Individual and Family Insurance Application Form

Deductible Plans • Copay Plans

Easy Application Process

- Fill out the application form completely. All adults including dependents age 18 and older must sign the application form.
- Select the benefit option on the Coverage Selection page.

Coverage Effective date

- Effective dates are available the first of the month.

  Example: If your application form is received on or before December 15th, your coverage can be effective January 1st. If your application form is received the 16th through the 31st of December your coverage will be effective February 1st.

Enclose Payment with your Application.

- See page 2 for available choices.
- Your funds/account will be deposited/debited for the initial month's premium upon issuance.

General Information

- Summary of Benefit and Coverage (SBC) documents are available online at www.preferredone.com/individualplan for viewing or you can call Customer Service at 763-847-4477 or 1-800-997-1750 to have an SBC mailed to you.
- Open enrollment dates: 10-1-2013 to 3-31-2014.
- Applicants can apply outside of open enrollment within 60 days of a qualifying event. See page 3 for a list of qualifying events.

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PreferredOne®
INSURANCE COMPANY

Individual Insurance Application Form

P.O. Box 59212
Minneapolis, MN 55459-0212
763.847.3020 1.855.717.5267

AGENT INFORMATION

Agent Name

OFFICE USE ONLY
Application ID# ______________________________

APPLICANT INFORMATION

Last Name (Legal Name)	First Name	MI	Date of Birth	Social Security Number

Street Address/Apt No.	City	County	State	Zip

E-mail Address ❑ Married ❑ Single ❑ Male ❑ Female

Do you consent to receive subsequent information about this application and possible coverage by e-mail at the address shown? ❑ Yes ❑ No

Telephone Number Home:	Telephone Number Work:	Telephone Number Cell:

Are you a U.S. Citizen or U.S National? ❑ Yes ❑ No

If you aren't a U.S. Citizen or U.S. National, do you have eligible immigration status? ❑ Yes ❑ No

If yes, fill in your immigration document type and ID number:
Document Type: ______________________ Document ID Number: __________________________

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 Month	Day	Year	SOCIAL SECURITY NUMBER
			Self					

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

I request coverage for: ❑ Self ❑ Spouse ❑ Domestic Partner ❑ Children ❑ Grandchildren

EFFECTIVE DATE AND PAYMENT SELECTION

Requested Effective Date:____________ **Effective dates are only available the 1st of the month**

Sample Effective Date: If your enrollment form is received on or before December 15th, your coverage can be effective January 1st. If your enrollment form is received the 16th through the 31st of December your coverage will be effective February 1st.

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

❑ Automatic Electronic Payment Plan (EPP)
❑ Check
❑ Credit Card

Ongoing Payment Option (check one):

❑ Monthly Automatic Electronic Payment Plan (EPP)
❑ Monthly Billing
❑ Credit Card

TOBACCO USE QUESTION

Has any applicant, spouse or dependent child age 18 years or older within the last six months used on average four or more times per week any tobacco products? ❑ Yes ❑ No

If yes, Name of person(s).____

OTHER COVERAGE

1. Will you or any applying family members have or continue to have other coverage in addition to this plan? ❑ No ❑ Yes If yes complete section below.
2. Are you or any applying family members covered by Medicare Part A, Part B or Part D? ❑ No ❑ Yes If yes complete section below.

PROPOSED INSURED'S NAME	CARRIER	TYPE OF COVERAGE	EFFECTIVE DATE

APPLYING OUTSIDE THE OPEN ENROLLMENT PERIOD

If applying outside of the open enrollment period, what is the special enrollment qualifying event?

❑ Loss of minimum essential coverage
❑ Marriage
❑ Birth
❑ Adoption/placement for adoption
❑ Permanent move into Minnesota
❑ Permanent move into new Minnesota service area
❑ Newly eligible or ineligible for premium tax credit
❑ Change in eligibility for cost sharing reductions
❑ Other (describe) ____

Date of qualifying event ____________________

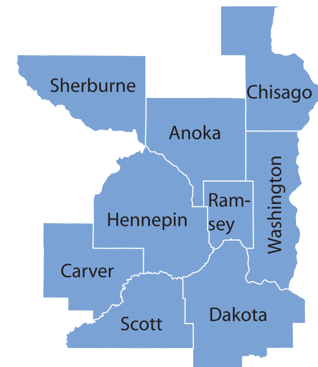
Proof of qualifying event must be provided.

COVERAGE SELECTION

Refer to product brochure for Plan highlights. The coverage selection must be completed in full or the application form will be returned for completion. Please follow the instructions below.

1. Select one of the Plan Types.
2. Select a network option, Choice State Wide or Select Metro Network (counties of Anoka, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, Sherburne, Washington).
3. Select a Plan Option/deductible level.

