



Vista Healthplan of South Florida, Inc. Individual Enrollment Application

**Received Date
Office Use Only**

DO NOT CANCEL ANY HEALTH INSURANCE COVERAGE YOU CURRENTLY HAVE OR DECLINE COBRA BENEFITS UNTIL YOU RECEIVE WRITTEN NOTICE OF ACCEPTANCE FROM VISTA. PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.

Requested Effective Date (1ST of): _____
(month/year)

Each family member accepted for coverage will be contracted with Vista Healthplan of South Florida, Inc. ("VISTA"), individually, (each an "Applicant").
Note: Dependents 18 and older must complete a separate Application and provide a separate premium check.

Section A. PERSONAL INFORMATION

Primary Applicant / Parent Last Name	First Name	MI
Address	City	State
	Zip	County
Applicant Occupation and Employer	Work Phone	Home Phone/Cell Phone
Spouse Occupation and Employer	Work Phone	Applicant e-mail Address

Have you and each Applicant been continuously residing in the United States for the past 3 years at the time you signed this Application? Yes No
If "No", list applicable Applicant(s): _____

Section B. PERSON(S) TO BE INSURED – List and complete for yourself and all applying family members (Applicants).

Last Name	First Name	MI	Date of Birth mm/dd/yyyy	Sex (M/F)	Height Ft In	Weight lbs	PCP Name / Office #	Plan	Maternity Plan	Premium Amount
1. Primary Applicant (same as listed above)					-		Name:		<input type="checkbox"/> Yes	\$
Social Security #:							PCP #:		<input type="checkbox"/> No	.
2. Spouse					-		Name:		<input type="checkbox"/> Yes	\$
Social Security #:							PCP #:		<input type="checkbox"/> No	.
3. Dependent Child					-		Name:		<input type="checkbox"/> Yes	\$
Social Security #:							PCP #:		<input type="checkbox"/> No	.
4. Dependent Child					-		Name:		<input type="checkbox"/> Yes	\$
Social Security #:							PCP #:		<input type="checkbox"/> No	.
5. Dependent Child					-		Name:		<input type="checkbox"/> Yes	\$
Social Security #:							PCP #:		<input type="checkbox"/> No	.
6. Dependent Child					-		Name:		<input type="checkbox"/> Yes	\$
Social Security #:							PCP #:		<input type="checkbox"/> No	.
									Total Premium	
									\$.

Section C. HIPAA ELIGIBILITY – Select one option in this section.

1. If you or any other applying family member wish to apply as HIPAA eligible, qualified individuals must meet ALL of the following criteria:
 - a. must have 18 months of continuous creditable coverage
 - b. most recent coverage must be a group, governmental or church plan; or whose most recent coverage was under an individual plan issued in this state and which coverage terminated as a result of the carrier becoming insolvent, or discontinuing the offering of all individual coverage in the state, or due to the insured no longer living in the service area of a carrier that provides coverage through a network plan
 - c. must not be eligible for group coverage, Medicare or Medicaid, or conversion coverage
 - d. cannot have other health insurance coverage
 - e. must have elected and exhausted any COBRA or state continuation coverage
 - f. most recent coverage must not have terminated due to premium lapse or fraud.
2. I and any other applying family members do not meet the HIPAA requirements and will be reviewed through the regular underwriting process.

NOTE: If not all of the applying family members meet the HIPAA requirements, those family members, who are not HIPAA eligible must complete a separate Individual Enrollment Application and will be reviewed through the regular underwriting process.

Section D. STATEMENT OF HEALTH AND MEDICAL HISTORY – Answer all questions on behalf of all Applicants

COMPLETE DETAILS FOR ALL "YES", CHECKED/CIRCLED ANSWERS MUST BE PROVIDED IN SECTION E

If accepted for coverage, any material misstatements or omissions in this Section D may result in rescission of coverage and the voiding of the contract back to the original effective date or termination of coverage, at VISTA's sole discretion. Answer the following health questions for yourself and each Applicant applying for coverage. You must notify VISTA of any changes in your or any Applicant's health and any answers to questions in this Section D that occurred at any time after the date of you signing this Application until the effective date of coverage for you or applying family members with VISTA as set forth in the Notice of Acceptance. Failure to provide this information may result in (i) termination or rescission of your coverage to the coverage effective date, as determined by VISTA, or (ii) imposition of a pre-existing condition waiting period by VISTA, as applicable. In the event of a termination or rescission of your coverage, VISTA shall not be financially liable for any services rendered to you and will seek remedies to recover any claims paid by VISTA for such services.

