ALTIUS ONE HEALTH PLAN APPLICATION

Please complete this form in its entirety. Any false statements or omission of facts can result in denial of claims and cancellation or termination of your policy from the date of enrollment.

10421 So. Jordan Gateway, Suite 400
South Jordan, Utah 84095

❑ Adding Dependent
❑ New Application
❑ Renewal with changes
Requested Effective Date: ____________________

I - APPLICANT INFORMATION

Name: Last:______________________________ First:_______________________ MI:______ Occupation: ______________________________

Street Address:____ E-mail Address:________________________________

City:_____________________________ State:______________ Zip Code:______________ Home Phone: (_______) _____________________

Spouse's Occupation:____ Applicant's Daytime Phone: (______) _______________

Marital Status: ❑Divorced ❑ Married ❑ Single ❑ Widowed

II - COVERAGE OPTIONS

Peak Qualified High Deductible Health Plan
❑ 80% ❑ 100%

Are you electing Altius One FlexChoice preferred Health Savings Account (HSA) vendor?
❑ Yes ❑ No

❑ Peak Plus 70%
Deductible Option:
❑ $1,000
❑ $2,000

❑ Peak Plus 80%
Deductible Option:
❑ $0
❑ $250
❑ $500
❑ $1,000

❑ Peak Plus Traditional (Deductible First)
Deductible Option:
❑ $500
❑ $1,000
❑ $2,000

Pharmacy Deductible Options
❑ No Deductible
❑ $250 Individual Deductible
❑ $500 Individual Deductible
❑ $1000 Individual Deductible

III - MEMBERS TO BE ENROLLED

To be eligible for coverage, children must be under 26, unmarried, and dependent upon you for 50% of their support. (Financial dependency not required for court-ordered dependent coverage.) ANY DEPENDENT NOT LISTED WILL NOT BE CONSIDERED FOR COVERAGE.

Social Security Number	Indicate Relationship	Last Name	First Name	MI	Birth Date	Age	M	F	Other Coverage (Circle Y or N) Medical	Rx	Medicare
	Applicant								Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N
									Y or N	Y or N	Y or N

IV - CURRENT & PRIOR INSURANCE COVERAGE

Do you or your dependent(s) have other health insurance? ❑ Yes ❑ No

If Yes: Name of Carrier: ___________________________________ Phone #: (____)______________________ Policy #: _________________

Policy Holder's Name:______________________________ Effective Date of Coverage:______________ End Date:_________________

Name(s) of covered dependents: ____

If this coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that Altius can determine whose coverage is Primary.

If No: When was the last date that you were insured?: ___________________________ Have you had prior coverage with Altius? ❑ Yes ❑No

If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) exclusion period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous carrier.

◆ **Submission of prior coverage information does not automatically waive any Pre-Existing Condition Limitation. However, you will be subject to an automatic 12-month Pre-Existing Condition Exclusion Period until we receive evidence of prior coverage.**

For Office Use Only
Agent/Broker ____ Effective Date_______________ Tier_________ Premium__________
PEC____ Payment Option: ❑ Automatic withdrawal ❑ Monthly billing
____

CHAL0060R05-07

V - HEALTH INFORMATION

EACH QUESTION MUST BE CHECKED "YES" OR "NO". This health statement must be complete or the application will be returned. Inaccurate health information may result in the policy being cancelled retroactively. It is your responsibility to notify Altius of any change in health status while the application is pending.

Respond to the following questions

	Question	Yes	No
1.	Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period? Date of last menstrual cycle ______________.	❏	❏
2.	Are you or your spouse financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?	❏	❏
3.	To the best of your knowledge, has any applicant been denied health or life insurance or been issued a modified or rated policy?	❏	❏

Within the past 12 MONTHS has any applicant:

	Question	Yes	No
4.	Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?	❏	❏
5.	Had a health condition, problem, or disorder for which medical advice or treatment has not been sought?	❏	❏
6.	Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?	❏	❏

Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:

	Question	Yes	No
7.	Physical, neurological, or neuromuscular impairments?	❏	❏
8.	Recurring headaches, migraines, head injury, epilepsy, seizures, or convulsions?	❏	❏
9.	Mental health counseling, psychotherapy, depression, stress, anxiety, mental health disorder, or chemical imbalance that required consultation or medication?	❏	❏
10.	Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?	❏	❏
11.	Eyes, ears, nose, sinus, or throat disorder?	❏	❏
12.	Jaw disorder?	❏	❏
13.	Allergies, hay fever, or adverse drug reactions and side effects?	❏	❏
14.	RSV, reactive airway disease, lung disease, or any other respiratory system disorder?	❏	❏
15.	Thyroid disorder, goiter, or any other lymph system disorder?	❏	❏
16.	Breast lumps, breast augmentation, or breast reduction?	❏	❏
17.	Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?	❏	❏
18.	Back, neck, spinal, or joint disorder?	❏	❏
19.	Connective tissue disorder?	❏	❏
20.	Hemophilia, anemia, blood or bleeding disorder?	❏	❏
21.	Obesity, bulimia, anorexia, or any other eating disorder?	❏	❏
22.	Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys, or pancreas?	❏	❏
23.	Hemorrhoids, polyps, or any other rectal disorder?	❏	❏
24.	Impotence, prostate or testicular disorder, or abnormal PSA?	❏	❏
25.	Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, or any other gallbladder or digestive disorder?	❏	❏
26.	Bladder or urinary disorder, or incontinence?	❏	❏
27.	Sexually transmitted diseases?	❏	❏

Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:

	Question	Yes	No
28.	Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, or pelvic inflammatory disease?	❏	❏
29.	Infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy (including premature births), or any other disorder of the reproductive system?	❏	❏
30.	Varicose veins, or any other circulatory disorder?	❏	❏
31.	Foot, knee, or bone disorder?	❏	❏
32.	Fracture or dislocation?	❏	❏
33.	Tobacco use (chewing or smoking)?	❏	❏
34.	Condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?	❏	❏
35.	Inability to work or to perform routine daily functions for more than 2 weeks (other than pregnancy)?	❏	❏

Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:

	Question	Yes	No
36.	Alcohol use/abuse, been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption?	❏	❏
37.	Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spinal bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis?	❏	❏
38.	Colitis, colostomy, or ilesotomy?	❏	❏
39.	Crohn's disease, lupus, gout, arthritis, fibromyalgia, or scleroderma?	❏	❏
40.	Cysts?	❏	❏
41.	Drug dependency, abuse, or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?	❏	❏
42.	Hospitalization or surgery?	❏	❏
43.	Stomach stapling, gastric bypass, or any surgical services for obesity?	❏	❏
44.	Tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?	❏	❏

Has any applicant EVER been diagnosed with or treated for any of the following:

	Question	Yes	No
45.	Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?	❏	❏
46.	Birth defect, premature birth, development or learning disability, mental impairment, Down syndrome, or autism?	❏	❏
47.	Cancer (including skin cancer) or tumors?	❏	❏
48.	Cirrhosis or hepatitis?	❏	❏
49.	Diabetes (type I or II)?	❏	❏
50.	Heart murmur, heart attack, bypass surgery, blood clot, stroke, heart surgery, or coronary artery disease?	❏	❏
51.	Immune system diseases, human immunodeficiency virus (HIV) acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?	❏	❏
52.	Joint replacement?	❏	❏
53.	Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?	❏	❏

List the height, current weight, and last year's weight for the applicant and spouse.

	Height	Current Weight	Last Year's Weight
APPLICANT:	_____ft _____in	________lbs	________lbs
SPOUSE:	_____ft _____in	________lbs	________lbs

IF ANY OF THE ABOVE CONDITIONS ARE CHECKED "YES", EXPLAIN IN THE SPACE PROVIDED ON THE FOLLOWING PAGE.

VI - RESIDENCY

Do any of the proposed insureds live, reside, work, or attend school outside the state of Utah at any time of the year? ❑ Yes* ❑ No

*If Yes, please explain: ____

VII - ADDITIONAL INFORMATION

For every “yes” answer in the health information section, complete the following information:

Question #	First name of individual receiving treatment	Diagnosis of illness, injury, treatment, testing, or medical attention	Start date mo/day/yr	End date mo/day/yr	Remaining symptoms or problems	Name of physician or hospital

VIII - PRESCRIPTION MEDICATION INFORMATION

First name of individual	Name of medication	Dosage	Start date mo/day/yr	End date mo/day/yr	Reason for medication	Name of prescribing physician

IX - AUTHORIZATION & ACKNOWLEDGEMENT

I hereby apply for coverage with Altius Health Plans (Altius) for the persons listed on this application (collectively referred to as Applicants). When incorporated with the policy, this application and the medical benefits brochure become part of the policy. Once fully signed and executed, Altius and I agree to the terms set forth in the policy. I understand that coverage is dependent upon my satisfaction of applicable underwriting criteria. I also understand that no coverage will be in force until each person listed above is approved by Altius, that no benefits will be provided for any services which begin before the coverage is effective, and that benefits will not extend beyond the termination of either my coverage or the policy.

CONSENT AT ENROLLMENT: I authorize 1) all health providers and insurers to furnish Altius, and 2) all health providers and Altius to furnish all insurers and health providers records concerning Applicants for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative may receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Altius. For purposes of collecting information for an insurance policy application, policy reinstatement, or a request for change in policy benefits, this authorization shall remain valid for 30 months from the date the authorization is signed.

I hereby declare that to the best of my knowledge and belief, the information given on this application, including the Health information in Sections V-VIII of this application is correctly recorded, true and complete. I understand that material omissions or misrepresentations regarding information provided on this application could cause an otherwise covered service to be denied and/or could void any coverage issued. If I subsequently become aware of information different from that provided in this application, I agree to provide that additional information promptly to Altius Health Plans. I understand that no agent or Altius representative is allowed to permit me to answer any questions inaccurately, untruthfully or incompletely, and I represent that such did not occur. I understand that it is my continuing responsibility to report to Altius changes in the eligibility of any Applicants who become members.

