Consumers Life Insurance Company

Application Instructions

1. Download and print all pages of the application including instructions.
2. When Filling out the application, write clearly using a blue or black ballpoint pen.
3. Complete all questions and sections of the application.
4. Complete the fax cover letter on the next page and fax to Consumers Life for review along with the completed application.

If you do not have access to a fax machine, send the completed application to:

Business Distribution Solutions
2720 Dupont Commerce Court
Suite 170
Fort Wayne, IN 46825

Helpful Tips

When completing your application, be sure to:

- Indicate your requested effective date
- Select your preferred billing method.
- Sign and date the application.

Important Note

If you have requested that your month premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign and date the financial institution portion of *Section V: Billing Information* of the application. *All applications will be considered invalid 60 days after the signature date.*

Consumers Life will review your application for completeness and accuracy before submitting to Consumers Life Underwriting department for further review. Within five to seven days, you will be notified of your acceptance and estimated monthly premium. At that time, if you accept the estimated premium rates and would like to continue, your application will be processed.

Do not cancel any current health insurance coverage until you receive an approval letter and insurance policy, also known as insurance contract or certificate, from Consumers Life Insurance Company. Make sure you understand and agree with the terms of this policy. Pay special attention to the effective date, premium amount, benefits, limitations, exclusions and riders.

The rate quoted are estimates only, and are subject to change based on your medical history, the underwriting practices of Consumers Life, the optional benefits selected, if any and the other relevant factors. Consumers Life reserves the right to change the terms of the policy under proper notification.

If you have any questions regarding the application process, please call 877/713-3311 or email quote@bdsagency.com.

Consumers Life Insurance Company
Fax Cover Sheet

Please fax the following information with the completed application to 800/341-1854.

Dear Consumers Life,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application.

Name ____

E-mail ____

Date ____

Phone ___________________________________

Consumers Life will contact you by phone after we have reviewed your application. If you wish to contact Consumers Life to verify receipt of your application, you may call 877/713-3311.

Thank you for your interest in Consumers Life Insurance Company.

☐ Consumers Life Insurance Company, Cleveland, Ohio

Coverage(s) will be provided by the Company indicated above. Healthcare benefits including dental and vision will be provided by Consumers Life Insurance Company.

INTERNAL USE ONLY
EFFECTIVE DATE: ____ / ____ / ____
GROUP NO: ______________

Health Application/Change Form — Indiana

INSTRUCTIONS: All questions must be answered. Incomplete applications will be returned.

Section I: Contract Holder Information

Last Name	MI	First Name	SS Number

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed | Marriage Date: / / | Divorce Date: / /

Permanent Residence	E-mail Address	City

County	State	Zip Code	Area Code/Phone Number	Occupation

Reason for Application: ☐ Applying for new coverage ☐ Applying for dependent only coverage ☐ Applying for change to current coverage

LIST BELOW ALL INDIVIDUALS TO BE COVERED

	First Name, MI (and last name, if different)	SS Number	Birth Date	Sex	Height	Weight	Tobacco User	Physician	Student (Circle)
Self							Y N		Y N
Spouse							Y N		Y N
1							Y N		Y N
2							Y N		Y N
3							Y N		Y N

Section II: Products

Desired Effective Date __________ / __________ / __________ (when coverage is to begin)

Network: ☐ SuperMed Plus/PHCS ☐ SuperMed Plus/Sagamore

Standard Plans – 80% Coinsurance
- ☐ $500/$1,500 Deductible
- ☐ $1,000/$3,000 Deductible
- ☐ $1,500/$4,500 Deductible
- ☐ $2,500/$5,000 Deductible
- ☐ $5,000/$10,000 Deductible

Select Copay for Above Plan – 80% Coinsurance
- ☐ No Copay
- ☐ $25
- ☐ $40

Standard Plans – 100% Coinsurance – No Copay
- ☐ $2,500/$5,000 Deductible
- ☐ $5,000/$10,000 Deductible

Available Riders for all Standard Plans:
- ☐ Preventive Services
- ☐ Prescription Drug
- ☐ Supplemental Accident

Personal Health Plans – HSA Compatible:
- ☐ $1,200/$2,400
- ☐ $2,000/$4,000
- ☐ $2,500/$5,000
- ☐ $3,000/$6,000
- ☐ $4,000/$8,000
- ☐ $5,000/$10,000

- ☐ $1,200/$2,400 Wellness
- ☐ $2,000/$4,000 Wellness
- ☐ $2,500/$5,000 Wellness
- ☐ $3,000/$6,000 Wellness
- ☐ $4,000/$8,000 Wellness
- ☐ $5,000/$10,000 Wellness

Personal Health Plans – Value Plans:
- ☐ $500/$1,500
- ☐ $1,000/$3,000
- ☐ $1,500/$4,500
- ☐ $2,500/$7,500
- ☐ $5,000/$15,000

