



HEALTH INS. CO.

# TRH HEALTH INSURANCE COMPANY APPLICATION FOR CHANGES TO GRANDFATHERED PLANS

PLEASE PRINT USING BLACK INK

Section 1 Primary Applicant Information						OFFICE USE ONLY		
First Name	MI	Last Name	Phone No. ( ) - -	Sub Group	County			
Mailing Address			Alternate No. ( ) - -	Effective Date				
City			State	Zip Code	ID Number			
Date of Birth	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status (Optional) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Date of Marriage/Divorce	Social Security No.	Rating Action:		
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:	Person	Rider(s) #	
TN Farm Bureau membership is in the name of:			TN Farm Bureau membership number:				1. _____	
							2. _____	
							3. _____	
							4. _____	

Section 2 Other Insurance Information			
Have you or anyone for whom you are applying been covered by or are you or anyone for whom you are applying currently covered by another TRHH, TRH or BlueCross BlueShield of Tennessee policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the following:			
Name of Insured	Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Step-Parent	ID/Policy No.	Group No.
			Person(s) Excluded: 1. _____ 2. _____

Section 3 Application Type	
<input type="checkbox"/> Add a Dependent to Existing Family Coverage	<input type="checkbox"/> Add a Dependent to Existing Individual Coverage and Change to Family Coverage
<input type="checkbox"/> Transfer From Other TRHH Coverage. Current ID Number: _____	

Section 4 Coverage Options	
<input type="checkbox"/> Complete Care - Deductible: \$1500 <input type="checkbox"/> Individual (No maternity benefits) <input type="checkbox"/> Family (Maternity benefits after a member's coverage has been in effect for 9 consecutive months.)	<input type="checkbox"/> Premier - Deductible Options: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> Individual (No maternity benefits) <input type="checkbox"/> Family (Maternity benefits after a member's coverage has been in effect for 9 consecutive months.)
<input type="checkbox"/> Major Medical - Deductible: \$5000 <input type="checkbox"/> Individual (No maternity benefits) <input type="checkbox"/> Family (Maternity benefits after a member's coverage has been in effect for 9 consecutive months.)	<input type="checkbox"/> High Deductible (HSA-Qualified) (Individual/Self only - No maternity benefits) (2 or 3-Person and Family - Maternity benefits after a member's coverage has been in effect for 9 consecutive months) <input type="checkbox"/> Self Only - \$1500 Deductible <input type="checkbox"/> 3-Person - \$5000 Deductible <input type="checkbox"/> Self Only - \$2500 Deductible <input type="checkbox"/> Family - \$3000 Deductible <input type="checkbox"/> 2-Person - \$5000 Deductible <input type="checkbox"/> Family - \$5000 Deductible
<input type="checkbox"/> Value Care - Deductible Options: <input type="checkbox"/> \$600 <input type="checkbox"/> \$1200 <input type="checkbox"/> \$2000 Individual Only (No maternity benefits)	
<input type="checkbox"/> Other _____	

Section 5 Spouse / Dependent Information							
Please complete only if your spouse and/or dependent children are applying for coverage.							
SPOUSE First Name	MI	Last Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Age	Social Security No.	
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:		
DEPENDENT 1 First Name	MI	Last Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Age	Social Security No.	
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:		
DEPENDENT 2 First Name	MI	Last Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Age	Social Security No.	
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:		
DEPENDENT 3 First Name	MI	Last Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Age	Social Security No.	
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:		
DEPENDENT 4 First Name	MI	Last Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	Age	Social Security No.	
Tobacco Use: <input type="checkbox"/> Never <input type="checkbox"/> Currently use tobacco products <input type="checkbox"/> Previously used tobacco products but stopped on (MM/YY): _____			Height	Weight	Primary Care Physician:		



Primary Applicant First Name

MI

Last

**Section 5 - Continued**

**Please answer the following questions if you are applying for any dependents other than your spouse:**

- Yes  No 1. Are all children for whom you are applying under the age of 26, and your (Please select all that apply):  
 Biological children  Adopted children  Step-children  Children placed with you in anticipation of adoption?  
 If "No," please explain \_\_\_\_\_
- Yes  No 2. Are there court documents establishing the responsible party for providing health coverage for any children for whom you are applying?  
 If "Yes," please submit a complete copy of the final court documents including but not limited to the Final Decree of Divorce, Permanent Parenting Plan or Final Order of Adoption.

TRHH reserves the right to request proof of continuing dependent eligibility at any time. In the event dependent eligibility cannot be determined based on the answers submitted on the application, additional information may be requested.

**Section 6 General Information**

**Please Read Carefully as this Contains Important Information**

You may change from individual coverage to family coverage and add eligible dependents by satisfying certain conditions as determined by TRH Health Insurance Company ("TRHH"). You must apply for such changes. If your application is approved, the change will become part of your contract. An existing family coverage cannot be modified unless the family unit is broken. The family unit is broken only when all dependents lose eligibility under the existing family coverage or upon the occurrence of certain qualifying events as determined by TRHH. You must apply to modify your family coverage. If your application to modify your family coverage is approved, the change will become a part of your contract.

Individual Coverage has no maternity benefits. Family coverage includes maternity benefits after a member's coverage has been in effect for nine consecutive months.

Quoted premiums are only an estimate. This application will be medically underwritten and TRHH may need to adjust your premium based on the information submitted on the application and any medical information submitted during the underwriting process. In addition to being medically underwritten, TRHH coverages are age-rated. Rate adjustments may occur as the oldest person on the contract ages. Overall general rate adjustments may also be necessary. You will be notified by letter thirty (30) days in advance of any rate adjustment.