1. Have you or any Applicant ever been a member of an individual or group plan by Vista Healthplan of South Florida, Vista Insurance Plan or any of their affiliates (i.e. Foundation Health, Vista Healthplan, Beacon Health Plans or Healthplan Southeast)? Yes No
If "Yes", please provide member number: _____
2. Have you or any Applicant been declined, had an exclusion imposed, postponed, had a waiver applied or been charged an extra premium for any life, disability, or health insurance or had such insurance rescinded or terminated? If "Yes", provide Applicants' name, insurance company's name and a brief explanation. _____ Yes No
3. Are you or any Applicant currently experiencing any persistent pain or symptoms (i.e. bleeding, excessive vomiting, migraines, etc.) for which you (they) have not sought or received medical advice, diagnosis, care, or treatment from a medical professional within the last 2 years? Yes No
4. Is any female Applicant listed on this Application currently pregnant or any male listed on this Application expecting a child with anyone, even if the child's mother is not listed on this Application? If "Yes", do not submit Application (unless HIPAA Applicant). Yes No
5. Have you or any Applicant been diagnosed with or treated in the past 10 years, by a medical professional, for alcoholism, drug (either legal or illegal) abuse or addiction? Yes.. No
6. In the past 10 years, has any Applicant:-
 - a. Had abnormal laboratory results, abnormal diagnostic tests or been advised to have treatment(s), surgery or hospitalization(s)? Yes No
 - b. Been a patient in a doctor's office, clinic, hospital, emergency room, or any other medical facility, other than for a routine physical exam? Yes No
 - c. Had a physical exam and the results were not within normal limits? Yes No
7. Have you or any Applicant ever tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having Aids Related Complex / Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency? Yes No
8. Are you or any Applicant currently taking or have taken any prescribed medication within the past two years? If "Yes", list the prescriptions in Section E – Drugs & Dosage Prescribed Yes No
9. Have you or any Applicant ever been treated, diagnosed, or have been advised to have treatment by a physician, hospital, or other Medical facility or provider outside the United States? If "Yes", explain in Section E. Yes No

10. Have you or any Applicant ever had a mammogram within the last 2 years (including males)? Yes No
 Results of Exam: Normal Abnormal Date: ____/____/____ (Provide physician information below. If abnormal, complete Section E.)

Physician name _____ phone _____ city _____ state _____

11. Have you or any Applicant smoked in the past 2 years? Yes No
 If "Yes", provide Applicant name(s) and date stopped (if applicable): _____

12. Do you or any Applicant currently have health insurance? If "Yes", provide Applicants' name and insurance company's name. Yes No

Females Only

13. A. Have you or any female Applicant had a Pap Smear/Pelvic Exam? Yes No
 Results of Exam: Normal Abnormal Date: ____/____/____ (Provide physician information below. If abnormal, complete Section E.)

Physician name _____ phone _____ city _____ state _____

B. Do you or any Applicant have regular monthly menstrual cycles? If answer is "No" provide explanation in Section E. Yes No

14. Have you or any Applicant ever had any testing, treatment, diagnosis, consultation, or been prescribed medication, by a medical professional, for any of the following illnesses, injuries, diseases, disorders or organs whether physical or psychological? Please check the conditions that apply and indicate the # of the Applicant from Section B that has that condition, on the same line. Also provide complete details in Section E by listing the question # from the chart below. (CHECK EACH APPLICABLE CONDITION)

(Do not draw a straight line or make a large X for multiple answers)