Available Riders for all Value Plans:
- ☐ Prescription Drug

Personal Health Plan – Short Term:
- ☐ $500/$1,000

Optional Coverage:
☐ Dental ☐ Vision

Section III: OTHER COVERAGE INFORMATION

1. ☐ Yes ☐ No Do **YOU,** your **SPOUSE,** or any listed **DEPENDENT** have any other type of coverage (Accident, Medicare, Medicaid, etc.) or are you currently applying for any other health insurance? If yes, please complete the following:

NAME	TYPE	NAME OF INSURANCE COMPANY

2. ☐ Yes ☐ No Were **YOU,** your **SPOUSE,** or any listed **DEPENDENT** covered by another health plan within the last 63 days? If yes, please complete the following:

NAME	NAME OF INSURANCE COMPANY	DATE OF COVERAGE FROM:	TO:

Section IV: MEDICAL ELIGIBILITY

A. ☐ Yes ☐ No Are **YOU,** your **SPOUSE** or any **DEPENDENT** currently pregnant or an expectant parent?

Name	Due Date

B. ☐ Yes ☐ No Are **YOU,** your **SPOUSE** or any listed **DEPENDENT** currently taking any prescription medications?

NAME	MEDICATION	DOSAGE	MEDICAL CONDITION

C. ☐ Yes ☐ No Has any insurance company refused, restricted or charged more for health coverage on any person listed on this Application?

NAME	REFUSAL OR RESTRICTION	MEDICAL CONDITION

D. ☐ Yes ☐ No DO **YOU,** your **SPOUSE** or any listed **DEPENDENT** have a condition covered by Workers' Compensation?

NAME	WORKERS' COMPENSATION NUMBER	MEDICAL CONDITION

E. ☐ Yes ☐ No In the past five years, have **YOU,** your **SPOUSE** or any listed **DEPENDENT** engaged in sports or hobbies such a scuba diving, automobile or motorcycle racing, skydiving or aero sports on a regular/routine basis? If YES, please complete the following:

NAME	SPECIFIC ACTIVITY

F. When was the last time **YOU,** your **SPOUSE** or any listed **DEPENDENT** saw a physician? Please complete the following:

NAME	DATE	REASON	RESULTS

Section IV: MEDICAL ELIGIBILITY (continued)

G. Have **YOU,** your **SPOUSE,** or any listed **DEPENDENT** within the past five years been treated for, diagnosed as having, hospitalized, had surgery, been recommended for future surgery, diagnostic testing or medical treatment or thought you should seek medical advice for any of the following conditions? Each condition must be checked (√) Yes or No.

