



PreferredOne For Individuals and Families

How to Apply:

- Complete the enclosed application, being sure to answer all questions completely. **Important: for any/all yes answer on page 5/section A, you must have complete corresponding information on page 6/section B. Be sure to include reason for visit, results of physicals or test (i.e. results normal) any date of complete recovery if applicable.**
- Important:** Page 7/section D must be filled out in it's entirety with the name of your primary care physician including date of your last physical exam along with the results.
- You are required to complete the Electronic Payment Plan (EPP Form) on page 9 and return it along with a voided check.
- Sign the enclosed HIPPA Authorization form.

Effective Date:

- If you currently have coverage, choose an effective no more than 60 days in advance.

Underwriting Review:

- You will want to expect about one month for the underwriting review, some application do go quicker and some do take longer – up to 60 days.

Monthly Premium:

- Send a check for the first months estimated premium made out to PIC. This is required in order for your application to be processed.

Sending in the Application:

- Sign and date the application. **NOTE: The application MUST be received within 10 days of the signature date.**
- Return the application to us in the enclosed pre-paid envelope.
- So the we can provide you with application status updates, complete the following contact information:

Email Address: _____

Daytime Phone # _____

For a complete provider directory visit: <http://www.preferredone.com/>

We will be happy to assist you wherever possible. Please contact us at 952.224.0123.

There is no guarantee the coverage will be offered. PreferredOne will either decline coverage, or offer coverage at the published rates... **Do not cancel your existing medical policy until you have verification of your acceptance.** Should you be declined coverage from any private health insurer, you would in most cases qualify for the Minnesota Comprehensive Health Association (MCHA) health coverage (<http://www.mchamn.com/> for more information).



Individual Insurance Application Form For High Deductible Plans For Individuals and Families

Easy Application Process:

- Fill out the application form completely (pages 3 – 9), providing details to all YES answers. You may need to refer to your records or contact your medical provider for requested information. The Electronic Payment Plan (EPP) form must be completed, page 9.

NOTE: Please review the Eligibility Review Form on the next page before you begin the application process.

- Select the benefit option (see Individual product brochure).
- Coverage effective date will be, if approved:
 - The day the completed application is received by mail in the home office of PreferredOne; or
 - The day after the completed application is received in the home office of PreferredOne if delivered to the lobby or submitted electronically; or
 - A later date as requested on page 3 of the application. (You may select an effective date from the 1st through the 28th provided the date is not greater than 60 days from the signature date.)
- Enclose payment with your application.

For the first full month's estimated premium see page 3 for available options.

Your funds/account will be debited the estimated premium upon approval.

NOTE: If your policy is approved with an effective date other than the 1st of the month, the premium for that partial month will be pro-rated and applied to the next bank withdrawal.

- To release health history information to your agent, please complete the HIPAA Authorization Individual Underwriting Form on the last page of this brochure.

IMPORTANT: Do Not cancel existing coverage until written notice of approval of this application that begins on page 3 is received.

Eligibility Review Form

The following is a guideline in determining eligibility:

1. The applicant and/or any person to be insured has or ever had any of the ineligible medical conditions?
(Refer to www.preferredone.com for a complete list) Y / N
2. The applicant and/or any person to be insured is over the acceptable height/weight limits.
(See Height/Weight Chart below) Y / N
3. The applicant and/or any person to be insured is employed in an ineligible occupation.
(See Ineligible Occupation List below) Y / N
4. The applicant and/or any person to be insured is currently pregnant or an expectant parent.
(The mother is not eligible for coverage until two months after delivery)..... Y / N
5. The applicant and/or person to be insured has plans for extended foreign travel.
(Extended foreign travel is defined as three months or more; this includes students who travel abroad
or study overseas) Y / N
6. The applicant and/or any person to be insured is eligible for Medicare. Y / N
7. The applicant and/or any person to be insured has been a U.S. Citizen or an immigrant on visa status
for at least one year at the time this application is being made. Y / N

