> <td></td> <td></td> <td></td> </tr> </table>	Y	N		Y	N	a.	<input type="checkbox"/>	<input type="checkbox"/>	g.	<input type="checkbox"/>	<input type="checkbox"/>			Heart attack, Angina, or other heart or circulatory disorder		<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	b.	<input type="checkbox"/>	<input type="checkbox"/>	h.	<input type="checkbox"/>	<input type="checkbox"/>			Stroke		<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	c.	<input type="checkbox"/>	<input type="checkbox"/>	i.	<input type="checkbox"/>	<input type="checkbox"/>			Hypertension (high blood pressure)		<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	d.	<input type="checkbox"/>	<input type="checkbox"/>	j.	<input type="checkbox"/>	<input type="checkbox"/>			Diabetes		<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	e.	<input type="checkbox"/>	<input type="checkbox"/>	k.	<input type="checkbox"/>	<input type="checkbox"/>			Cancer or Tumors		<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/>	<input type="checkbox"/>	f.	<input type="checkbox"/>	<input type="checkbox"/>						Liver disorders			
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<input type="checkbox"/> YES	<input type="checkbox"/> NO	4. Have you or any person applying for coverage ever been treated for or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS or other immune system disorder, or ever tested positive by a medical professional for antibodies to the Human Immunodeficiency Virus (HIV)?																																																																																																											
<input type="checkbox"/> YES	<input type="checkbox"/> 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?																																																																																																											
<input type="checkbox"/> YES	<input type="checkbox"/> 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?																																																																																																											
<input type="checkbox"/> YES	<input type="checkbox"/> NO	7. Are you or any person applying for coverage enrolled in training for or engaged in college-level, semi-pro or professional athletics?																																																																																																											
<input type="checkbox"/> YES	<input type="checkbox"/> NO	8. Have you or any person applying for coverage been denied insurance due to any health reasons that are still present?																																																																																																											
<input type="checkbox"/> YES	<input type="checkbox"/> 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 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	Producer Number:	
Address:	NAIC #2048780		
<small>CITY</small>	<small>STATE</small>	<small>ZIP</small>	
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)



Insured by Celtic Insurance Company

Celtic Group Company