CONDITION	YES	NO
1. Abnormal Pap Smears	☐	☐
2. AIDS, ARC, or HIV	☐	☐
3. Allergies	☐	☐
4. Alzheimer's Disease	☐	☐
5. Aneurysm	☐	☐
6. Anorexia/Bulimia	☐	☐
7. Arthritis (Type: _____________)	☐	☐
8. Asthma	☐	☐
9. Back Sprains/Strains	☐	☐
10. Bronchitis	☐	☐
11. Bursitis	☐	☐
12. Cancer (Type: _____________)	☐	☐
13. Cardiomyopathy	☐	☐
14. Carotid Artery Disease	☐	☐
15. Carpal Tunnel Syndrome	☐	☐
16. Cataracts	☐	☐
17. Cerebral Palsy	☐	☐
18. Cholesterol (High)	☐	☐
19. COPD or Emphysema	☐	☐
20. Cirrhosis of the Liver	☐	☐
21. Colitis (Including Ulcerative)	☐	☐
22. Colon Polyps	☐	☐
23. Congenital Disorders	☐	☐
24. Congestive Heart Failure	☐	☐
25. Coronary Artery Disease (Including Angina and Angioplasty)	☐	☐
26. Coronary Insufficiency	☐	☐
27. Crohns Disease	☐	☐
28. Cystic Fibrosis	☐	☐
29. Cystitis (Chronic or interstitial)	☐	☐
30. Cysts, Tumors or Growths	☐	☐
31. Diabetes/Blood Sugar Disorder Last 3 Blood Sugars & Dates: 1) ______________________ 2) ______________________ 3) ______________________	☐	☐
32. Diverticulitis/Diverticulosis	☐	☐
33. Down's Syndrome	☐	☐
34. Drug/Alcohol Abuse (Including DUI's)	☐	☐
35. Endometriosis	☐	☐
36. Fibrocystic Breast Disease	☐	☐
37. Fibromyalgia	☐	☐
38. Gallbladder Disease	☐	☐
39. Gastric Reflux (GERD)	☐	☐
40. Gout	☐	☐
41. Graves Disease	☐	☐
42. Growth Deficiency	☐	☐
43. Guillan Barre Syndrome	☐	☐
44. Heart Attack	☐	☐
45. Heart Bypass Grafting	☐	☐
46. Heart Murmur	☐	☐
47. Heart Palpitations/Arrhythmia	☐	☐
48. Heart Valve Disorders	☐	☐
49. Hemorrhoids	☐	☐
50. Hemophilia	☐	☐
51. Hydrocephalus/Shunt	☐	☐
52. Hypertension (High Blood Pressure) Last 3 Pressures & Dates: 1) ______________________ 2) ______________________ 3) ______________________	☐	☐
53. Ileostomy/Colostomy	☐	☐
54. Infertility	☐	☐
55. Kidney Failure	☐	☐
56. Kidney Stones	☐	☐
57. Liver Disorders/Hepatitis	☐	☐
58. Lou Gehrig's Disease (ALS)	☐	☐
59. Meningitis	☐	☐
60. Menstrual Disorders (including Abnormal Cycles/Uterine Bleeding)	☐	☐
61. Mental Health Disorders (Including Depression, Anxiety, ADD/ADHD and counseling)	☐	☐
62. Migraines	☐	☐
63. Multiple Sclerosis	☐	☐
64. Muscular Dystrophy	☐	☐
65. Organ Transplant/Failure	☐	☐
66. Osteoporosis	☐	☐
67. Otitis Media (ear infections)	☐	☐
68. Ovarian Cyst/Polycystic Ovarian Disease	☐	☐
69. Pacemaker Implantation	☐	☐
70. Pancreatitis	☐	☐
71. Paralysis	☐	☐
72. Parkinson's Disease	☐	☐
73. Peptic/Gastric Ulcer	☐	☐
74. Peripheral Vascular Disease	☐	☐
75. Phlebitis/Blood Clot	☐	☐
76. Polycystic Kidney Disease	☐	☐
77. Prostate Disorders	☐	☐
78. Schizophrenia/Bipolar	☐	☐
79. Scleroderma	☐	☐
80. Seizure Disorder/Epilepsy	☐	☐
81. Sexually Transmitted Diseases	☐	☐
82. Sleep Apnea	☐	☐
83. Spina Bifida Cystica/Occulta	☐	☐
84. Spinal Disorders/Disc Disease	☐	☐
85. Stroke	☐	☐
86. Suicide Attempts/Psych Admits	☐	☐
87. Systemic Lupus	☐	☐
88. Tendonitis	☐	☐
89. Thyroid Disorder	☐	☐
90. TMJ	☐	☐
91. Tonsillitis	☐	☐
92. Transient Ischemic Attacks (TIA)	☐	☐
93. Varicose Veins	☐	☐
94. Other conditions not listed	☐	☐

H. If any questions A through G or conditions 1 through 94 are checked "YES", please explain below, (use additional paper, if necessary). Indicate all details of the injury, ailment or condition. Include items such as specific location of condition (example: right knee), diagnosis, type of treatment and hospitalization.

Question/ Condition	Patient's Name	Details of Injury, Ailment or Condition	Start Date(s) of Treatment(s)	End Date(s) of Treatment(s)	Physician

Section V: BILLING INFORMATION

CHOOSE ONE:

☐ **HOME — Receive monthly premium billings**

☐ **FINANCIAL INSTITUTION — Have monthly automatic premium withdrawls**

If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Consumers Life Insurance Company® to initiate premium deductions from my account. The authorization will remain in effect until Consumers Life Insurance Company and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from: ☐ Checking ☐ Savings (deducted on 1st business day of the month)

(*Please note: Not all Financial Institutions allow deductions from a savings account. Please verify this information with your financial institution.)*

In case of insufficient funds, a $20 returned check fee will be applied.

Name and branch of bank/financial institution			Account Number
Address			Account Holder's Name
City	State	Zip	Transit Routing Number
Account Holder's Signature			Date

Please attach a voided check for checking account or a deposit slip for savings account in order for our office to verify the bank information.

☐ **CREDIT CARD – Have monthly premium billed to credit card**

If you wish to be billed through your credit card, please complete the following authorization: (charged on 1st business day of the month)

☐ Mastercard ☐ Visa ☐ Discover ☐ American Express

Cardholder Name	Card Number
Bank Name (if applicable)	Expiration Date
Account Holder's Signature	Date

☐ **LIST BILLING THROUGH EMPLOYER– is available only to employees of a common employer who has agreed to collect the premiums on a monthly basis through payroll deduction and where the employer is not paying any portion of the premium.**

Name of Employer	Occupation	
Address	Area Code and Phone Number	
City	State	Zip Code

☐ **DIFFERENT BILLING ADDRESS Have home billing sent to a different address**

If your mailing address is different than your permanent address, complete the following:

Last Name (C/O)	First Name	MI
Address		
City	State	Zip Code

ATTACH VOIDED CHECK OR DEPOSIT SLIP HERE

FOR OFFICE USE ONLY

Sold – Account Executive and Code
Service – Account Executive and Code

or

Agent of Record	Tax I.D.
Royal Advantage® Broker	Commission Indicator

Section VI: TERMS AND CONDITIONS

aI hereby apply to Consumers Life Insurance Company (CLIC) for the coverage indicated on this Application.