<input type="checkbox"/> 14.1 Allergies / Sinusitis	<input type="checkbox"/> 14.19 Diabetes / Hypoglycemia	<input type="checkbox"/> 14.37 Organ Transplants
<input type="checkbox"/> 14.2 Aneurysm	<input type="checkbox"/> 14.20 Digestive: Esophagus / Gallbladder / Gastroesophageal Reflux (GERD)	<input type="checkbox"/> 14.38 Pancreas
<input type="checkbox"/> 14.3 Arthritis / Osteoporosis / Gout	<input type="checkbox"/> 14.21 Dislocations / Sprains / Strains / Fracture	<input type="checkbox"/> 14.39 Paralysis / Polio
<input type="checkbox"/> 14.4 Asthma / Chronic Cough / Shortness of Breath	<input type="checkbox"/> 14.22 Ear / Eye Disease or Disorder	<input type="checkbox"/> 14.40 Pelvic Pain
<input type="checkbox"/> 14.5 Back / Spine / Joint	<input type="checkbox"/> 14.23 Head Injury	<input type="checkbox"/> 14.41 Penis / Prostate / Scrotum Pain
<input type="checkbox"/> 14.6 Benign Growth / Cyst / Tumor / Polyp / Mass / Lump	<input type="checkbox"/> 14.24 Headaches / Migraines	<input type="checkbox"/> 14.42 Pituitary / Adrenal Gland
<input type="checkbox"/> 14.7 Blood / Spleen / Anemia / Platelet Disorders	<input type="checkbox"/> 14.25 Heart Disease or Disorder / Arteriosclerosis	<input type="checkbox"/> 14.43 Reproductive Organs: Disease / Disorder / Abnormal Uterine Bleeding
<input type="checkbox"/> 14.8 Brain Disease or Disorder / Stroke (TIA)	<input type="checkbox"/> 14.26 Heart Murmur / Mitral Valve Prolapse	<input type="checkbox"/> 14.44 Respiratory: Emphysema / COPD / Tuberculosis
<input type="checkbox"/> 14.9 Breast Disease or Disorder	<input type="checkbox"/> 14.27 Hepatitis A <input type="checkbox"/> B <input type="checkbox"/> C / Liver Complications	<input type="checkbox"/> 14.45 Seizures / Convulsions / Epilepsy
<input type="checkbox"/> 14.10 Bursitis / Tendonitis / Carpal Tunnel Syndrome	<input type="checkbox"/> 14.28 High Blood Pressure (Hypertension)	<input type="checkbox"/> 14.46 Sexually transmitted diseases / Herpes / Human Papilloma Virus (HPV)
<input type="checkbox"/> 14.11 Cancer	<input type="checkbox"/> 14.29 High (Elevated) Cholesterol / Triglycerides	<input type="checkbox"/> 14.47 Skin / Psoriasis
<input type="checkbox"/> 14.12 Cerebral Palsy / Cystic Fibrosis / Multiple Sclerosis / Muscular Dystrophy /	<input type="checkbox"/> 14.30 Immune Disorder	<input type="checkbox"/> 14.48 Sleep Apnea
<input type="checkbox"/> 14.13 Chest Pain / Palpitations	<input type="checkbox"/> 14.31 Internal Fixations (i.e., pins, plates, screws) / Prosthesis	<input type="checkbox"/> 14.49 Thyroid / Goiter
<input type="checkbox"/> 14.14 Chronic Fatigue Syndrome / Fibromyalgia	<input type="checkbox"/> 14.32 Intestinal Bleeding / Ulcers / Hernia	<input type="checkbox"/> 14.50 Tinnitus / Vertigo / Dizziness / Fainting
<input type="checkbox"/> 14.15 Congenital Deformity, Defect: Premature Birth / Cleft Lip / Palate	<input type="checkbox"/> 14.33 Kidney / Bladder / Urinary Incontinence	<input type="checkbox"/> 14.51 Tonsils / Adenoids
<input type="checkbox"/> 14.16 Connective Tissue Disorder / Lupus	<input type="checkbox"/> 14.34 Lymphoma	<input type="checkbox"/> 14.52 Tremors / Tics
<input type="checkbox"/> 14.17 Developmental Delay / Speech Delay	<input type="checkbox"/> 14.35 Malignant Growth	<input type="checkbox"/> 14.53 Ulcerative Colitis / Crohn's Disease / Irritable Bowel Syndrome (IBS) / Hemorrhoids
<input type="checkbox"/> 14.18 Deviated Septum / Temporomandibular Joint (TMJ)	<input type="checkbox"/> 14.36 Mental / Psychiatric Disorder / Mental Retardation / Down's Syndrome / Autism	<input type="checkbox"/> 14.54 Other treatment, diagnosis or consultation not listed
<p>If no boxes are checked, must check "No" below and initial. <input type="checkbox"/> No Applicant has any of the above listed conditions. _____ (Primary Applicant initials)</p>		

Any "Yes" answers for Section D (including question 14) need to be explained in Section E.