Height/Weight Chart

Male		Female	
Height	Max Ratings (lbs.)	Height	Max Rating (lbs.)
5' 01"	203	4' 09"	179
5' 02"	206	4' 10"	182
5' 03"	210	4' 11"	185
5' 04"	214	5' 00"	198
5' 05"	219	5' 01"	202
5' 06"	223	5' 02"	205
5' 07"	227	5' 03"	208
5' 08"	232	5' 04"	213
5' 09"	236	5' 05"	217
5' 10"	249	5' 06"	221
5' 11"	253	5' 07"	226
6' 00"	256	5' 08"	230
6' 01"	261	5' 09"	241
6' 02"	271	5' 10"	245
6' 03"	275	5' 11"	248
6' 04"	282	6' 00"	253
6' 05"	290		

Ineligible Occupation List

Applicants on medical disability are not eligible.

Active Military Personnel	Nuclear Industry Workers
Air Traffic Controllers	Offshore Drillers/Workers
Aviation & Air Transportation	Oil and Gas Exploration
Blasters or Explosive Handlers	and Drilling
Bodyguards	Pilots
Crop Dusters	(Stunt, Test or otherwise)
Firefighters/EMTs w/Fire Dept.	Professional Athletes
Hang Gliding	Sawmill Operators
Hazardous Material	Scuba Diving
Transporters/Handlers	Security Guards
Iron Workers	Steel Metal Workers
Law Enforcement Officers/ Private Detectives	Steeplejacks
Loggers	Strong Man Competitors
Meat Packers/Processors	Taxicab Drivers
Mining	Window Washers



Individual Insurance Application Form

P.O. Box 59212
Minneapolis MN 55459-0212
763.847.4477 1.800.997.1750

Agent Information

Agent Name _____

OFFICE USE ONLY

Application ID # _____

Premium amount sent: \$ _____

Member Information

Last Name (Legal Name)		First Name		MI	Date of Birth		Social Security Number		
Street Address/Apt. No.				City			State	Zip	
E-mail Address					Height		Weight		<input type="checkbox"/> Married <input type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Female
Telephone Number: Home			Telephone Number: Work			Telephone Number: Cell			
Occupation Applicant					Occupation Spouse				

Fill in the following information for each person requesting coverage, starting with yourself

LAST NAME ONLY IF DIFFERENT FROM ABOVE	FIRST NAME	M.I.	RELATIONSHIP	SEX (M or F)	DATE OF BIRTH			Ht	Wt	SOCIAL SECURITY NO.
					Month	Day	Year			
			Self							

If last name is different for dependents, please explain why: _____

Other than your spouse, are any of the above listed dependent(s) age 26 or older? No Yes If yes, list name(s) _____

I request coverage for: Self Spouse Children

Effective Date and Payment Selection

Requested Effective Date: _____

First month's estimated premium taken via (check one):

Automatic Electronic Payment Plan (EPP)
 Check
 Credit Card

Ongoing Payment Option (check one):

Monthly Automatic Electronic Payment Plan (EPP)
 Quarterly Billing
(only available with the 1st of the month effective date)

Chemical Dependency Related Disorders: I want to include at an additional cost, benefits for the diagnosis and treatment of chemical dependency related disorders including inpatient and outpatient services. I understand this election applies to all persons identified on this application. Eligibility for this option is only upon initial enrollment. No Yes

Do you or any family members listed below have other coverage in addition to this plan? No Yes

If yes, name _____ Single Family

Are you, your spouse or any dependent covered by Medicare Part A, Part B or Part D? No Yes

OTHER COVERAGE:

Do you or any family members included on this enrollment form currently have or have you had continuous health coverage for the last 12 months? No Yes If yes, complete section below

PROPOSED INSURED'S NAME	COMPANY NAME	GROUP/ INDIVIDUAL/ COBRA	TYPE OF COVERAGE	EFFECTIVE DATE	TERMINATION DATE

If you, your spouse or any of your dependent applicants have past or current medical coverage through a contract or plan issued or administered by PreferredOne Community Health Plan (PCHP), PreferredOne Administrative Services, Inc. (PAS), or PreferredOne Insurance Company (PIC), by executing and submitting this application, you give PIC/PCHP permission to view all claims history for you, your spouse and dependents as a result of such coverage except for claims history that PAS obtained acting in its capacity as a Preferred Provider Organization (PPO). For proprietary reasons, PPO claims history information will not be reviewed as part of the PIC/PCHP underwriting process. Regardless of what type of coverage you have now or previously had through a PreferredOne entity, you must answer all questions on all parts of the Health Information questionnaire portion of this application fully and completely even if you believe that a PreferredOne entity has such information already.

