

FLORIDA

CELTIC

## CeltiCare Preferred

UNDERWRITTEN BY CELTIC INSURANCE COMPANY, CHICAGO, IL

Please print in ink

<b>Requested Effective Date:</b> NOTE: the 29, 30 and 31 of the month are not eligible as effective dates. Application is valid within 60 days from the signature date.		<b>Please check if this application is for:</b> <input type="checkbox"/> New Applicant <input type="checkbox"/> Add Dependent <input type="checkbox"/> Plan Change <input type="checkbox"/> Reapply	
<b>Initial Payment Method:</b> One month/quarter premium (Complete Section 4): <input type="checkbox"/> Credit card (including Check/Debit cards) <input type="checkbox"/> Check <input type="checkbox"/> Bill me later - online application only		<b>Subsequent Payment Schedule:</b> <input type="checkbox"/> Monthly Automatic Pay - One month premium required (Complete Section 4) <input type="checkbox"/> Monthly Billing* - One month premium required <input type="checkbox"/> Quarterly Billing* - Three months premium required *\$10 billing fee per month or quarter	
<b>Total Payment Submitted</b> (Application fee waived for online application, www.celtic-net.com): \$ _____ /Monthly + \$25.00 One-time, non refundable Application Fee = \$ _____ Total Payment submitted \$ _____ /Quarterly + \$25.00 One-time, non refundable Application Fee = \$ _____ Total Payment submitted			
<b>Have you and/or any dependent to be covered previously applied for insurance with Celtic Insurance Company?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes," provide policy or certificate # _____			

## SECTION 1: GENERAL INFORMATION

If child-only coverage is being requested, the child is the primary applicant and a separate application must be completed for each child.

<b>Primary Applicant's Name:</b>			<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		
First	Middle	Last			
<b>Birth Date:</b> / /	<b>Age:</b>	<b>Social Security Number:</b>	<b>Height:</b> ft. in.	<b>Weight:</b> lbs.	
<b>Email Address:</b>			<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Home Phone Number:</b> ( )	<b>Phone Number during regular business hours:</b> ( )	<b>Occupation:</b> ( Position and Type of Business)			
<b>Best Time To Call:</b> a.m. p.m.	<b>Primary Applicant's Residential Address:</b>				
	<b>Primary Applicant's Mailing Address:</b>				
	Street	City	State	Zip	

## GUARDIAN INFORMATION (For Applicants under 18 years of age):

<b>Guardian's Name:</b> (with whom the child resides):	<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian
	<input type="checkbox"/> Grandparent	<input type="checkbox"/> Other _____
First	Middle	Last

## BILLING INFORMATION If different from Applicant's Home Address (Please send bills to):

<b>Name and Billing Address:</b>			
Name	Street	City	State, Zip
<b>Relationship to Applicant:</b> <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other _____			
<b>Does the payor want to include other family members on one billing statement?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes," the Family Billing Statement Form needs to be completed, dated, signed and submitted with the application.			

## CITIZENSHIP INFORMATION

<b>Is each of the following Applicants to be insured a U.S. citizen or a permanent legal resident of the U.S. for the last two years?</b>			
<b>Primary applicant:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No*	<b>Spouse:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No*	<b>Dependent(s):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No*	
* If "No," coverage cannot be granted for that applicant.			

**SECTION 1: GENERAL INFORMATION (continued)****PLAN INFORMATION**

**Who is to be insured?**     Applicant (only)     Applicant/Spouse     Applicant/Child(ren)     Family

**DEPENDENT INFORMATION** (Complete only for dependents to be covered under this plan.)

**Spouse's Name:** \_\_\_\_\_ **Sex:**  Male     Female    **Spouse's Social Security Number:** \_\_\_\_\_

**First**                      **Middle**                      **Last**

**Phone Number during regular business hours:** (      )                      **Best Time To Call:** \_\_\_\_\_ a.m.                      p.m.

**Birth Date:**                      /                      /                      **Age:**                      **Height:**                      ft.                      in.                      **Weight:**                      lbs.

