

# Major Medical Insurance - Application

## Personal Information:

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male/Female: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Contact # \_\_\_\_\_

## Coverage Selection:

Type of Coverage Requested:  Individual  Individual + Spouse  Individual + Child(ren)  Family

Plan Type:  PPO  HMO  High-Deductible Health Plan (HDHP)  Other:

Household Members to Be Covered: *(Complete only if applying for more than one person)*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Gender: \_\_\_\_\_ Relationship: \_\_\_\_\_

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## Current Coverage:

Do you currently have health insurance? Yes No

If yes, Carrier Name: \_\_\_\_\_ Policy End Date: \_\_\_\_\_

Have you had continuous coverage for the past 12 months? Yes No

## Medical Background:

Has any applicant been hospitalized in the past 12 months? Yes No

Has any applicant been advised of surgery that has not yet been performed? Yes No

Is any applicant currently pregnant? Yes No

Does any applicant have a chronic condition requiring ongoing treatment? Yes No

If yes, provide general details: \_\_\_\_\_

Is any applicant currently taking prescription medications? Yes No

If yes, list medication names only: \_\_\_\_\_

Has any applicant used tobacco or nicotine products in the past 12 months? Yes No

Does any applicant engage in high-risk activities? *(e.g., aviation, motorsports)* Yes No

## Primary Care Provider:

Do you have a preferred primary care physician? Yes No

If yes, Name/Clinic: \_\_\_\_\_

# Recurring ACH Payment Authorization

You authorize regularly scheduled charges to your checking/savings account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your bank statement as an "ACH Debit". You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I \_\_\_\_\_ authorize \_\_\_\_\_ to charge my  
(Full Name) (Merchant's Name)

bank account indicated below for \$ \_\_\_\_\_ on the \_\_\_\_\_ of  
(Amount \$) (day)  
each \_\_\_\_\_.  
(week, month, etc.)

This payment is for \_\_\_\_\_.  
(Description of Goods/Services)

## Billing Information

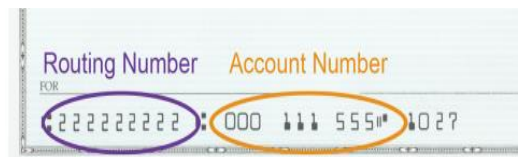
Billing Address \_\_\_\_\_ Phone # \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

## Bank Details

Checking  Savings

Account Name \_\_\_\_\_  
Bank Name \_\_\_\_\_  
Account Number \_\_\_\_\_  
Routing Number \_\_\_\_\_



I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify \_\_\_\_\_ in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that \_\_\_\_\_ may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$ \_\_\_\_\_ charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE \_\_\_\_\_  
(Account Holder's Signature)

DATE \_\_\_\_\_