COVERAGE SELECTION:

I am applying for one (1) of the following calendar-year deductible options:

Options:	<input type="checkbox"/> PIC 5450	<input type="checkbox"/> PIC 5510	<input type="checkbox"/> PIC 5700	<input type="checkbox"/> PIC 5515
Single Contract Deductible	\$4,500	\$5,500	\$7,000	\$15,000
OR				
Family Contract Deductible	\$9,000	\$11,000	\$14,000	\$25,000

Health Information

A. Complete information is required below for each applicant. If you answer YES to any of these questions, please explain in section B, indicating which applicant the YES answer involves. Please attach a separate sheet if additional space is needed.

Have you or any family member applying for coverage:	YES	NO
1. Had an electrocardiogram, chest x-ray, CT scan, MRI scan or blood test or any other diagnostic testing of any kind or been hospitalized in the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
2. Been declined, charged additional premium, or had benefits excluded by any health or life insurance company in the last 10 years?	<input type="checkbox"/>	<input type="checkbox"/>
3. Used tobacco products of any kind or nicotine cessation products during the last 24 months? If yes, indicate whom below. <input type="checkbox"/> You <input type="checkbox"/> Your spouse <input type="checkbox"/> Both you and your spouse	<input type="checkbox"/>	<input type="checkbox"/>
B. Have you or any family member applying for coverage had any diagnosis of, received treatment, services or supplies for, or consulted with a physician or practitioner concerning:	YES	NO
4. Respiratory or lung disorders, including but not limited to asthma, allergies, COPD, emphysema, chronic bronchitis, tuberculosis, or sleep apnea in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
5. Musculoskeletal disorders or injuries, including but not limited to back disorders or injuries, scoliosis, temporomandibular joint disorder (TMJ), fibrositis, fibromyalgia, carpal tunnel syndrome, gout, arthritis, joint disorders or injuries, or amputation in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
6. Blood disorders, including but not limited to anemia, leukemia or hemophilia in the past five years.	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you or any family member applying EVER been treated for or diagnosed as having cancer? Tumors, cysts, polyps or growths in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
8. Emotional, mental or personality disorders, including but not limited to, depression, anxiety, adjustment disorders, eating disorders, attention deficit disorders, hyperactivity, behavioral, or psychotic disorders in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
9. Nervous system disorders, including but not limited to epilepsy, fainting, dizziness, seizures, multiple sclerosis, paralysis, headaches, migraine or any other disease or disorder of the brain or nervous system in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
10. Endocrine or glandular disorders or injuries, including but not limited to, diabetes, thyroid, adrenal, pituitary, pancreas, or lymph node/gland enlargement in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
11. Heart or circulatory system disorders including but not limited to, high blood pressure, heart attack, heart murmur, blood clots, chest pain, irregular heartbeat, stroke, varicose veins, phlebitis or elevated cholesterol in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
12. Digestive disorders or injuries, including but not limited to, stomach, liver, gallbladder, intestinal, ulcer, colitis, hernia, hepatitis, chronic diarrhea, jaundice, cirrhosis, rectum or any treatment for obesity, including bariatric surgery in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
13. Any disease or disorder of the eyes, ears, nose, throat, tonsils or sinuses including but not limited to, hearing impairment, cataracts or otitis media.	<input type="checkbox"/>	<input type="checkbox"/>
14. Reproductive system disorders, including but not limited to, any disease or disorder of the breast or reproductive organs (male and female), complication of breast implants, infertility, abnormal menstrual periods, or sexually transmitted disease in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any female applying been instructed to have a repeat pap smear or any follow-up treatment or testing as a result of an abnormal pap smear?	<input type="checkbox"/>	<input type="checkbox"/>
16. Had surgery, diagnostic testing, treatment or referral to a medical care provider recently completed or recommended or scheduled that has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>
17. Immune system disorders, including but not limited to, HIV positive, AIDS, lupus, collagen disease, scleroderma, or any other connective tissue disease?	<input type="checkbox"/>	<input type="checkbox"/>
18. Renal disorders or injuries, including, but not limited to, kidney, bladder, prostate or urinary disorders or injuries in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
19. Congenital or developmental disorders or injuries, including but not limited to, cleft palate, club foot, congenital heart defects, chromosomal abnormalities, physical or cognitive delays or autism?	<input type="checkbox"/>	<input type="checkbox"/>
20. Skin disorders, acne, psoriasis, warts, or other in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
21. Inpatient or outpatient treatment for, or participation in any organization for the abuse of alcohol or drugs, or been convicted for or had a drivers' license suspended for DWI/DUI or moving violation in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
22. Been advised by a health care professional to modify or quit the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
23. Any injury as a result of an accident including but not limited to motor vehicle, motorcycle, ATV or blunt force in the past 24 months?	<input type="checkbox"/>	<input type="checkbox"/>
24. A medical condition or injury in the last five years not already listed on this application?	<input type="checkbox"/>	<input type="checkbox"/>
25. Does any person have any fixation/prosthetic devices presently, including but not limited to plates, screws, pins, implants (including breast implants), shunts, pacemakers or valve replacements?	<input type="checkbox"/>	<input type="checkbox"/>
26. Is any family member now pregnant, an expectant mother or father, have a daughter who is currently pregnant (even if not applying), in the process of adopting a child, or undergoing infertility treatment?	<input type="checkbox"/>	<input type="checkbox"/>
27. Any condition that may require medical, surgical, or hospital care?	<input type="checkbox"/>	<input type="checkbox"/>
28. Is any family member applying currently disabled or receiving disability or workers compensation benefits?	<input type="checkbox"/>	<input type="checkbox"/>