Section E. Provide details to all "yes", checked/circled answers in the space below by question # or as otherwise required in Section D. If more space is needed, please attach a separate sheet of paper detailing the same format as below, sign and date the paper. VISTA may require that you provide medical records or have a medical examination and you will be responsible for the cost. If so, such records and examination become a part of this Application.

Question Number	Applicant's Name	Illness / Condition Treated or Results of Physical Exam	1 ST Date of Treatment or Exam	Last Date of Treatment or Exam	Drugs & Dosage Prescribed	Degree of Recovery (i.e. 50%, 75%, 100%)	Treating Physician's Name, Address and Phone Number

Section F. CONDITIONS OF ENROLLMENT – Read carefully the information below.

GENERAL CONDITIONS

VISTA reserves the right to reject any Application for enrollment. There is no coverage unless this Application is accepted by VISTA and a Letter of Approval is issued to you, even though you sent VISTA a check for the first month's premium. If your or any Applicants' Application is rejected, your money will be returned to you or applied to other Applicants who applied under this Application who are accepted for coverage.

No other department, officer, agent or employee of VISTA other than VISTA's Underwriting Department is authorized to grant enrollment. An agent cannot grant approval, change terms or waive requirements of coverage. VISTA may require that you provide medical records or have a medical examination, and you will be responsible for the cost. If so, such records and examination become a part of this Application.

You understand that it is your responsibility to provide VISTA with any changes in your or any other Applicant's health status prior to the effective date of coverage. You must notify VISTA of any additional or different information regarding you and/or any Applicant's health or any change in any information provided on this Application from the date you sign this Application until the coverage effective date. VISTA may suspend your coverage in the event of any change in the information disclosed in your Application until VISTA reviews and approves your Application considering such new information. Your failure to provide this additional information may be cause for VISTA, to rescind coverage back to the effective date and to proceed to recoup any amounts paid for services as a result of such nondisclosure. In that event, VISTA shall have no liability for the provision of coverage under the contract.

Any intentional or unintentional non-disclosure or misstatement of fact in Application materials is cause for rescission or termination of this Contract and VISTA may recoup any amounts paid for services obtained as a result of such non-disclosure or misstatement of fact. In the event of termination or rescission of the Contract, VISTA shall have no liability for the provision of coverage under the Contract.

PAYMENT OF PREMIUM

Please note that this coverage is not to be sold as a commercial group policy. If accepted for coverage, each Applicant is responsible for the initial premium as well as any future payments. If funds are drawn from a business account, I certify that I am the business owner and the payments are for myself and/or other Applicants as individuals and not as employees. I understand that payments from a business account are not for employees or others outside of my immediate family. Refund of premiums is only payable to the primary Applicant.

BINDING AGREEMENT

The applicable Certificate of Coverage, this Application and the Letter of Approval, (collectively the "Contract"), shall constitute the entire agreement between the Applicant(s) and VISTA. The Applicant(s) hereby agree to be bound by the terms and conditions as set forth in the Contract if approved for coverage in accordance herewith. **PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS.**

If Applicant(s) is accepted for coverage by VISTA, the primary Applicants' signature below shall constitute acceptance of the Contract on behalf of the primary Applicant and all other Applicants, as listed in Section B above.

I hereby agree that the Contract shall automatically renew on each subsequent anniversary of the coverage effective date subject to any and all amendments to the Contract, including but not limited to rate or benefit changes, as determined by VISTA or elected by me on behalf of myself and all Applicants, without my express consent unless I, any Applicant, or VISTA determines to terminate the Contract in accordance with its terms.

MEDICAL INFORMATION BUREAU (MIB)

Information regarding an Applicant's insurability will be treated as confidential. VISTA or the reinsurers may, however, make a brief report thereon to the MIB, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB's file,

you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

VISTA or the reinsurers, may also release information in their files to other life/health insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

OMISSIONS CLAUSE

I represent that all statements and answers made in this document, by whomsoever written including its reverse side and on any attached papers, are complete, true and correct to the best of my knowledge. I agree that this shall be the basis of my and all Applicants' acceptance of enrollment with VISTA. I understand that any misrepresentation or omission, for any reason, including but not limited to, the presence or history of pre-existing conditions may result in rescission or termination of my or any Applicant's coverage.