Select Network
(Twin City Metro)



INDIVIDUAL AND FAMILY PLANS – *These Plans are for Individuals and Families*

	Plan Type	Network Option		Plan Options	Deductible	
					Single	Family
Deductible and HSA Qualified Plans	❑	❑ Choice ❑ Select (Metro Network)	Coinsurance 100%	❑ Ultimate ❑ Signature ❑ Savers ❑ Afford ❑ Afford 2	$750 $2,000 $3,500 $5,700 $6,300	$1,500 $4,000 $7,000 $11,400 $12,600
PreferredOne 5 Office Copay Plans	❑	❑ Choice ❑ Select (Metro Network)	Office Copay $35 Coinsurance 100%	❑ Ultimate+ ❑ Signature+ ❑ Aspire+ ❑ Accent+	$1,000 $2,000 $3,600 $4,400	$2,000 $4,000 $7,200 $8,800
PreferredOne 2 Office Copay Plans	❑	❑ Choice ❑ Select (Metro Network)	Office Copay $50 Coinsurance 100%	❑ Afford+	$6,350	$12,700

These Plans are only for individuals and families in which all persons requesting coverage are under the age of 30.

	Plan Type	Network Option		Plan Option	Deductible	
					Single	Family
Catastrophic Plans - 3 PCP Copay Plans	❑	❑ Choice ❑ Select (Metro Network)	3 PCP Office Copays $35 Coinsurance 100%	❑ PreferredPlus	$6,350	$12,700

On behalf of myself (and if applicable), my dependent applicants, I authorize any insurer, Medicare or Medicaid program, medical provider, pharmacy benefit manager, health benefit plan manager or administrator, veterans' administration facility, any third-party database provider, any public records, any medically related organization or entity, MNsure, any other exchange, PreferredOne Insurance Company and its affiliates (PreferredOne Community Health Plan and PreferredOne Administrative Services, Inc. (PAS)), who has treated or has claim or payment history (other than claim history that PAS obtained acting in its capacity as a preferred provider organization) or has medical or other relevant information about me (and if applicable), and/or my dependent applicants, to release to PreferredOne Insurance Company information as to diagnosis, treatment, payment and prognosis with respect to any physical or mental conditions of me (or, if requested, my dependent applicants) for plan administration, payment or operations purposes. On behalf of myself (and if applicable), 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, medical provider, health benefit plan manager or administrator, veterans' administration facility, any third-party database provider, who has treated, has claim history or has medical information about me (and if applicable), 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, dependents for plan administration, payment or operations purposes. These authorizations exclude the release of information about HIV (AIDS virus) tests that 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). Re-disclosed information may not be protected under federal privacy rules. This authorization may be revoked at any time by submitting a written revocation to PreferredOne Customer Service. Such revocation will not affect actions taken prior to the revocation.

If applying as a domestic partner (2nd adult) the subscriber's domestic partner will be considered eligible as an eligible dependent of the subscriber provided that the subscriber and domestic partner; share the same permanent residence; are jointly responsible for basic living expenses; are not married to anyone and are each other's sole domestic partner with the intent to remain together indefinitely; are not related by blood closer than permitted under Minnesota marriage laws; are each mentally competent to consent to a contract; have completed or will complete a domestic partner affidavit form and have agreed or will agree to the conditions of such form. A domestic partner's child(ren) that qualifies as a dependent under IRS regulations will be considered eligible as an eligible dependant of the subscriber.

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

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 lawful action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

I understand and agree that if PreferredOne Insurance Company approves this application, coverage will be issued under an individual contract for myself (and if applicable), dependents listed on page 1. 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 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, rescission of coverage, or an increase in premiums, and may be considered insurance fraud.

Applicants signature	Date	Print full name
Spouses/Domestic Partner (if applying for coverage)	Date	Print full name
Dependent signature (if over 18 & 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
Agents signature (if applicable)	Date	Print full name

INITIAL PAYMENT OPTION **AND** ONGOING PAYMENT ELECTION

Step 1. Initial Payment *(check one)*

❑ **I have enclosed a check with my application form**

❑ **Authorization via Credit Card - Credit Card Type (check one):** ❑ Visa ❑ MasterCard ❑ American Express

Name of Credit Card Holder (first and last) ______________________

Street Address ______________________

City ______________________ State __________ Zip __________

Credit Card Number: ______________________ Expiration Month/Year: __________

❑ **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 (if joint account) ______________________

Step 2. Ongoing Payment *(check one)*

❑ **Monthly Bill to My Home Address** **or** ❑ **Monthly Bill to the following Address**

Name ______________________ Street ______________________

City ______________________ State __________ Zip __________

❑ **Authorization via Credit Card - Credit Card Type (check one):** ❑ Visa ❑ MasterCard ❑ American Express

Name of Credit Card Holder (first and last) ______________________

Street Address ______________________

City ______________________ State __________ Zip __________

Credit Card Number: ______________________ Expiration Month/Year: __________

❑ **Monthly Electronic Payment Plan (EPP)***

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 (if joint account) ______________________

***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

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 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.

PreferredOne®
INSURANCE COMPANY