**Spouse's Occupation:** (Position and Type of Business) \_\_\_\_\_

**Accurate Readings Required**

Name of Dependent Child(ren): First & Last Name	Social Security Number:	Birth Date:	Sex: (M/F)	HT. (ft. & in.)	WT. (lbs.)	US Citizen or Permanent Legal Resident (yes/no)

**PLAN OPTIONS** (Choose one of the three plans)

**Select PPO Plan:**  
 80/20 of the next \$10,000 \_\_\_\_\_ deductible     100% \$ \_\_\_\_\_ deductible  
(\$500, \$1,000, \$1,500, \$2,500, \$5,000)                      (\$2,500, \$5,000)

**"Any Doc" PPO Plan:**  
 80/20 of the next \$10,000 \_\_\_\_\_ deductible     100% \$ \_\_\_\_\_ deductible  
(\$500, \$1,000, \$1,500, \$2,500, \$5,000)                      (\$2,500, \$5,000)

**Managed Indemnity Plan:**  
 80/20 of the next \$10,000 \_\_\_\_\_ deductible     100% \$ \_\_\_\_\_ deductible  
(\$500, \$1,000, \$1,500, \$2,500, \$5,000)                      (\$2,500, \$5,000)

**BENEFIT OPTIONS**

<b>Prescription Drug Option</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Supplemental Accident Option</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**OTHER HEALTH COVERAGE**

**Do you or any dependents to be insured have any major medical health insurance coverage currently in force?**  
 Yes\*     No

**\*If "Yes," will the insurance coverage applied for be used to replace this existing coverage?**     Yes     No  
 (If "Yes," a replacement form may be required in your state. Consult your agent. If "No," coverage cannot be issued.)

**Were you or your dependents covered under any other Health Insurance plan in the last 18 months?**     Yes\*     No

**\*If "Yes," what type of coverage was your or your dependents last plan?**  
 Employer Based Group     Individual     COBRA     Other

**If you currently have a major medical plan in force or had coverage in the last 18 months complete the following:**  
 Name of covered individual(s): \_\_\_\_\_  
 Carrier Name: \_\_\_\_\_  
 Telephone number: \_\_\_\_\_  
 Policy Number or Group Number: \_\_\_\_\_  
 Effective Date of Policy: \_\_\_\_\_                      Termination Date of Policy: \_\_\_\_\_

**IMPORTANT: DO NOT** cancel any existing health coverage until written notification of your acceptance by Celtic.

## SECTION 2: HEALTH AND OCCUPATION QUESTIONS

### HEALTH QUESTIONS

For this insurance to be issued, the answers to the following health questions must be true, complete, and accurately recorded. All health information must be provided in Section 3 of this application, and Celtic Insurance Company must approve this application. No one may change this requirement in any way. If any information on any form is misstated or omitted, coverage may later be rescinded. Rescission voids coverage from the effective date, and any premiums already paid will be refunded, minus any claims already paid. No payments will be made for any claims submitted, whether or not the treatment was related to the condition that was omitted or misstated. **PLEASE DO NOT MARK OVER OR STRIKE OUT ANY SIGNATURE, DATE OR HEALTH QUESTION INFORMATION.** (Any changes, corrections or alterations must be initialed and dated by the primary applicant.)

YES     NO

#### 1. PREGNANCY

Are you, your spouse or any dependent, whether to be covered or not, now pregnant or an expectant parent or have an adoption pending?  
(If "YES," this coverage cannot be provided.)

YES     NO

#### 2. GENERAL HEALTH

a. Within the last 10 years, has anyone to be insured been counseled or advised that they have or may have had any disease, disorder, impairment, deformity, familial or congenital abnormality, injury or any chronic or untreatable condition whether active or in remission?

YES     NO

b. Does anyone to be insured have a prosthetic device or implant (including breast implants)?

YES     NO

c. Have you or any dependent to be insured used any type of tobacco product in the past 12 months?

If "Yes," check all who apply:     Applicant     Spouse     Dependent(s)

YES     NO

d. Have you or any of your dependents been prescribed any medications in the last 12 months?

#### 3. SPECIFIC HEALTH CONDITIONS

Within the last 10 years, have you or any dependent(s) to be insured ever been treated for, had symptoms of, or been advised or counseled that they have or may have had: (Y=Yes and N=No)

**Y N**

a.   Heart condition, (including chest pains or a heart murmur), stroke, high blood pressure or other circulatory disorder

b.   Blood disorder

c.   Diabetes

d.   Cancer, tumor or cyst

e.   Liver, kidney, genital or urinary tract disorder

f.   Any disease or disorder of the reproductive system including infertility, complications of pregnancy, sexual dysfunction or sexually transmitted disease(s)

g.   Elevated Cholesterol

h.   Neurological disorders or condition

i.   Migraines

**Y N**

j.   Seizures or other nervous system disorder

k.   Arthritis, fibromyalgia, gout, back, spine, joint or other musculoskeletal system disorder

l.   Chronic Fatigue Syndrome

m.   Digestive system disorder

n.   Asthma, allergies or other respiratory disorder

o.   Eye, ear or skin disorders

p.   Alcohol, substance or drug abuse or dependence.

