

HEALTHAMERICA OHIO INSURANCE TRUST
TRUST PARTICIPATION AGREEMENT

In order to receive a certificate evidencing insurance coverage for the undersigned and their dependents under a group sickness and accident insurance policy (the "Policy") issued to the HealthAmerica Ohio Insurance Trust (the "Trust"), and underwritten by Coventry Health and Life Insurance Company, a Delaware corporation doing business as "HealthAssurance", the undersigned requests participation in the Trust. If the undersigned's participation in the Trust is approved by the Trustee (the "Trustee"), then the undersigned is an Insured (as the term is defined in the Trust Agreement) effective as of the date that the Trustee signs this Trust Participation Agreement. But, the undersigned acknowledges and agrees that even if they are approved by the Trustee as an Insured, neither the undersigned nor their dependents are insured under the Policy, until each satisfies the specific eligibility requirements of the Policy, as determined by HealthAssurance. All undefined capitalized terms have the meaning given them in the Trust Agreement.

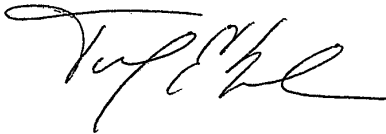
The undersigned acknowledges and agrees to be bound by all the terms and conditions of the Trust Agreement and Policy, as each may be amended from time to time, and specifically acknowledges and agrees: (a) to furnish any information that the Trustee or HealthAssurance requests and that is reasonably related to the proper administration of the Trust or Policy, (b) that they have no right, title or interest in or to the Trust Funds or the Policy, (c) benefits payable under the Policy are solely governed by the terms and conditions of the Policy and all claims and causes of action for benefits may only be asserted against HealthAssurance, and not against any other Insured, the Trust, or the Trustee, (d) Trustee has no rights or obligations under the Policy, (e) the undersigned may withdraw from the Trust and cancel coverage under the Policy upon 30 days prior written notice to the Trustee, (f) failure by an Insured to remit premium amounts when due automatically constitutes withdrawal and cancellation of all coverage effective as of the due date or last day of any applicable grace period, whichever is later.

The undersigned is executing this Trust Participation Agreement on the date set forth after their name.

Print: _____
Date: _____, 20____
Address: _____

ACCEPTED BY:

HEALTHAMERICA PENNSYLVANIA, INC.
As Trustee for the
HEALTHAMERICA OHIO INSURANCE TRUST



By: Timothy E. Nolan
Its: President and Chief Executive Officer
Date: May 1, 2009



**IMPORTANT NOTICE ABOUT
HEALTHAMERICAOne Insurance Product**

The insurance plan you are about to apply for (**HealthAmericaOne™**) is not an employer-sponsored health plan. Before you apply, you should be aware of the differences between employer-sponsored health plans and HealthAmericaOne.

HealthAmericaOne is offered through an out-of-state, Non-Employer Group Insurance Trust in Ohio. The trust is called the HealthAmerica Ohio Insurance Trust (“Trust”). It was set up to offer group health insurance to individuals who are not eligible for health care coverage through an employer.

The rules for Trusts are different from the rules for employer-sponsored health plans. A few of the differences are that HealthAmericaOne:

- Does not follow the rules of ERISA (Employee Retirement Income Security Act) or HIPAA (Health Insurance Portability and Accountability Act).*
- **Has a 12 month pre-existing condition exclusion.**
- **If You are accepted for Coverage, Your premium rate will be calculated to include any Pre-existing Medical Condition that You disclosed on Your Enrollment Form, and such conditions will be Covered under the terms of Your Group Contract beginning on Your Effective Date.**
- **Proof of prior creditable coverage does not reduce the exclusion.**
- Uses your health history to determine how much your premium will cost. This is called medical underwriting.
- Can deny you coverage because of medical treatment you had in the past.

A non-employer group insurance trust like HealthAmericaOne has more flexibility to accept individuals who might not be eligible for coverage by an individual plan because of medical underwriting.

I certify by my/our signature(s) below that I/we have read and understand the above information pertaining to HealthAmericaOne pre-existing condition information.