MINOR AS A SOLE APPLICANT

If the sole Applicant on this Application is under 18 years of age, the Applicant's parent or legal guardian must sign as such. In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information on this Application and for payment of all premiums. A legal guardian applying for a minor must submit copies of the court papers authorizing guardianship with this Application.

MATERNITY SERVICES

I understand that there is a 15-month waiting period for maternity (obstetrics) benefits if I choose a benefit plan that includes the maternity benefit. No benefits are payable for: pre-natal, delivery and post-natal care provided by a physician, hospital or other medical provider during the first 15 consecutive months of coverage. If I am a HIPAA qualified individual, the waiting period will only be waived if I am currently pregnant at the time of the effective date of coverage.

PRE-EXISTING CLAUSE

I understand that there is a 24-month waiting period for pre-existing conditions, as defined by the Contract and the Member Handbook. If you and/or any Applicant have not been continuously covered by creditable health insurance coverage over the last 24 months, you and/or such Applicant(s) may be subject to pre-existing condition exclusion. Pre-existing conditions are conditions that, during the 24 month period immediately preceding the effective date of coverage, have manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received; or a pregnancy existing on the effective date of coverage.

If HIPAA qualified, to satisfy your and/or all Applicants' continuous coverage over the applicable time period, please attach Certificates of Creditable Coverage for you and/or all HIPAA-eligible Applicants from each qualified health insurance carrier by which you and all Applicants were covered over the preceding applicable time period. If you do not have the certificates at the time of Application submission, you and/or any such Applicant may be subject to a pre-existing condition exclusion until VISTA receives such certificates or the Applicant presents relevant corroborating evidence of Creditable Coverage. Please attach all Certificates of Creditable Coverage to this Enrollment Application. HIPAA qualified individuals are not subject to the pre-existing condition limitations.

SUBSTANDARD RISK (non-preferred status) (if applicable)

Those Applicants accepted for coverage under the provisions of substandard risk (non-preferred status), will pay a higher monthly premium than those members of the same age, sex and county of residence that are not determined to be substandard risk (non-preferred status). The underwriting criteria used to determine substandard risk (non-preferred status) is developed and applied in VISTA's sole discretion.

SELECTION OF PCP

I understand that for HMO members, all referrals for specialty care and services must be coordinated by my primary care physician unless otherwise required by State or Federal law or in accordance with the applicable Certificate of Coverage. All HMO members must obtain a written referral form, which shall be provided by their primary care physician or by VISTA prior to seeing any specialist, unless this requirement is waived by VISTA or State Federal Law.

INDEPENDENT CONTRACTOR

I understand that VISTA does not directly employ any participating providers or facilities. All health care providers and facilities are independent contractors and are not the agents or employees of VISTA.

COUNTERPARTS

This Application may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall constitute a single agreement

ACKNOWLEDGMENT AND AGREEMENT

I understand and agree to abide by all terms, conditions and provisions of the Contract. I have read and understand this Application including the conditions of enrollment. I understand if this Application is accepted it will become part of the Contract. My signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct.

Section G. AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION

I, on behalf of myself and all Applicants, authorize any licensed physician, hospital, healthcare provider, insurer or any other medical or insuring entity in possession of my and/or any Applicant's medical records and information, including any and all mental health records and information, to identify possible pre-existing conditions. I, on behalf of myself and all Applicants, hereby provide VISTA with consent to use identifiable information for general treatment, payment or health care operations, including but not limited to coordination of care, quality assessment, utilization review, fraud detection or accreditation purposes. If personally identifiable information is to be used for any other purpose, VISTA will obtain specific authorization from me and all other Applicants as required.

I, on behalf of myself and all Applicants, do hereby authorize VISTA and its authorized employees, agents, independent contractors and contracted providers to release to, or obtain from, any person, health care provider, organization or government agency, any information and records, including patient records of Applicants and information on any condition which VISTA requires or is obligated to provide pursuant to legal process, federal, state or local law, or otherwise requires to administer the Contract or determine whether to accept me or any Applicant for coverage as requested under this Application. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other health care facility or provider, insurance company, the MIB or other organization, institution or person, that has any records or knowledge of me or any Applicant or our health, to give to VISTA and the re-insurers, any such information. A photocopy of this authorization is considered as valid as the original. VISTA is entitled to make a photocopy of this authorization. This authorization shall remain in effect indefinitely unless properly terminated by written notice by you to VISTA.