q.   Emotional, psychological, psychiatric or nervous condition or disorder

r.   Thyroid disorder

#### 4. RECENT MEDICAL TREATMENT

a. Within the past 24 months, have you or any dependent(s) to be insured undergone or been advised or recommended for: (Y=Yes and N=No)

**Y N**

Lab work or tests

Hospitalization

Surgery or surgical consultation

Treatment for any condition(s)

**Y N**

Psychological or marital counseling

Physical, occupational, or disability therapy

Second opinion from another physician

**SECTION 2: HEALTH AND OCCUPATION QUESTIONS (continued)**

YES  NO **b.** Are you or any dependent(s) to be insured scheduled for or awaiting the results of any tests, biopsies, procedures or lab work?

YES  NO **5a. HUMAN IMMUNODEFICIENCY VIRUS, ACQUIRED IMMUNE DEFICIENCY SYNDROME AND IMMUNODEFICIENCY SYNDROME**  
Have you or any dependent(s) tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immunodeficiency Syndrome (AIDS) caused by the HIV infection or other sickness or condition derived from such infection?

YES  NO **5b. OTHER IMMUNE SYSTEM DISORDERS**  
Have you or any dependent(s) to be insured ever been diagnosed as having an immune system disorder or other disease associated with an immune system disorder?

YES  NO **6. OCCUPATION/AVOCATION QUESTION**  
Do you or any dependent(s) to be insured participate in or work in any of the following occupations/avocations?

- |                      |                          |                                  |
|----------------------|--------------------------|----------------------------------|
| Bartending           | Modeling                 | Professional fire fighting       |
| Crop dusting         | Motorized vehicle racing | Professional sports or athletics |
| Hazardous materials  | Musician                 | Roofing                          |
| Inter-state trucking | Off-shore drilling       |                                  |
| Mining               | Police                   |                                  |

If "Yes," please provide the name(s) of each person and their occupation/avocation.

Name: \_\_\_\_\_ Occupation/Avocation: \_\_\_\_\_

Name: \_\_\_\_\_ Occupation/Avocation: \_\_\_\_\_

**7. FOR APPLICANTS AGE 50 OR OLDER**

YES  NO **a. General**  
Have you or any dependent age 50 or over had a physical exam and/or diagnostic testing within the last 24 months?

If "Yes," please indicate:

Primary: Date \_\_\_\_\_ ,  
MM / DD / YYYY

Were all results of the physical exam and diagnostic testing - Normal:  Yes  No

Spouse: Date \_\_\_\_\_ ,  
MM / DD / YYYY

Were all results of the physical exam and diagnostic testing - Normal:  Yes  No

If "No," please provide complete details in Section 3.

**b. Female Applicants Only - Mammogram Results:**

What was the date of your most recent mammogram? \_\_\_\_\_

Results normal?  Yes  No MM / DD / YYYY

**SECTION 3: ADDITIONAL HEALTH QUESTION INFORMATION**

To be completed if the applicant or any dependent(s) answered "Yes" to any questions in Section 2. If more space is needed attach a separate sheet, each separate sheet must be signed and dated by the primary applicant.

Please give month and year when providing dates. Also, please give specifics when listing conditions, (Ex. Broken left leg.)

**Ques. No.:**      Applicant's Name: \_\_\_\_\_

Diagnosis/Condition: \_\_\_\_\_

Onset Date: \_\_\_\_\_ Date Last Treated: \_\_\_\_\_

Length of Treatment: \_\_\_\_\_

Medication(s), including over the counter (*please list med/dosage and date last taken*): \_\_\_\_\_

Name of Test/Surgery/Date/Results: \_\_\_\_\_

Is the condition still present? If not, date of recovery: \_\_\_\_\_

Details of Treatment/Treatment pending or scheduled: \_\_\_\_\_

Doctor's name, Address and Phone Number: \_\_\_\_\_

**Ques. No.:**      Applicant's Name: \_\_\_\_\_

Diagnosis/Condition: \_\_\_\_\_

Onset Date: \_\_\_\_\_ Date Last Treated: \_\_\_\_\_

Length of Treatment: \_\_\_\_\_

Medication(s), including over the counter (*please list med/dosage and date last taken*): \_\_\_\_\_

Name of Test/Surgery/Date/Results: \_\_\_\_\_

Is the condition still present? If not, date of recovery: \_\_\_\_\_

Details of Treatment/Treatment pending or scheduled: \_\_\_\_\_

Doctor's name, Address and Phone Number: \_\_\_\_\_

**Ques. No.:**      Applicant's Name: \_\_\_\_\_

Diagnosis/Condition: \_\_\_\_\_

Onset Date: \_\_\_\_\_ Date Last Treated: \_\_\_\_\_

Length of Treatment: \_\_\_\_\_

Medication(s), including over the counter (*please list med/dosage and date last taken*): \_\_\_\_\_