Signature (Primary Applicant)

Date

Signature (Spouse)

Date

Signature (Dependent over 18)

Date

Signature (Dependent over 18)

Date

Signature (Dependent over 18)

Date



Non-Employer Group PPO Plans for the HealthAmerica Ohio Insurance Trust
Underwritten by Coventry Health and Life Insurance Company

HealthAmericaOne
Received Date: _____

Submit completed Application for Health Coverage to:
HealthAmerica
Individual Marketing Dept.
11 Stanwix St. Suite 2300
Pittsburgh, PA 15222
or e-mail at: HAPAINdividualSales@cvty.com
Or by fax at: 1-866-669-2615

Application for Health Coverage

Important: Please print clearly in BLACK ink as instructed in each section. Initial and date corrections; correction fluid is not permitted. Read and sign the Acknowledgements Section on page 6.

Check all that apply:

- New Application Add a Dependent Plan Benefits Increase

Plan Choice

Choose one (1) plan only. If other individuals applying for coverage wish to apply for different plans, a separate Application must be used

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Copay 100% \$0 Ded \$20/\$40 12-11 | <input type="checkbox"/> Copay 90% \$2000 12-11 | <input type="checkbox"/> Rewards \$1750 | <input type="checkbox"/> Choice1 \$1250 12-11 | <input type="checkbox"/> QHDHP 100% \$1250 |
| <input type="checkbox"/> Copay 100% \$0 Ded \$25/\$50 12-11 | <input type="checkbox"/> Copay 90% \$750 12-11 | <input type="checkbox"/> Rewards \$2500 | <input type="checkbox"/> Choice1 \$2000 12-11 | <input type="checkbox"/> QHDHP 100% \$2500 |
| <input type="checkbox"/> Copay 100% \$1200 12-11 | <input type="checkbox"/> Copay 80% \$500 12-11 | <input type="checkbox"/> Rewards \$5000 | <input type="checkbox"/> Choice1 \$4000 12-11 | <input type="checkbox"/> QHDHP 100% \$3750 |
| <input type="checkbox"/> Copay 90% \$1000/ \$2K OOPM 12-11 | | | | <input type="checkbox"/> QHDHP 90 % \$1500 |
| | | | | <input type="checkbox"/> QHDHP 90 % \$3000 |

If you have selected an eligible HealthAmericaOne Qualified High-Deductible Health Plan (QHDHP), you are eligible to open a Health Savings Account (HSA) through our HSA trustee, Health Equity, upon approval.

- I elect to have an HSA opened through HealthEquity

Requested Effective Date: Day of HealthAmericaOne Approval OR ___ / ___ / 20 ___

Requested Effective Date must be after, but no MORE than sixty (60) days past the signature date of the Application. Requested Effective Date is not guaranteed.

Amount quoted for Requested Effective Date: \$ _____ / Month Individual Family

Note: The amount quoted is an estimated cost of the selected health plan, which is subject to change based on medical history, the underwriting process, and, if any, other relevant factors.

Primary Applicant Information

Please provide information on the Primary Applicant. If applying for Child-Only coverage, please fill in the parent or legal guardian's information below.

Last name	First name			MI	Primary phone number () -
Home address	City	State	ZIP	County	
Mailing address (If different from address above)	City	State	ZIP	Best time and phone number to receive a call regarding this Application, if necessary: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Anytime (8am-8pm)	
E-mail address (if we may correspond with you via E-mail)	Occupation / Title			() -	
Relationship (if Child-Only Application)					

Applicant and Dependent Information

General Information List all individuals applying for health coverage in this section. For a Child-Only Application, begin listing child(ren) on Line 3 with the youngest child listed first. If you need more space, attach a separate sheet of paper with the details in the same format as the box below. Sign and date any attachments.

Full Name (Last, First, MI)	Social Security Number	Birthdate (mm/dd/yyyy)	Gender (M or F)	Height (ft. in.)	Weight (lbs.)	Tobacco use in past 12 months? ¹	U.S. residency 2 yrs? ²
1 Primary Applicant (blank if Child-Only)						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2 Spouse (blank if Child-Only)						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
3 Dependent Child or Child-Only						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
4 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
5 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							
6 Additional Child						<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Home address (if different from Primary Applicant)							

¹ 'Tobacco use' constitutes use of tobacco or tobacco cessation products in the past twelve (12) months. ² 'U.S. residency' refers to the designated individual living legally in the United States for the past 2 years.

