

NORTH CAROLINA

CELTIC

CeltiCare Preferred

UNDERWRITTEN BY CELTIC INSURANCE COMPANY, CHICAGO, IL

Please print in ink

Requested Effective Date:

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.

MO. / DAY / YR.

Please check if this application is for:

- New Applicant Add Dependent
 Plan Change Reapply

Initial Payment Method:One month/quarter premium
(Complete Section 4):

- Credit card (including Check/Debit cards)
 Check
 Bill me later - online application only

Subsequent Payment Schedule:

- Monthly Automatic Pay - One month premium required (Complete Section 4)
 Monthly Billing* - One month premium required
 Quarterly Billing* - Three months premium required

*\$10 billing fee per month or quarter

Total Payment Submitted (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

Have you and/or any dependent to be covered previously applied for insurance with Celtic Insurance Company? Yes 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.

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

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

Guardian's Name: (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):

Name and Billing Address:			
Name	Street	City	State, Zip
Relationship to Applicant: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other _____			
Does the payor want to include other family members on one billing statement? <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

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?			
Primary applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No*	Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No*	Dependent(s): <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

Prescription Drug Option <input type="checkbox"/> Yes <input type="checkbox"/> No	Supplemental Accident Option <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 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 | Y | N | | | | | | |
|--------------------------|--------------------------|-----------|--------------------------|--------------------------|---|-----------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | a. | <input type="checkbox"/> | <input type="checkbox"/> | Heart condition, (including chest pains or a heart murmur), stroke, high blood pressure or other circulatory disorder | k. | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, fibromyalgia, gout, back, spine, joint or other musculoskeletal system disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | b. | <input type="checkbox"/> | <input type="checkbox"/> | Blood disorder** | l. | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Fatigue Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | c. | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | m. | <input type="checkbox"/> | <input type="checkbox"/> | Digestive system disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | d. | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, tumor or cyst | n. | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, allergies or other respiratory disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | e. | <input type="checkbox"/> | <input type="checkbox"/> | Liver, kidney, genital or urinary tract disorder | o. | <input type="checkbox"/> | <input type="checkbox"/> | Eye, ear or skin disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | f. | <input type="checkbox"/> | <input type="checkbox"/> | Any disease or disorder of the reproductive system including infertility, complications of pregnancy, sexual dysfunction or sexually transmitted disease(s) | p. | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol, substance or drug abuse or dependence. (Do not include information related to membership in substance or chemical dependency support groups.) |
| <input type="checkbox"/> | <input type="checkbox"/> | g. | <input type="checkbox"/> | <input type="checkbox"/> | Elevated Cholesterol | q. | <input type="checkbox"/> | <input type="checkbox"/> | Emotional, psychological, psychiatric or nervous condition or disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | h. | <input type="checkbox"/> | <input type="checkbox"/> | Neurological disorders or condition | r. | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | i. | <input type="checkbox"/> | <input type="checkbox"/> | Migraines | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | j. | <input type="checkbox"/> | <input type="checkbox"/> | Seizures or other nervous system 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 | Y | N | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lab work or tests | <input type="checkbox"/> | <input type="checkbox"/> | Psychological or marital counseling |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hospitalization | <input type="checkbox"/> | <input type="checkbox"/> | Physical, occupational, or disability therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Surgery or surgical consultation | <input type="checkbox"/> | <input type="checkbox"/> | Second opinion from another physician |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Treatment for any condition(s) | | | |

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 **5. IMMUNE SYSTEM DISORDER**
Have you or any dependent(s) to be insured ever been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS or other immune system disorders***, or ever tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?

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 any applicants to be insured 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
- Dependent Child(ren): _____, name(s) 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. Mammogram Results:
Have any applicants had a mammogram? Yes No

If "Yes," please indicate:

- Primary:
What was the date of the most recent mammogram? _____, (MM/DD/YYYY)
Results Normal: Yes No
- Spouse:
What was the date of the most recent mammogram? _____, (MM/DD/YYYY)
Results Normal: Yes No
- Dependent Child(ren): _____, name(s)
What was the date of the most recent mammogram? _____, (MM/DD/YYYY)
Results Normal: Yes No

**Blood disorder includes all conditions of the blood presently recognized as disorders, both primary disorders of the blood (e.g. anemia, polycythemia, leukopenia, leukocytosis, clotting disorders, platelet disorders, immune disorders whether congenital or acquired, or disorders of gammaglobulin) and disorders that reflect other disease processes (e.g. infections, malignancies, sources of blood loss, biliary tract disease)

***Immune system disorder includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation and the immune-deficiency disorders, both congenital and acquired. Also included in disorders of immunity are lupus erythematosus, Grave's disease, rheumatoid arthritis, primary biliary cirrhosis and others.