Name of Test/Surgery/Date/Results: \_\_\_\_\_

Is the condition still present? If not, date of recovery: \_\_\_\_\_

Details of Treatment/Treatment pending or scheduled: \_\_\_\_\_

Doctor's name, Address and Phone Number: \_\_\_\_\_

**SECTION 4: PREMIUM PAYMENT METHOD AND AUTHORIZATION AGREEMENT**

**Initial Payment (Credit Card or Check): PRODUCER PAYMENTS ARE NOT ACCEPTED.**

1. For Initial Payment Only: I authorize Celtic 18 Plus Health Plan to bill my account for the initial payment and I agree to pay the initial payment billed in accordance to my payment selection on this application by checking the following credit card box:

VISA® (including Check/Debit cards\*)  Mastercard® (including Check/Debit cards\*)  Discover®

\* Debit cards must have a Visa or Mastercard logo on the front of the Debit Card.

Card No.:           Expiration Date (MO/YR):   /

Cardholder's Name: \_\_\_\_\_

2. Or, attach your check below for total payment submitted.

**MONTHLY AUTOMATIC PAY PLAN**

Payor Name or Depositor if different (Please print):

First Middle Last

Relationship to Applicant:  Self  Parent  Legal Guardian  Other \_\_\_\_\_

Signature of Primary Payor: \_\_\_\_\_ Date: / /

Name of Financial Institution: \_\_\_\_\_ Address: CITY STATE ZIP

Specify type of account:  Checking or  Savings Checking/Savings Account Number: \_\_\_\_\_

ABA 9 Digit Routing Number (See below or please call your Financial Institution for assistance):

Celtic Insurance Company is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month, until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Certificate is not issued.

I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by Celtic Insurance Company, and I agree that the bank named shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Celtic Insurance Company in writing.

**MONTHLY AUTOMATIC PAY PLAN APPLICANTS ONLY**

**Voided Check**

*(Deposit Slips are not acceptable)*

**DO NOT STAPLE CHECKS TO FORM.**

**ATTACH YOUR INITIAL CHECK OR MONEY ORDER FOR PREMIUM PAYMENT**

Joe Smith  
123 Main Street  
Anytown, IL 12345

Pay to the order of \_\_\_\_\_

Date \_\_\_\_\_

Routing Number \_\_\_\_\_

For

123456789 1234567891011 1117

1117

## SECTION 5: AGREEMENT AND SIGNATURE

- 1. TRUE AND COMPLETE:** My answers to the questions on this application and any additional information I have provided are true and complete and accurately recorded. I understand that under no circumstances is a producer or company representative allowed to permit me to answer any question inaccurately or untruthfully and I represent that such did not occur. The producer is not authorized to alter any terms of the Certificate. I understand that I may not pay cash or make checks payable to the agent or broker, or leave the payee blank.
- 2. PRE-EXISTING CONDITIONS:** I understand that eligible expenses for pre-existing conditions may be limited.
- 3. EFFECTIVE DATE:** Except as provided in the Conditional Receipt, I understand that this insurance, if approved, will become effective the day after the confirmed receipt date the application and all required medical and other information is received by Celtic. Application is valid within 60 days from the signature date.
- 4. HEALTH CARE CERTIFICATION:** I understand that a Health Care Certification Program is a part of the Health Plan. This program requires me to have all hospital confinements, outpatient surgeries, and major diagnostic tests Certified. I understand that failure to do so will result in a reduction of my health plan benefits or no benefits paid at all. The Health Care Certification Program number is 1-800-477-7870.
- 5. OTHER COVERAGE:** I understand that in order to be eligible for this coverage, neither I, nor any dependents to be insured can be covered under any other major medical plan. I hereby attest that no one applying for coverage under the Health Plan will be covered under any other coverage.
- 6. PREFERRED PROVIDER ORGANIZATION:** I understand if I have selected one of the PPO plan options as part of my Health Plan, then I agree to participate and comply with all requirements of the PPO plan. I understand that I will maximize my benefits when treatment is received from a participating hospital (and physician, if the Select PPO plan is chosen) and that it is my responsibility to ensure that a PPO hospital (and physician, if the Select PPO plan is chosen) is near me. I understand this applies not only to myself, but to any dependent to be insured under this health plan.
- 7. APPLICATION:** I understand that I am applying for membership in the Celtic 18 Plus Health Plan Trust and am responsible for ensuring that all premium payments are met. I understand that Celtic will individually underwrite my application and that if my application is accepted by Celtic, a Certificate will be issued to me. I understand that the plan applied for is not an employer-sponsored group health plan, that it will in no way be related to any employer/employee relationship, and it is not offered pursuant to and does not comply with state or federal small employer laws. If premium will be paid from a business/employer account, I hereby certify that no person to be insured under this plan will receive favorable tax treatment under sections 162, 125 or 106 of the United States Revenue Code, unless such favorable tax treatment would not make the plan subject to any state or federal small employer laws.
- 8. AUTHORIZATION TO RELEASE INFORMATION:** I authorize any physician, medical or health care practitioner, hospital, clinic, other medically related facility, insurance company, third party administrator, employer or consumer reporting agency having information regarding me and all eligible dependents, including information concerning advice, diagnosis, treatment or care of physical, psychiatric, mental or emotional conditions, drug, substance, or alcohol abuse, illness, and copies of all hospital or medical records, or non-medical information, to give to Celtic Insurance Company, its reinsurers, or its legal representatives, and its affiliates, any and all such information. I understand that I can revoke this authorization at any time by giving written notice to Celtic and my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. Such information may be used by Celtic Insurance Company to determine eligibility for insurance and make claim determinations. This authorization shall remain valid for two years from the date shown below. Anyone who knowingly misrepresents or falsifies such requested information may, upon conviction, be subject to a fine or imprisonment. I acknowledge having received and read the Notice of Information Practice.