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), government agency or person to CLIC and/or any affiliates or division of CLIC: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize CLIC to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.
2. I agree that a medical examination of me may be required in connection with this Application. I further agree that I, as the Applicant, will be responsible to pay for the medical examination and/or the release of any and all records on behalf of myself, my spouse, and/or the listed dependents.
3. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true; and (d) I did not sign a blank or partially completed Application. I agree that CLIC, in its sole discretion, may rescind my policy at any time on the basis of any untrue, inaccurate or incomplete answer to any question in this Application, or any misrepresentation, omission or concealment on this Application, whether intentional or otherwise. I further agree that if a policy is issued, it will be issued by CLIC in full reliance and in consideration of the information, answers and statements contained herein. I understand that the policy for which I am applying will be medically underwritten, and that I must notify CLIC if there is a change in the health history of any applicant between the time I sign this application and the effective date of coverage, if approved.
4. I have read the sales materials and understand the plan benefits, exclusions, and limitations as outlined therein. I acknowledge that the managed care features of the health policy for which I am applying have been explained to my satisfaction.
5. No issuance, waiver, modification or change of policy or any of CLIC rules or amendments shall be binding upon CLIC unless it is in writing and signed by an authorized officer of CLIC, as applicable.
6. Notice: Certain Pre-Existing Condition limitations will apply. For health insurance, a Pre-Existing Condition is a condition which had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical or surgical care, advise, consultation, equipment, devices, diagnosis, drugs (prescribed or non-prescribed), examination, observation, services, supplies or testing, prior to the covered person's Enrollment Date. The Enrollment Date is the covered person's effective date. If a Pre-Existing Condition existed at any time during the six (6) month period immediately preceding the covered person's Enrollment Date, the Pre-Existing Condition will be covered no later than twelve (12) months after the covered person's Enrollment Date.
7. I represent that neither I nor my spouse are receiving any form of reimbursement or compensation for this coverage from any employer.
8. I also understand that information submitted with this Application may require further medical underwriting. If that underwriting discloses additional medical risk, I understand that there may be a significant change in the rate charged for this coverage or, in certain cases, the coverage may be rescinded. A permanent ID card will be issued following the final review and acceptance of the Application.
9. I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this Application. I understand and agree that no agent or broker who may be assisting in the completion of this Application has any authority: (a) to waive any answer or any portion of any answer to any question on this Application or any information CLIC requests; (b) to advise me that I am not obligated to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application; (c) to make any representation concerning benefits that are inconsistent with, or different from, any written information provided by CLIC; (d) to bind CLIC in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy; (e) to answer any questions in, or insert any information on, this Application on my behalf; or (f) to approve coverage.
10. I understand and agree that I am responsible for disclosing all information required by this Application, including but not limited to, all health conditions and diagnoses of which I am aware. I understand and agree that CLIC has the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this Application and that I am obligated to disclose even those conditions or diagnoses that I do not believe are significant or important.
11. My dependents and I understand and agree that any information obtained will not be released by CLIC to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any Application, claim, or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I (we) may request to be interviewed in connection with the preparation of the report. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may be not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to CLIC's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by CLIC's Privacy Office.
12. I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV – AIDS test results or diagnosis. I expressly consent to the release of such information.

I am signing this Application on my own behalf and on behalf of all listed dependents. An unaltered copy of this authorization is as valid as the original. I understand that I should not cancel any current insurance coverage until I receive an approval letter and policy from CLIC.

Contract Holder's or Guardian's Signature	Date	Guardian's Social Security Number if child only policy	
Spouse's Signature	Date	Dependent's Signature (if 18 or older)	Date
Dependent's Signature (if 18 or older)	Date	Dependent's Signature (if 18 or older)	Date

Section VII: HOW DID YOU HEAR ABOUT PERSONAL HEALTH PLAN? (CHECK ONE)

☐ 1. Friend/Family Member
☐ 2. Yellow Pages
☐ 3. Insurance Agent
☐ 4. Advertisement in Newspaper, Magazine, etc.
☐ 5. Newspaper Article
☐ 6. Internet/Web site
☐ 7. Radio
☐ 8. Mail
☐ 9. Through current employer
☐ 10. Other ____________________

WARNING: Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.