1 Prior Insurance Coverage	
Has any individual applying for coverage had any health insurance coverage in the past 2 years? If "Yes," list names, start and end dates below. _____	<input type="radio"/> Yes <input type="radio"/> No

Medical Information The Medical Details section requires your careful attention to each question. The questions below should be answered by you and not by any broker representing you. If you fail to provide truthful or accurate health history information you may lose your coverage or other penalties may apply. You may want to consult your physicians if you have questions regarding the information requested below

Answer questions on behalf of all individuals applying for coverage. Each individual applying for coverage needs to provide his or her own medical history. Only provide a family member's medical history if the family member is also applying for coverage on this Application. A person applying for coverage does not need to provide any genetic information (including genetic testing, genetic counseling, or genetic education).

Check "Yes" or "No," and provide additional information in the Medical Details section when necessary.

1 Physical Exam	
Has any individual applying for coverage had a physical or wellness exam within the past [6 months / 2 years]? If "Yes," provide details in the Medical Details section on Page 7.	<input type="radio"/> Yes <input type="radio"/> No
2 Pregnancy	

Primary Applicant Name: _____ 4 of 10 Agent Name: _____

Is any individual applying for coverage currently pregnant, expecting a child with anyone, an expectant or surrogate parent, or in the process of adopting a child? If "Yes," provide details in the Medical Details section on Page 7.	<input type="radio"/> Yes <input type="radio"/> No
3 Transplants	
Has any individual applying for coverage been a candidate or recipient of an organ or bone marrow transplant? If "Yes," provide details in the Medical Details section on Page 7.	<input type="radio"/> Yes <input type="radio"/> No
4 HIV / ARC / AIDS	
Has any individual applying for coverage ever tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having AIDS Related Complex / Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency?	<input type="radio"/> Yes <input type="radio"/> No

Check all that apply. In the past 5 years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated or tested for, been advised to have treatment or testing for, been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any of the following? If nothing in a category applies, select the "None" box. Provide details for all checked items (including "Other") in the Medical Details section on Page 7.

5 Cancer / Cyst / Tumor		
<input type="radio"/> Carcinoma, sarcoma, leukemia, lymphoma, myeloma, central nervous system cancers or carcinoma in situ	<input type="radio"/> Cyst, growth, lump, mass, tumor or polyp <input type="radio"/> Other	<input type="radio"/> None
6 Respiratory System		
<input type="radio"/> Allergies or asthma <input type="radio"/> Emphysema or chronic lung disease (COPD)	<input type="radio"/> Sleep apnea <input type="radio"/> Other	<input type="radio"/> None
7 Cardiovascular and Circulatory System		
<input type="radio"/> Hypertension or high blood pressure <input type="radio"/> Deep Venous Thrombosis or phlebitis <input type="radio"/> Varicose veins, blood clot or aneurysm	<input type="radio"/> Irregular heartbeat, heart murmur, or mitral valve prolapse <input type="radio"/> Heart attack, chest pain or angina <input type="radio"/> Other	<input type="radio"/> None
8 Digestive System		
<input type="radio"/> Chronic abdominal pain, ulcer, acid reflux or hiatal hernia <input type="radio"/> Diverticulitis, diverticulosis, hemorrhoids, or hernia <input type="radio"/> Disorder of the esophagus, stomach, colon, rectum, intestine, bowel, gallbladder or pancreas	<input type="radio"/> Liver condition or hepatitis A <input type="radio"/> Cirrhosis, fatty liver or hepatitis B or C <input type="radio"/> Surgical treatment for obesity, gastric bypass or banding <input type="radio"/> Other	<input type="radio"/> None
9 Emotional or Mental Health		
<input type="radio"/> Anxiety or depression <input type="radio"/> Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder <input type="radio"/> Bipolar disorder	<input type="radio"/> Obsessive Compulsive Disorder, schizophrenia <input type="radio"/> Eating disorder <input type="radio"/> Therapy or counseling <input type="radio"/> Other	<input type="radio"/> None

10 Muscular or Skeletal System		
<input type="radio"/> Bursitis, tendonitis or gout <input type="radio"/> Disorder of the back, neck or spine <input type="radio"/> Connective tissue disorder, systemic lupus, rheumatoid arthritis <input type="radio"/> Fibromyalgia <input type="radio"/> Disorder of the knee, shoulder, hip or other joint <input type="radio"/> Osteoarthritis, osteoporosis or osteopenia	<input type="radio"/> Temporomandibular joint disorder (TMJ) <input type="radio"/> Fractures or broken bones <input type="radio"/> Prosthetic limbs or devices, or internal fixations (pins, plates, screws) <input type="radio"/> Any chiropractic treatments <input type="radio"/> Other	<input type="radio"/> None
11 Skin		
<input type="radio"/> Acne or rosacea <input type="radio"/> Eczema or psoriasis	<input type="radio"/> Abnormal or cancerous moles, melanoma <input type="radio"/> Other	<input type="radio"/> None
12 Eyes / Ears / Nose / Throat		
<input type="radio"/> Disease or injury of eye <input type="radio"/> Cataracts or glaucoma <input type="radio"/> Ear disorder, ear infections or tubes in ears <input type="radio"/> Hearing loss or cochlear implant	<input type="radio"/> Deviated septum or sinus infection <input type="radio"/> Disorder of the throat, tonsils or adenoids <input type="radio"/> Other	<input type="radio"/> None
13 Kidney or Urinary Tract		