B. ADDITIONAL MEDICAL DETAILS:

If you have answered YES to any of the health questions, please complete this section. Give complete details, attach a separate sheet if additional space is needed.

Question #	Name of person	Date(s) occurred/treated	Remaining effects	Complete name and address of physician/hospital where treated

Explanations of "yes" answers to medical conditions. Include date of onset, name of condition, treatment and days in hospital.

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Explanations of "yes" answers to medical conditions. Include date of onset, name of condition, treatment and days in hospital.

C. MEDICATIONS:

Please list all medications taken for any proposed insured in the past 24 months.

Name	Drug Name	Condition	Currently taking? (Yes or No)	Dosage

D. REGULAR PHYSICIAN:

Please list regular physician or medical practitioner for each proposed insured: (If none, provide last doctor seen, date, reason and results.) Attach additional sheet if necessary.

Primary Proposed Insured's Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Spouse's Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason and Results _____

Date of Last Routine Physical _____ Results _____

PreferredOne Insurance Company complies with the Minnesota Insurance Fair Information Reporting Act. In compliance with this law, this notice is to inform the applicant that during the health underwriting process personal information about the applicant may be collected from persons other than the applicant. The information collected by PreferredOne Insurance Company or the insurance broker may, in certain circumstances, be disclosed for health underwriting purposes to third parties without authorization of the applicant, but only if permitted by applicable state and federal privacy laws. The applicant has a right to see the personal information collected about the applicant in the health underwriting process, and there is a procedure by which the applicant may correct inaccurate personal information collected. For further information about these rights, contact the PreferredOne Insurance Company individual sales customer service area.