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 Insurance Company 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 Policy 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 Policy. 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. Prior authorization is not required for medical emergencies. 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 as an individual for the Health Plan 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 Policy 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.
8. **AUTHORIZATION TO RELEASE INFORMATION:** The undersigned 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 the undersigned and all eligible minor 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. I or a person authorized to act on my behalf have the right to receive a copy of the authorization form. 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.

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 may subject such person to criminal and civil penalties.

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

DEPENDENT CHILD: _____ DEPENDENT CHILD: _____
(age 18 years of age or older) (age 18 years of age or older)

DATED AND SIGNED AT: _____ on ____/____/____
City State 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	
Address:		
City	State	Zip
Telephone Number: ()	Fax Number: ()	

Mail this application to:

**Celtic Insurance Co.
P.O. Box 33640
Indianapolis, IN 46203-0640**

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.**

**HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION (“PHI”)
FOR CELTIC INSURANCE COMPANY (“CELTIC”)
EFFECTIVE NOVEMBER 1, 2003**

**This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information.
Please Review It Carefully.**

Celtic is committed to protecting the confidentiality and security of information it collects about you and does not share information about you with any other companies for their use in marketing products to you. ***If the practices described in this Notice are acceptable to you, there is nothing you need to do.*** If after reading this notice you still have questions, feel free to send them to
Attn: HIPAA Privacy Officer, 233 South Wacker Drive, Suite 700, Chicago, IL 60606.

You have received this notice because of your proposed or actual health insurance coverage with Celtic Insurance Company. Celtic is required by federal law to maintain the privacy of your Protected Health Information (“PHI”), and to provide you with this notice of its legal duties and privacy practices regarding your PHI. Celtic is required to abide by the terms of this notice as currently in effect, and reserves the right to change the terms of this notice and to make new notice provisions effective for all PHI that it maintains. Notice of any such changes will be provided to you.

1. Protected Health Information (“PHI”):

This notice describes how Celtic may use and disclose your PHI if needed, to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, which is individually identifiable information that relates to your past, present or future health or condition and related health care services. Examples of PHI used by Celtic include, but are not limited to, your application for coverage and claims submitted by you or health care providers on your behalf.

2. Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations:

Your PHI may be used and disclosed by Celtic for purposes of payment or health care operations. Celtic may use or share your PHI with providers for payment purposes. Celtic may share your PHI with third party “business associates” that perform various functions for the Company. Celtic maintains written agreements with its business associates contractually binding them to protect the privacy of your PHI. Celtic may use or disclose, as needed, your PHI to support the Company’s business activities related to providing health insurance benefits. These activities may include, but are not limited to, quality assessment, underwriting, premium rating, actuarial analysis, reinsurance, medical review, legal services, auditing, fraud and abuse detection, regulatory compliance, business planning and development, and general management and administration.

3. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object:

Celtic may use or disclose your PHI in certain circumstances without your consent or authorization. These situations may include, but are not limited to, the following:

Required by Law: Celtic may use or disclose your PHI to the extent state or federal law requires use or disclosure. Any use or disclosure will be compliant with applicable law, and will be limited to the requirements of such law. Celtic will notify you of the uses or disclosures if the law requires such notification.

Public Health: Celtic may disclose your PHI to a public health authority for public health activities and purposes if applicable law permits the authority to collect or receive the information. Celtic also may disclose your PHI, when directed by a public health authority, to a foreign government agency that is collaborating with such authority.

Health Oversight: Celtic may disclose PHI to a health oversight agency for activities authorized by state or federal law, such as audits and investigations.

Abuse or Neglect: Celtic may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. Furthermore, Celtic may disclose your PHI to the governmental entity authorized to receive such information, in accordance with state or federal law, if the Company reasonably believes that you have been a victim of abuse, neglect or domestic violence.

Legal Proceedings: Celtic may disclose PHI in the course of judicial or administrative proceedings, in response to a court order or administrative tribunal, to the extent such disclosure is expressly authorized, and in response to a subpoena, discovery request, or other lawful purpose.