Primary Applicant Name: _____ 5 of 10 Agent Name: _____

<input type="radio"/> Bladder or urinary tract infection or disorder <input type="radio"/> Kidney infection or disorder	<input type="radio"/> Kidney or bladder stones <input type="radio"/> Other	<input type="radio"/> None
14 Female Reproductive System		
<input type="radio"/> Disorder of the breast or abnormal mammogram <input type="radio"/> Saline breast implants <input type="radio"/> Silicone breast implants <input type="radio"/> Abnormal Pap smear <input type="radio"/> Endometriosis, uterine fibroids or uterine prolapse	<input type="radio"/> Infertility or complications of pregnancy <input type="radio"/> Menopausal disorder <input type="radio"/> Menstrual disorder <input type="radio"/> Cervical, ovarian, uterine or vaginal disorder <input type="radio"/> Other	<input type="radio"/> None
15 Male Reproductive System		
<input type="radio"/> Infertility <input type="radio"/> Penile or testicular disorder	<input type="radio"/> Prostate disorder, elevated PSA, Prostatitis <input type="radio"/> Other	<input type="radio"/> None
16 Sexually Transmitted Diseases		
<input type="radio"/> Chlamydia <input type="radio"/> Genital warts <input type="radio"/> Genital herpes	<input type="radio"/> Human Papilloma Virus (HPV) <input type="radio"/> Gonorrhea or syphilis <input type="radio"/> Other	<input type="radio"/> None
17 Blood / Adrenal / Endocrine / Pituitary / Thyroid		
<input type="radio"/> Anemia <input type="radio"/> Diabetes <input type="radio"/> Elevated blood sugar <input type="radio"/> Elevated cholesterol or triglycerides	<input type="radio"/> Endocrine, adrenal, or pituitary disorder <input type="radio"/> Weight disorder <input type="radio"/> Thyroid disorder <input type="radio"/> Other	<input type="radio"/> None
18 Brain or Nervous System		
<input type="radio"/> Concussion or head injury <input type="radio"/> Migraines or chronic headaches <input type="radio"/> Convulsions, seizures, epilepsy, fainting, tics or tremors	<input type="radio"/> Stroke, Transient Ischemic Attack (TIA) or paralysis <input type="radio"/> Multiple sclerosis <input type="radio"/> Other	<input type="radio"/> None
19 Congenital or Development		
<input type="radio"/> Cleft palate or cleft lip <input type="radio"/> Developmental disorder or delay	<input type="radio"/> Mental retardation, autism, or Down's Syndrome <input type="radio"/> Other	<input type="radio"/> None
20 Alcohol / Drug		
<input type="radio"/> Alcohol abuse, dependency or alcoholism <input type="radio"/> Drug / substance abuse or dependency	<input type="radio"/> A citation or conviction for driving under the influence of alcohol or any drug / substance <input type="radio"/> Other	<input type="radio"/> None
21 Other Conditions		
In the past 5 years, has any individual applying for coverage experienced or been experiencing any persistent pain or symptoms, had symptoms of, been treated, been tested for (except for HIV), been advised to have treatment or testing for (except for HIV), been hospitalized for, had surgery for, taken medication for, or been advised that they have or may have had any other condition(s) not listed on this Application? If "Yes," provide details in the Medical Details Section on Page 7.		<input type="radio"/> Yes <input type="radio"/> No

Medical Details Please provide COMPLETE details for all questions with a "Yes" answer or a checked box in the Medical Information section. Provide the question number you are referencing in the first column. If you need more space, attach a separate sheet of paper with the details in the same format as the box below. Sign and date any attachments.