I hereby represent that I have authority to act on behalf of and bind all Applicants listed in Section B to the terms and conditions set forth in this Application.

The Certificate of Coverage can be obtained through the VISTA website at www.vistahealthplan.com, or by calling the VISTA Customer Service Department at 1-800-441-5501 and requesting a hardcopy of the Contract be mailed via U.S. regular mail. Your signature on this Application represents acceptance of these delivery options.

I have read and understand the terms of this Application. By signing this Application, I agree to these terms. The information I have provided on this Application is complete, true and correct to the best of my knowledge. I understand that VISTA reserves the right to rescind or terminate coverage due to any material misrepresentation on this Application. Material misrepresentation is determined at the sole discretion of VISTA. Failure to provide updated medical history information as required in Section D of this Application may result in: (i) termination or rescission of your coverage to the coverage effective date, as determined by VISTA, or (ii) imposition of a pre-existing condition waiting period by VISTA, as applicable. In the event of a termination or rescission of your coverage, VISTA shall not be financially liable for any services rendered to you and will seek remedies to recover any claims paid by VISTA for such services.

I have received a conditional cash receipt.

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.

Adult Applicant(s) / Parent or Legal Guardian and agent (if required) must sign and date below

PRIMARY APPLICANT'S / PARENT or LEGAL GUARDIAN SIGNATURE
(circle) if sole Applicant is under 18 years old

DATE

PRINT NAME

SPOUSE'S SIGNATURE

DATE

PRINT NAME

ALL MATERIALS WILL BE PROVIDED IN ENGLISH ONLY.

Each member of the family will be medically underwritten separately and assigned a separate medical coverage based on his own health risk. If one or more family members are not approved, VISTA will cover the approved family members unless indicated below:
 I, the Applicant, instruct VISTA not to cover any eligible members unless all family members are approved for coverage.

Section H. STATEMENT OF ACCOUNTABILITY

To be completed when the Applicant cannot complete the Application.

I, _____, personally read and completed this Individual Enrollment Application for the Applicant.
X _____ / / _____
Signature Translator (required) Date signed (required)

Section I. BILLING OPTIONS

- First Month EFT, thereafter monthly EFT (No Administrative Fee). Complete EFT Authorization below and provide copy of a voided check. Premium check not required with Application. (See the last page)
- First Month EFT, thereafter monthly billing (subject to Administrative Fee of \$5 per person per month). Complete EFT Authorization below and provide copy of a voided check. Premium check not required with Application. (See the last page)
- Bill Monthly (subject to Administrative Fee of \$5 per person, per month). *Premium check required with Application. (See the last page)

Date of Check: _____ Check #: _____
Total Premium paid: _____
All withdrawals will be on the first business day of the month.

ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION

Account Holder's Name: _____ Account Number: _____
Bank's Name: _____ Bank's Routing #: _____

I hereby authorize Vista Healthplan of South Florida, Inc. ("VISTA") to initiate withdrawals to my account indicated above at the depository financial institution named above each month to collect the monthly premium amount due. The monthly withdrawal will be made to my account on or after the first

day of each month. In addition, if I owe additional balances to VISTA, I authorize VISTA to initiate withdrawals from my account indicated above at the depository financial institution named above to collect, in a single withdrawal, the monthly premium amount due, plus the additional balances due, not to exceed two times the monthly premium amount. For any month in that VISTA will withdraw more than the monthly premium amount, VISTA will send me by mail an invoice or letter in writing at least ten (10) days prior to the first day of the month identifying the varying amount that will be withdrawn that month on or after the first day of the month.

If my premium is past due or I have outstanding balances, the withdrawal by VISTA will be applied to the outstanding premium or balances first. Unless I also make a payment by check or authorize a separate electronic withdrawal by VISTA so that VISTA receives my payment no later than the last day of the grace period, my account will remain past due and my VISTA coverage could be terminated for non-payment. My payments to VISTA (whether made by electronic withdrawal, mail or other delivery) must be in VISTA's possession by the last day of the grace period or VISTA may terminate my VISTA coverage for non-payment. At all times, my VISTA coverage is subject to retroactive termination for non-payment up to 45 days after a premium due-date in accordance with Fla.Stat. 641.3108(2).