Military Activity and National Security: Celtic may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3)

to a foreign military authority if you are a member of that foreign military. Celtic also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities.

4. Other Permitted or Required Uses and Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to Object:

Celtic may use or disclose your PHI in certain circumstances with your consent, authorization or if you have no objection. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of your PHI, then Celtic may determine, using professional judgment, whether such use or disclosure is in your best interest. If such circumstances arise, only the PHI that is necessary and relevant to the provision of your health insurance benefits will be disclosed.

EOBs Sent to Primary Insured: Unless you object and instruct otherwise, all explanations of benefits (“EOBs”), including for all covered family members and eligible dependents, will be sent to the primary insured person.

5. Uses and Disclosures of PHI Based Upon Your Written Authorization:

Celtic may engage in other uses and disclosures of your PHI upon receiving your written authorization. You may revoke an authorization, in writing, at any time, except to the extent that an action has been taken in reasonable reliance on the use or disclosure indicated in the authorization.

6. Your Rights:

The following is a description of your rights with respect to your PHI and a brief description of how you may exercise those rights.

Inspect and Copy Your PHI: You may obtain and inspect a copy of your PHI that is in a designated record set for as long as Celtic maintains it. However, federal law prohibits Celtic from allowing an inspection or copy of psychotherapy notes; privileged information compiled in reasonable anticipation of or use in a legal proceeding; or PHI that is subject to a law which prohibits its access. If you wish to receive a copy of your PHI, your request must be made using Celtic’s “Medical Records Request” form. You may request this form by submitting a written request to Attn: HIPAA Records Request Department, Celtic Insurance Company, 233 S. Wacker Dr., Suite 700, Chicago, IL 60606. Note that there is a fee of \$25 per provider that must be received by Celtic from you before records will be released. Since your health care providers are the original source of this information, and they may or may not charge a fee for copies, you may wish to request this information from your provider(s) before requesting it from Celtic.

Place a Restriction on Your PHI: You may request that Celtic not use or disclose your PHI. Your request should be in writing, it must state the specific restriction requested, and it must state to whom the restriction applies. Your request should be sent to: Attn: Policyowner Service Department, Celtic Insurance Company, P.O. Box 33839, Indianapolis, IN 46203-0839. Celtic is not required to agree to a request for such a restriction, but will deny such a request only for a reasonable reason and will provide a written explanation of the reason for the denial. If Celtic agrees to the restriction, it may still disclose your PHI as permitted by law, or if your restricted PHI is needed for emergency medical treatment.

Alternative Means of Receiving Confidential Communications: You have the right to request that Celtic send and/or receive confidential communications by alternative means or to an alternative location. Celtic will accommodate your reasonable requests. Your request should be sent to: Attn: Policyowner Service Department, Celtic Insurance Company, P.O. Box 33839, Indianapolis, IN 46203-0839.

Amend Your PHI: You may request an amendment to your PHI in a designated record set for as long as Celtic maintains this information. Your request must be in writing, provide a reason to support the requested amendment, and sent to Attn: HIPAA Records Request Department, Celtic Insurance Company, 233 S. Wacker Dr., Suite 700, Chicago, IL 60606. In certain circumstances, Celtic may deny your request for an amendment. If Celtic denies your request for an amendment, you have the right to submit a statement of disagreement and Celtic may prepare a rebuttal to your statement. Celtic will provide you with a copy of any rebuttal. Since your health care providers are the original source of this information, you may consider making a request to amend your PHI directly to the individual providers.

Receive an Accounting of Certain Disclosures: You have the right to request an accounting of disclosures Celtic has made of your PHI. However, this right does not include any disclosures Celtic has made for purposes of treatment, payment or healthcare operations as described in this notice, nor does it include disclosures made for notification purposes. Please note that at the current time Celtic does not disclose PHI for any reason other than treatment, payment or healthcare operations.

Complaints: You have the right to voice a complaint to the U.S. Secretary of Health and Human Services if you believe your privacy rights have been violated. You also may file a complaint with Celtic by sending it to Attn: HIPAA Privacy Officer, 233 South Wacker Drive, Suite 700, Chicago, IL 60606. Celtic will not retaliate against you for filing a complaint.



Insured by Celtic Insurance Company

Celtic Group Company