Q#	Name of Individual Applying for Coverage (Last, First, MI)	Explain Nature of Illness / Condition (include results of any physical exam)	Date of Onset (mm/yy)	Date of Recovery (mm/yy)	Remaining or Ongoing Symptoms or Treatment
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		
	Treating Physician's Name	Address	Phone Number		

Medications Please provide COMPLETE details for all medications (prescription or over-the-counter) currently being taken or that have been taken by (including samples), or were prescribed or recommended for, any individual applying for coverage in the past twelve (12) months. If you need more space, attach a separate sheet of paper with the details in the same format as the box below. Sign and date any attachments.

Name of Individual Applying for Coverage (Last, First, MI)	Date Started (mm/yy)	Date Discontinued (mm/yy)	Medication Name	Dosage and Frequency	Condition / Reason for taking

Primary Applicant Name: _____ 7 of 10 Agent Name: _____

Acknowledgements

By signing this Application form, I, the Applicant, including any undersigned Spouse and Dependents, agree to the following statements:

- I understand that all individuals applying for health coverage listed on this Application are subject to medical underwriting review. I understand that the selling agent (if applicable) has no authority to promise coverage to the applicant or any individual applying for coverage, or to modify HealthAmericaOne underwriting criteria or terms of coverage.
- I understand that the information that I provide on this Application will be used to determine whether HealthAmericaOne accepts my Application and so provides me with a policy of health coverage for which I'm applying I attest that my Application responses are complete and accurate to the best of my knowledge.
- I understand that if any material information is omitted or misrepresented from any section of the Application, coverage may be refused, terminated, or rescinded, at HealthAmericaOne sole discretion. In the event that coverage is rescinded, the policy will be voided back to the original effective date and all premium payments will be refunded. HealthAmericaOne shall not be financially liable for any health care services rendered prior to the rescission.
- I agree to notify HealthAmericaOne in writing if I or any individual applying for health coverage receives any new diagnosis, treatment, or health service, or if any of the answers or statements provided on this Application change between the date this Application is signed and the effective date or approval date of coverage, whichever is later. My failure to provide HealthAmericaOne with this updated health information may result in a denial or rescission of coverage.
- I understand that if any individual applying for coverage is declined for coverage, that individual may not re-apply for HealthAmericaOne coverage for six (6) months from date of signature.
- I understand that this Application is valid for sixty (60) days from the earliest date of signature in the Acknowledgements section.
- I understand that some of the conditions stated herein may or may not be considered covered benefits should a policy of coverage be issued.
- I UNDERSTAND AND ACKNOWLEDGE THAT BENEFIT DOCUMENTS, LEGAL DOCUMENT, AND PROVIDER NETWORK INFORMATION FOR HEALTHAMERICA PLANS WILL BE MADE AVAILABLE TO ME IN ELECTRONIC FORMAT THROUGH THE HEALTHAMERICA WEBSITE AND MY ONLINE SERVICES AT WWW.HEALTHAMERICA.CVTY.COM. MY ENROLLMENT IN THE PLAN INCLUDES THIS ELECTRONIC ACCESS. TO RECEIVE PRINTED DOCUMENTS AT NO COST TO ME, I MUST CONTACT CUSTOMER SERVICE TOLL-FREE AT 1-800-788-8445 IN CENTRAL AND EASTERN PA OR 1-800-735-4404 IN WESTERN PA AND OH.

OHIO: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

PENNSYLVANIA: 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 ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

DO NOT cancel your existing insurance coverage until an offer of coverage has been extended by HealthAmericaOne in writing. Please retain a copy of this application for your records.

Primary Applicant's Signature	Date	Spouse's Signature (if applying for coverage)	Date
Dependent Signature	Date	Dependent Signature	Date

The below signatures must be completed if this is a Child-Only Application or if any child applying for health coverage (under the age of 18) has a Custodial Parent that is not the Primary Applicant or Spouse of the Primary Applicant.

Parent/Legal Guardian Signature	Print Name	Relationship to individual applying for coverage	Date
Custodial Parent Signature	Print Name	Name of child(ren) to whom this applies	Date

Dependent Signature is required for individuals applying for coverage ages 18 and over; The 'Custodial Parent' is the person with physical or legal custody of a child under 18 years of age.

FOR AGENT -INTERNAL USE ONLY Agent Certification: I am not aware of any other information which may have a bearing on the insurability of anyone to be covered and have not altered any responses recorded on this Application or any supplement to it. I have not advised any individual applying for coverage to withhold any information regarding the answers to the questions and have advised the individuals applying for coverage to review the Application and the answers recorded to confirm completeness and accuracy. I further attest that all my answers recorded in this application are correct, complete, and wholly true to the best of my knowledge and belief.