By signing this application, I agree on behalf of all Applicants that Altius may use or disclose to third parties the information contained on this application and individually identifiable health information relating to the Applicants for purposes of administering my health insurance benefits including treatment, payment, or health care operations, as those terms are explained in detail in the Altius Notice of Privacy Practices and to the extent permitted by law. My consent includes agreement for the use or disclosure of health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV). By signing this form, I also agree on behalf of myself and the other Applicants, to the extent permitted by law, health care providers, insurers, claims administrators, employers, and others may disclose the Applicants' personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness including substance abuse, AIDS, ARC, or HIV to Altius for administration of health insurance benefits including treatment, payment, or health care operations purposes and other purposes permitted by law.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE:
According to information you have furnished, you may intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Altius. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

1. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in a denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.
4. Failure to include all material medical information on an application may provide a basis for Altius to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

I understand the coverage for which I am applying excludes certain conditions/procedures for twelve months, regardless of whether or not they are pre-existing. I also understand that the coverage may limit or exclude conditions for which a family member or I have received, or have been recommended to receive, any medical advice, diagnosis, care, or treatment during the six months immediately preceding the date Altius receives my completed application, according to the pre-existing conditions limitations provisions of the policy. Both exclusion periods will be reduced by my prior creditable coverage, if applicable. I understand that this application will become part of the policy.

X - SIGNATURE

I have read and agree to the statements above.

Signature: ____ Date Signed: __________________________

XI - PAYMENT OPTION

Is any employer reimbursing or paying for any portion of this plan? ❑ Yes ❑ No

Are you self-employed? ❑ Yes ❑ No

If self-employed, do you have any part- or full-time employees? ❑ Yes ❑ No

Method of Payment

Please choose one of the following premium payment options:

❑ **Monthly Automatic Withdrawal (complete Section XII)**

❑ **Monthly Billing (a $5 administrative fee will be added to your monthly billing statement)**
Your first payment is due when your application is approved. You will receive a monthly billing statement by mail. Payment is due on the first day of each month.

A $25 service charge will be assessed if your check is returned or we cannot deduct the premium amount from your account due to insufficient funds.

XII - MONTHLY AUTOMATIC WITHDRAWAL

If you choose to pay by monthly automatic withdrawal, please attach your voided check or savings deposit slip here. Please complete the following:

I (we) authorize Altius Health Plans to initiate debit entries to my (our) ❑ Checking Account ❑ Savings Account

I (we) understand that debit entries will be submitted to my (our) account on or about the 10th of each month, regardless of my (our) Policy's effective date. I further understand that if my application is approved or accepted after the date coverage is to become effective, the first premium withdrawal may not occur until the 10th of the following month. When this happens, the first premium withdrawal will be twice the normal monthly amount to pay for both the first and second months of coverage.

Account Holder's Signature: ____________________________ Date: ____________________

MONTHLY AUTOMATIC WITHDRAWAL

PLEASE ATTACH A VOIDED CHECK OR VOIDED SAVINGS DEPOSIT SLIP HERE

Do not use a deposit slip for a checking withdrawal.
Checking deposit slips do not always contain the necessary routing information.

Important Note:

Coverage is not in effect until Altius Health Plans approves your application and determines an effective date.
We strongly suggest that you carefully consider the impact of changing coverage, and do not cancel any current coverage until you are officially notified by Altius Health Plans Inc. of approval. We reserve the right to reject coverage for any individual.

XIII - AGENT/BROKER AGREEMENT

I understand and agree that in acting as the agent/broker for this applicant:

1. The application was completed by the applicant.
2. I am in possession of a valid license issued by the State of Utah authorizing me to sell and service health insurance contracts.
3. I must be an Altius-appointed broker or agent to sell Altius One plans.
4. I have no authority to do the following: make, alter, interpret, or change an application or contract in the name of Altius Health Plans Inc.; or waive any of the terms or conditions of the contract.
5. I have no authority to assign effective dates or to effect membership changes.
6. Cancellation of this Health Care Agreement by either the subscriber or Altius Health Plans will terminate the Agency Agreement.

Agent/Broker Name: ____ Agency: ________________________________

Phone Number: (______) ________________ Date Signed: ____

Fax Number: (______) __________________ Email: ____

Agent/Broker Signature: ____

If you do not have an agent, please sign below and one will be assigned to you.

Applicant Signature: ____ **Date:** _________________________________

XIV - CHECKLIST

Send the following completed forms:

❑ Application

❑ Certificate of Creditable Coverage (This certificate is provided by your previous health insurance carrier and should be submitted to receive credit for your Pre-Existing Condition Exclusion Period. If you are currently covered with Altius Health Plans, this is not necessary.)

❑ Voided check for Monthly Automatic Withdrawal option

❑ Signature on Section X

You may submit your application to Altius through your Altius-appointed agent or broker, or directly to Altius Health Plans by facsimile, email, or mail.

Facsimile:
Altius One
801-323-6100

email:
altiusone@ahplans.com

Mail:
Altius Health Plans
Underwriting Department — Altius One
10421 South Jordan Gateway, Suite 400
South Jordan, UT 84095

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www.altiushealthplans.com