This policy is primarily governed by the laws of Illinois. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

SIGNATURE: PRIMARY APPLICANT: \_\_\_\_\_ SPOUSE: \_\_\_\_\_  
(Parent or Guardian if under 18 years of age)

DATE: \_\_\_\_\_

## SECTION 6: PRODUCER INFORMATION

You must be currently licensed and appointed with Celtic in the state where the application was completed.

**NOTE:** If you have written business with Celtic *in this state* during this calendar year, just complete your name, Social Security number and sign below. There is no need to submit a copy of your license with every case.

Writing Producer's Name:	Producer Number or Agent Number	
Florida Agent's License Identification Number:		
Address:		
City	State	Zip
Telephone Number: (       )	Fax Number: (       )	

**Mail this application to:**

**Celtic 18 Plus Health Plan Trust  
P.O. Box 33640  
Indianapolis, IN 46203-0640  
[www.celtic-net.com](http://www.celtic-net.com)**

PLEASE KEEP THE FOLLOWING SECTIONS FOR YOUR RECORDS

NOTICE OF INFORMATION PRACTICES

In order to properly underwrite and administer your insurance coverage, we must collect personal information concerning your insurability. You are our most important source of information, but we may also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see (and copy if you wish) items of personal information about you which appear in our files, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment, or deletion of information you believe to be inaccurate.

If you have questions or desire additional information about the items disclosed above, please write to us at Celtic Insurance Company, Underwriting Department, 233 South Wacker Drive, Suite 700, Chicago, IL 60606.

Requests for medical information will only be disclosed to your attending physician.

CONDITIONAL RECEIPT FOR HEALTHPLAN

ALWAYS COLLECT THE INITIAL PREMIUM AND GIVE THE APPLICANT THIS CONDITIONAL RECEIPT.

No insurance will become effective prior to the approval of your application by Celtic. No producer or broker is authorized to alter or waive any of the following provisions of the receipt:

Applicant's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Amount Received: \_\_\_\_\_

Date: \_\_\_\_\_

Coverage will become effective on the "Effective Date" (as defined below) if all of the following conditions are met: (1) On the Date of Application, the applicant and all proposed insureds must be a risk acceptable to Celtic. (2) If Celtic cannot determine the acceptability of the applicant(s) as defined in (1) above, due to the nonreceipt (within 60 days of the date of application), of medical or other material information that Celtic has requested from the applicant or other sources; then this condition has not been fulfilled and no coverage will be provided under the terms of this Conditional Receipt. (3) The initial premium, equal to one month/quarter of the first yearly premium, has been paid on or prior to the Effective Date, and the check or credit card is honored on the first presentation for payment.

"Effective Date" as used herein means 12:01 a.m. on the later of: (A) the Requested Effective Date; (B) the day following the postmarked date on the application envelope addressed to Celtic, if no effective date is requested; (C) if no postmarked date, the effective date is the day after the confirmed receipt date of the application and all required medical and other information is received by Celtic. **Note: Metered mail is not an acceptable postmark.**



**Insured by Celtic Insurance Company**

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Celtic Group Company