Agent name	Agent ID#	Agent E-mail
Agency name	Agent / Agency phone	Name of General Agent
Payee (who is paid commissions) <input type="radio"/> Agent <input type="radio"/> Agency <input type="radio"/> General Agent		Payee Tax ID#
Agent Signature		Date

Primary Applicant Name: _____ 8 of 10 Agent Name: _____

Premium Payment

Premium Payment Options You must complete the applicable sections regarding your account information.

Initial payment by EFT, then:

Monthly EFT (no administrative fee)

Payroll Deduction Program This program allows your premium to be deducted directly from your paycheck, post-taxes. Other details apply. To choose this option, you **MUST** submit a separate HealthAmericaOne Payroll Deduction Authorization Form with your Application.

NEW Payroll Deduction Program (PDP)

EXISTING Payroll Deduction Program (PDP)

PDP number: _____ PDP name: _____

EFT (Electronic Funds Transfer) Information Complete this section if you have chosen to pay by EFT. The monthly premium shown above will be withdrawn automatically from the bank account listed on the application on the 10th day (or next business day if a weekend or holiday) of the month for which premium is due. The premium amount due is calculated per day, so if the effective date is anything other than the 1st of the month, the initial premium will be prorated.

<input type="radio"/> Checking Account <input type="radio"/> Savings Account	Name of account holder	9-digit routing number						Account number					
		<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>											
Name of bank / savings institution		Relationship of account holder to Primary Applicant											
		<input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Other _____											
Account holder address		City				State	ZIP]						

Important Note: HealthAmericaOne is not an employer-sponsored group health plan. If your banking information is from a business account, or you are submitting a check drawn from a business account, you must contact your agent to complete a HealthAmericaOne Payroll Deduction Authorization Form.

By signing this Premium Payment section, you are agreeing to the following statements:

- You understand that it is your responsibility to notify HealthAmericaOne should your payment information change at any time while you continue to hold a HealthAmericaOne policy.
- You understand that if premium payment is returned unpaid, a fee will be assessed in the amount of \$20.00. You authorize HealthAmericaOne to collect the premium payment due between the 20th – 30th of the month, including any unpaid fee amount. Failure to remit the first payment rescinds the policy.
- You understand that providing this payment information does not guarantee approval or coverage.
- Upon approval and acceptance of this Application, you authorize HealthAmericaOne to initiate automatic withdrawal and / or a billing cycle of applicable premium payments from your provided account or billing information. If your effective date is entered into the system after the third business day of the month, your first automatic withdrawal may include premium amounts for multiple months.

Account / Card Holder Signature: _____ Date: _____

Authorization of Release of Information

I, the Applicant, for myself and any of my Dependents who are under the age of 18 and who are applying for coverage hereunder, hereby make the following authorizations:

I authorize any physician, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, insurance company, claims administrator, employer, governmental agency or other person or firm, to disclose to HealthAmericaOne or its authorized representatives, my (or my Dependents') personal information, including copies of records concerning physical or mental illness, advice, diagnosis, prognosis, prescription information, care or treatment provided to me, including without limitation, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), or the use of drugs or alcohol. I also authorize the release of information relating to mental illness.

In addition, I authorize HealthAmericaOne to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by HealthAmericaOne for the purpose of evaluating my Application for health insurance. Further, I understand that my authorization is required for HealthAmericaOne to consider my Application and to determine whether or not an offer of coverage will be made. No action will be taken on my Application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by HealthAmericaOne as permitted or required by law and may no longer be protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request.

I authorize HealthAmericaOne to use or disclose the information I provide in this Application (or that the HealthAmericaOne has or receives from third parties) for purposes of administering my health insurance benefits. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) but not to exceed 24 months from the date this authorization is signed. Any revocation will not affect the activities of HealthAmericaOne prior to the date such revocation is received by HealthAmericaOne

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

_____ Primary Applicant's Signature	_____ Date	_____ Spouse's Signature (If applying for coverage)	_____ Date
_____ Dependent Signature* *Required age 18 and over.	_____ Date	_____ Dependent Signature*	_____ Date
The below signature must be completed if this is a Child-Only Application.			
_____ Parent/Legal Guardian Signature	_____ Print Name	_____ Relationship to child applying for coverage	_____ Date

Primary Applicant Name: _____ 10 of 10 Agent Name: _____