On behalf of myself, my spouse and my dependent applicants, I authorize any insurer, Medicare or Medicaid program, pharmacy, health benefit plan manager or administrator, physician, medical practitioner, hospital, clinic, veterans' administration facility, any third-party database provider, any medically related organization or entity, PreferredOne Insurance Company and its affiliates (PreferredOne Community Health Plan and PreferredOne Administrative Services, Inc. (PAS)), who has treated or has claim history (other than claim history that PAS obtained acting in its capacity as a preferred provider organization) or has medical information about me, my spouse, and/or my dependent applicants, to release to PreferredOne Insurance Company information as to diagnosis, treatment, and prognosis with respect to any physical or mental conditions of me (or, if requested, my dependent applicants) for insurance underwriting and plan administration purposes. On behalf of myself, my spouse and my dependents, I, my spouse and my dependents further agree to authorize, execute and submit all authorizations and releases required by any insurer, Medicare or Medicaid program, pharmacy, health benefit plan manager or administrator, physician, medical practitioner, hospital, clinic, veterans' administration facility, any third-party database provider, or any medically related facility who has treated, has claim history or has medical information about me, my spouse and/or my dependents to release to PreferredOne Insurance Company information as to diagnosis, treatment and prognosis with respect to any physical or mental conditions of me or if requested, of my spouse or dependents for insurance underwriting purposes and/or plan administration purposes. These authorizations exclude the release of information about HIV (AIDS virus) tests which were administered: 1) to a criminal offender or crime victim as a result of a crime that was reported to the police; 2) to a patient who received the services of emergency medical personnel at a hospital or medical facility; or 3) to emergency medical personnel who were tested as a result of performing emergency medical services. This authorization also excludes psychotherapy notes.

This authorization shall remain valid as long as I am continually covered by the medical plan in which I am enrolling with this form. I agree that a copy of this authorization shall be valid as the original. Information released pursuant to this authorization is released to an entity subject to the Health Insurance Portability and Accountability Act (HIPAA). This authorization may be revoked at any time by submitting a written revocation to PreferredOne Customer Service. Such revocation will not effect actions taken prior to the revocation. Because this authorization is for underwriting, risk rating, and enrollment purposes, revocation of this authorization or failure to give this authorization may result in denial or termination of coverage.

I understand and agree that payment of a claim does not preclude the right of PreferredOne Insurance Company to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

I represent to the best of my knowledge and belief that the answers to the questions and statements made on this application are true and complete and agree that any telephone conversations required to clarify information on this application will become a part of this application.

I understand and agree that if PreferredOne Insurance Company approves this application, coverage will be issued under an individual contract for myself and all family members. I understand and agree that PreferredOne Insurance Company does not issue individual coverage through any arrangement with an employer. PreferredOne Insurance Company is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

I agree to notify PreferredOne Insurance Company of any change and I understand that I must update this form and resubmit it if anything changes to my (or my dependent applicants) health condition that affects the information on this form between submission of the form and effective date of coverage. I understand and agree that PreferredOne Insurance Company will act in reliance upon the information I have provided herein. I understand that providing false information or omission of relevant information on this form which materially affects either the acceptance of risk or hazard assumed by PreferredOne Insurance Company may result in denial of claims, retroactive cancellation of coverage, or an increase in premiums, and may be considered insurance fraud. I understand that, subject to the terms and conditions of the contract under which I am enrolling for coverage, I may be subject to a pre-existing condition limitation.

Applicant's signature	Date	Print full name
Spouse's signature (if applying for coverage)	Date	Print full name
Dependent signature (if over 18 & applying for coverage)	Date	Print full name
Dependent/guardian signature (if minor(s), with legal guardian)	Date	Print full name
Agent's signature (if applicable)	Date	Print full name

How to Elect Your Initial Payment Option and Ongoing Payments:

Initial Payment (*check one*):

<input type="checkbox"/> I have enclosed a check with my application form.
<input type="checkbox"/> Authorization via Credit Card - Credit Card Type (<i>check one</i>): <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard
Name of Credit Card Holder (first and last) _____
Street Address _____
City _____ State _____ Zip _____
Credit Card Number: _____ Expiration Month/Year: _____
<i>(This option is only available for the initial monthly estimated premium)</i>
<input type="checkbox"/> Electronic Payment Plan (EPP) Authorization Form*
Name on Bank Account _____
Bank ABA/Routing Number _____
Bank Account Number _____
Bank Name _____
Print Name of Applicant _____
Signature of Bank Account Holder _____ Date _____
Signature of Bank Account Holder (<i>if joint account</i>) _____

Ongoing Payments (*check one*):

<input type="checkbox"/> Billed to My Address Quarterly
<input type="checkbox"/> Monthly Electronic Payment Plan (EPP)*
<i>(I have completed the EPP Authorization above)</i>

Note any shortfall or overpayment on the initial premium payment will be reconciled with your first quarterly billing or first scheduled monthly EPP.