This authorization will remain in effect until I notify VISTA in writing and VISTA has a reasonable opportunity to act on the notice. I may also stop payment by notifying my depository financial institution. I agree that VISTA's rights with respect to any electronic withdrawal shall be the same as if it were a check signed personally by me. I acknowledge and agree that I shall be financially responsible for any services received after the termination date of my VISTA coverage if I am terminated for non-payment.

I agree to be bound by the terms of this Payment Authorization, the laws of the State of Florida, and the Rules and Operating Guidelines of the National Automated Clearing House Association.

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 OF ACCOUNT HOLDER _____ DATE ____ / ____ / ____

Section J. AGENT INFORMATION

Agent must complete information below (HIPAA Applications do not require an agent)

General Agent Name, if applicable		Agent Name		Agent Social Security #		Agent License Number		
Address			Suite #	City			State	Zip
Business Phone Number - -		Cell Phone Number - -		Fax Number - -		E-mail Address		
Was sale generated from a VISTA lead? <input type="checkbox"/> Yes <input type="checkbox"/> No								

Are you aware of any information not disclosed in this Application which may have a bearing on this risk? Yes No
If yes, please attach explanation. _____

Did you see the Applicant(s) and did you ask each question in this Application exactly as set forth? Yes No
If No explain: _____

I have read the Application and all questions have been answered in full. (Incomplete Applications will be returned.)

Agent's Signature

Date Signed

Attach voided check here.

(This is required for billing options 1 and 2.)

Attach premium check here for billing option 3.

Attach any additional checks here.



Vista Healthplan of South Florida

Medical Records Release & Pharmacy Information Retrieval Authorization Form (FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR HEALTH BENEFITS)

This form must be completed by each Applicant

NAME: _____ Maiden name or other _____

ADDRESS: _____

SSN: _____ Date of Birth: _____

I hereby request and authorize any physician indicated below or as may be requested by Vista Healthplan of South Florida:

PHYSICIAN NAME: _____

ADDRESS: _____

PHYSICIAN NAME: _____

ADDRESS: _____

PHYSICIAN NAME: _____

ADDRESS: _____

To release the specified information from my medical records to:
Management Research Services, Inc.
P.O. BOX 510304
New Berlin, WI 53151
FAX: (866) 422-6603

Medical records should include copies of the physician's charts/notes as well as the results of any laboratory or diagnostic tests performed in the last 24 months.

Applicant's Authorization for Release of Medical Information

I, on behalf of myself and all dependents, authorize any licensed physician, medical practitioner, hospital, clinic pharmacy benefits manager or other pharmacy related services provider or other medical or medically related facility provider, insurance company or other organization, institution or person, that has any records or knowledge of me or any dependent, including but not limited to personal information, records concerning physical or mental illness, information relating to autoimmune deficiency syndrome (AIDS), human immunodeficiency virus (HIV), the use of drugs or alcohol or other advice, diagnosis, prognosis, prescription information, care or treatment provided to me or any dependent, to release such information to VISTA or its authorized representatives. I, on behalf of myself and all dependents, hereby provide VISTA with consent to use personally identifiable information for general treatment, underwriting, payment or health care operations, including but not limited to coordination of care, quality assessment, utilization review, fraud detection or accreditation purposes. I understand information obtained with my authorization may be re-disclosed by VISTA as permitted or required by law and in some instances may no longer qualify for protection under Federal and State privacy laws. If personally identifiable information is to be used for any other purpose, VISTA will obtain specific authorization from my and all other dependents as required by applicable law. This authorization is valid from the date signed until revoked by me in writing (which I may do at any time) or such shorter period required by applicable law. Any revocation will not affect the activities of VISTA prior to the date revocation is received by VISTA.

In completing this form and answering the questions set forth herein, you should not include any of your and/or your dependent's family history or genetic information (including, but not limited to, genetic testing, genetic services, genetic counseling, or genetic diseases for which you and/or your dependents may be at risk).

If the Individual Application for health coverage has been submitted on-line, by entering my name below I am indicating my intent to electronically sign this form and warrant that all the information I have provided is true, complete and accurate.

Authorization must be signed by patient or authorized representative of the patient.

Applicant/Parent or Legal Guardian: _____
Signature Date