PreferredOne®
INSURANCE COMPANY

Individual Insurance Application Form For Qualified 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.

  Paper applications require a check for the first full month's estimated premium or the first month's premium will be debited via Electronic Payment Plan (EPP) from your designated account.

  Online applications can be completed at www.preferredone.com, and will require credit card authorization for the first month's estimated premium.

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

PreferredOne®
INSURANCE COMPANY

Individual Insurance Application Form

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

OFFICE USE ONLY

Underwriting Approval ____________________

Effective Date ____________________ Chemical Dependency Rider ____________________

Product ____________________ Application/Contract # ____________________

Plan I.D. ____________ Area: ____________

Premium amount sent: $ ____________________

Agent Information

Agent Name	Agent #	General Agent #
Jamie Williams	20310795	Leslie Hoppe

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	☐ Married ☐ Single	☐ Male ☐ Female

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

Occupation Applicant	Occupation Spouse	Requested Effective Date

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	Ht	Wt	SOCIAL SECURITY NO.	INTERNAL USE ONLY RATE TABLE
			Self								

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

Other than your spouse, are any of the above listed dependent(s) age 25 or older? ☐ No ☐ Yes If yes, list name(s)

Other than your spouse, are any of the above listed dependent(s) married? ☐ No ☐ Yes If yes, list name(s)

I request coverage for: ☐ Self ☐ Spouse ☐ Children

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 covered by or eligible for Medicare Part A and/or Part B? ☐ No ☐ Yes If yes, attach a copy of Medicare card.

Effective Date: Part A ____________ Part B ____________

Are your spouse or any dependent covered by or eligible for Medicare Part A and/or Part B? ☐ No ☐ Yes If yes, attach a copy of Medicare card.

Effective Date: Part A ____________ Part B ____________

Are you, your spouse or any dependent covered by Medicare Part D? ☐ No ☐ Yes If yes, attach a copy of Medicare card.

Effective Date: ____________

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

Do 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)? ☐ No ☐ Yes*

*If Yes, please provide:

Employer Name (for group coverage) ____________________

Name(s) of all covered person(s): ____________________

Member ID #: ____________________

*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:	☐ PIC 5200	☐ PIC 5250	☐ PIC 5450	☐ PIC 5510	☐ PIC 5700	☐ PIC 5515
Single Contract Deductible	$2,000	$2,850	$4,500	$5,500	$7,000	$15,000
OR						
Family Contract Deductible	$4,000	$5,650	$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, or blood test or any other diagnostic testing of any kind or been hospitalized in the last 5 years? If yes, give name of physician or hospital and results.		
2. Been declined, charged additional premium, or had benefits excluded by any health or life insurance company in the last 10 years?		
3. Used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application? If yes, please indicate whether you, your spouse or both used tobacco or smokeless tobacco: ☐ You ☐ Your spouse ☐ Both you and your spouse		
Have you or any family member applying for coverage had any diagnosis of, received treatment, services or supplies for, or consulted with a physician concerning:	**YES**	**NO**
4. Lung or respiratory disorders, including but not limited to asthma, allergies, emphysema or chronic bronchitis in the past five years?		
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?		
6. Blood disorders, including but not limited to, anemia, or hemophilia in the past five years?		
7. Cancer? List type, past and current treatment. Tumors? List treatment in the past five years.		
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?		
9. Nervous system disorders, including but not limited to, stroke, epilepsy, fainting, dizziness, seizures, headaches, migraines or any other disease or disorder of the brain or nervous system in the past five years?		
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?		
11. The heart or circulatory system condition including but not limited to, high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis or elevated cholesterol in the past five years? Please provide last blood pressure reading and cholesterol level if known of each adult applying for coverage. Applicant: Blood Pressure ________ Cholesterol ________ Spouse: Blood Pressure ________ Cholesterol ________		
12. Digestive disorders or injuries, including but not limited to, stomach or duodenal ulcer, other ulcer, hernia, colitis, hepatitis, chronic diarrhea, jaundice, cirrhosis, or any disorder of the liver, gallbladder, stomach, intestine or rectum in the past five years?		
13. Any disease of the eyes, ears, nose, throat, tonsils or sinuses in the past five years?		
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?		
15. Date of last pap smear ________ Results ________ Have you been instructed to have a repeat pap smear or any follow-up treatment or tests as a result of your last pap smear?		
16. Had surgery, diagnostic testing, treatment or referral to a medical care provider recently completed or recommended or scheduled that has not been completed?		
17. Immune system disorders, including but not limited to, HIV positive, AIDS, lupus, collagen disease, scleroderma, or any other connective tissue disease?		
18. Renal disorders or injuries, including, but not limited to, kidney, bladder, prostate or urinary disorders or injuries in the past five years?		
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?		
20. Skin disorders, acne, psoriasis, warts, or other in the past five years?		
21. Treatment for, or participation in any organization for alcoholism/chemical dependency, or been convicted for or had a driver's license suspended for DWI/DUI or moving violation in the past five years?		
22. Result of an accident including but not limited to (motor vehicle, motorcycle, ATV, blunt force, etc.) in the past 24 months?		
23. A medical condition or injury in the last five years not already listed on this application?		
24. 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?		
25. Is any family member now pregnant or an expectant parent, even if they are not applying on this application? If yes, expected date of birth: ________ Maternity coverage will begin after the member has been eligible under the PIC individual contract for 18 months.		
26. Any condition that may require medical, surgical, or hospital care?		
27. Gastric bypass surgery?		

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 ______________________________

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Child's Name ______________________ Physician ______________________

Address ______________________________

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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 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 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

Additional dependent signature(s) (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

Here’s How to Sign Up for the Plan:

- Complete the authorization form below and attach a voided check or savings deposit slip from the account designated for the electronic payment plan.
- If your effective date is other then the 1st of the month the initial premium payment due will be an estimation of the pro-rated partial month’s premium amount in addition to the first full calendar month’s premium.
- Complete the Electronic Payment Plan (EPP) authorization for ongoing premium collection. Any shortfall on the initial premium payment will be collected with your first electronic debit from your account. Any overpayment on your initial payment will be applied towards your first electronic payment amount.

Electronic Payment Plan (EPP) – REQUIRED

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.

Advantages of using the Electronic Payment Plan to pay your premiums:

- Ensures proper credit to your account.
- Reduces the potential for lost or stolen checks.
- Reduces postage costs and check writing fees.

Electronic Payment Plan (EPP) Authorization Form

Name on bank account: ______________________________

Bank ABA/routing number: ______________________________

Bank account number: ______________________________

Bank name: ______________________ Telephone: ______________

City: ______________________ State: ________ Zip code: ____________

I authorize PIC and the bank named above to initiate monthly withdrawals from my checking or savings account, as indicated.
This agreement will remain in effect until I notify PIC and my bank in writing to cancel it.

______________________________ ______________________________
Print name of applicant Social Security Number

______________________________ ______________________________
Signature of bank account holder Date

______________________________ ______________________________
Signature of bank account holder (if joint account) Date

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 $300,000. Subject to this $300,000 limit, the guaranty association will pay up to $300,000 in life insurance death benefits, $100,000 in net cash surrender and net cash withdrawal values for life insurance, $300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $100,000 in annuity net cash surrender and net cash withdrawal values, $300,000 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 $300,000 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 $100,000 in 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 $7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $7,500,000, the $7,500,000 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.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

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

www.preferredone.com

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 the authorization will remain in effect until one year from the date this authorization is signed or electronically approved.

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: ____________