***Electronic Payment Plan (EPP)**

PreferredOne Insurance Company (PIC) offers its Electronic Payment Plan (EPP) premium collection feature. This service utilizes the Automated Clearing House (ACH) system to effectively and accurately debit your designated account each payment cycle. The ACH funds transfer system is used nation-wide by member financial institutions. On or near the 8th of each month we will initiate a funds transfer from your account for the amount due. This process will continue on a monthly basis during the policy period. In the event your account lacks sufficient funds, additional fund transfers from your account will occur. You may be charged up to a \$25 processing fee for each occurrence.

If you have questions, please contact PIC at 763.847.4477 or 1.800.997.1750.

PreferredOne Insurance Company

6105 Golden Hills Drive
Golden Valley, MN 55416
763.847.4477 1.800.997.1750



**NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE
MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW**

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway Suite 101
White Bear Lake, MN 55110
Phone Number: 651.407.3149 Fax Number: 651.407.3150

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to \$500,000. Subject to this \$500,000 limit, the guaranty association will pay up to \$500,000 in life insurance death benefits, \$130,000 in net cash surrender and net cash withdrawal values for life insurance, \$500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, \$410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be \$500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than \$10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed \$10,000,000, the \$10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THIS POLICY OR CONTRACT IS NOT PROTECTED BY THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE MINNESOTA INSURANCE GUARANTY ASSOCIATION. IN THE CASE OF INSOLVENCY, PAYMENT OF CLAIMS IS NOT GUARANTEED. ONLY THE ASSETS OF THIS INSURER WILL BE AVAILABLE TO PAY YOUR CLAIM.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.



HIPAA Authorization Individual Underwriting Form

Mail form to: Attn: Individual Underwriting
PreferredOne Insurance Company
6105 Golden Hills Drive
Golden Valley MN 55416

Or

Fax form to: 763.847.4012
Attn: Individual Underwriting

I authorize PreferredOne Community Health Plan, PreferredOne Administrative Services, Inc., and/or PreferredOne Insurance Company to use or disclose the following specific protected health information, for the purposes and to the parties described below.

1. Below describes the information you are giving us permission to use or disclose. Copies of any and all written or electronic documents or communications concerning my application for an individual insurance policy submitted to PreferredOne Insurance Company. If my application is rejected in whole or part, I understand that the letter denying my coverage will include specific information about the health conditions of me or my spouse or dependents, and I hereby authorize release of that information.
2. Please identify the person, entity or agency you authorize to receive this information. If my agent works with a general agency, I authorize the release of this information to both the agent listed below and the general agency of the agent. List full name and address of the entity the information will be released to.

Name: _____

Address: _____

3. I release this information so that the individual(s) or entities named in #2 above can work with me to secure health insurance coverage for me and/or my spouse and dependents.
4. Please enter a date or describe how long you want this authorization to remain valid. In no case will your authorization be valid for more than 1 year from the date signed. The authorization shall remain in effect until: _____. If no date is provided, this authorization shall remain valid for one year after it is signed, or until any contract of insurance issued as a result of this application ends, whichever comes first.

I understand and agree that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing at any time by contacting PreferredOne Insurance Company at the address above.
- Information I used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
- Issuance of the contract or eligibility for benefits may be conditioned on signing this authorization for underwriting and risk determinations prior to coverage or issuance of the contract. I will be informed if my eligibility is conditioned on my signing this authorization.
- Please retain a copy of this form for your records.

This authorization must be signed by the individual who is the subject of the protected health information or the personal representative with authority to sign for the individual.

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Signature: _____ Date: _____