THERE IS AT LEAST A 12-MONTH PRE-EXISTING CONDITION WAITING PERIOD FOR ANY CONDITIONS THAT WERE IN EXISTENCE PRIOR TO THE COVERAGE'S EFFECTIVE DATE FOR ANYONE ON THE CONTRACT AGE 19 AND ABOVE. A pre-existing condition is defined in the contract as: "An illness, injury, pregnancy or any other medical condition which existed at any time preceding the effective date of coverage under this contract for which: medical advice or treatment was recommended by, or received from, a provider of health care services; or symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment." The pre-existing condition waiting period applies regardless of any previous or current coverage (unless you are a dependent eligible to transfer from an existing TRH coverage).

**Section 7 Health Questionnaire**

**Please Read Carefully as this Contains Important Instructions for Completing the Health Questionnaire**

All health questions must be answered "Yes" or "No". If any of the answers are "Yes", please provide complete and accurate details in the space provided. We are relying on the information you provide on this application to determine eligibility for coverage for you, your spouse and any children for whom you are applying. Inaccurate or incomplete information provided on this application may constitute misrepresentation. Material misrepresentation could result in amended coverage or termination of coverage. Your full signature is required next to any changes you make to your responses to these questions.

Additional medical information may be needed to complete underwriting. The applicant is responsible for requesting and obtaining medical information from providers and ensuring the medical information is received by TRHH. Any charges rendered by providers associated with obtaining medical information are to be paid by the applicant.

The applicant is encouraged to keep a personal copy of all medical records submitted to TRHH. Once medical records are submitted to TRHH, the applicant must contact the TRHH Privacy Office to obtain a copy of medical records. The applicant will be charged a fee for the return of medical records.

All persons age 40 and older and children age 25 months and under will automatically receive a request for medical information (details below). This information may be submitted with the application to help expedite the application process.

The following medical records will be required for ages:

(a) 40 and older: COPY OF MEDICAL RECORDS WITH A CURRENT MEDICAL EXAM TO INCLUDE HEIGHT, WEIGHT AND BLOOD PRESSURE READINGS (COMPLETED WITHIN THE LAST 6 MONTHS); A LIST OF CURRENT HEALTH CONDITIONS, CURRENT MEDICATIONS, AND FASTING CHOLESTEROL (LIPID) PANEL TEST RESULTS AND FASTING GLUCOSE (SUGAR) TEST RESULTS (DONE WITHIN THE LAST 12 MONTHS)

(b) 25 months and under: COPY OF MEDICAL RECORDS REGARDING ALL PEDIATRIC VISITS FROM BIRTH TO PRESENT TO INCLUDE THE NEWBORN METABOLIC SCREENING RESULTS, IMMUNIZATION HISTORY OR STATEMENT OF INTENT TO IMMUNIZE

If medical information is not received by TRHH within thirty (30) days from the date of the request, your application for coverage will expire. To reapply for coverage, a new application and \$6 application fee will be required.

When answering the questions in this application, consider the health of yourself, your spouse and all children for whom you are applying. Claims experience from any previous TRHH plan or BlueCross BlueShield of Tennessee policy may be considered during the underwriting process.



Primary Applicant First Name

MI

Last

**Section 7 - A**

**Heart / Circulatory**

**During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?**

1. Aneurysm	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Arrhythmia / Tachycardia / Heart Murmur / Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Arteriosclerosis / Hardening of the arteries	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Blood Clot / Deep Vein Thrombosis (DVT)	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Heart Valve Disease / Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Varicose Veins, Chronic Venous Insufficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Congenital Heart Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Cardiomyopathy / Enlarged Heart	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. High Blood Pressure / Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Chest Pain / Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Heart surgery of any type	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Shunt / Stent placement	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Kawasaki Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Stroke / TIA	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Peripheral Vascular Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	19. High Cholesterol / Triglycerides / Lipids	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Raynaud's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Other Heart or Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions listed in Section 7 - A, please explain below and provide full details.**

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
Is the Condition still present? <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	Was Surgery Performed? <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No	What medications do you take for this condition or illness?		
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
Is the Condition still present? <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	Was Surgery Performed? <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No	What medications do you take for this condition or illness?		
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:				

**Section 7 - B**

**Hematology**

**During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?**

1. Anemia of any type	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Lymphadenitis / Lymph Node Enlargement	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Hemochromatosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. High or Low Platelet Count	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Blood Transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. High or Low White Blood Cell Count	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Hemophilia / other Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Blood Clotting Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. High or Low Red Blood Cell Count	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Acquired Immunodeficiency Syndrome (AIDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Enlarged Spleen	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Human Immunodeficiency Virus (HIV)	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Splenectomy / Surgical Removal of Spleen	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Mononucleosis / Epstein-Barr Virus	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Other Blood Disease or Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions listed in Section 7 - B, please explain below and provide full details.**

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
Is the Condition still present? <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	Was Surgery Performed? <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No	What medications do you take for this condition or illness?		
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
Is the Condition still present? <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	Was Surgery Performed? <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No	What medications do you take for this condition or illness?		
Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:				



Primary Applicant First Name	MI	Last
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**Section 7 - C Endocrine / Metabolic**

**During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?**

1. Adrenal Gland Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Hyperglycemia / Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Addison's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Hyperparathyroidism / Hypoparathyroidism <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Cushing's Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Hyperthyroidism / Hypothyroidism <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes / Pre-Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Goiter / Thyroid Nodule / Thyroid Cyst <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Gestational Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Grave's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Impaired Glucose Tolerance <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Pituitary Tumor / Pituitary Gland Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Insulin Resistance <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Metabolic Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions listed in Section 7 - C, please explain below and provide full details.**

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

**Section 7 - D Digestive / Gastrointestinal**

**During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?**

1. Stomach or Gastric Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Esophageal Reflux / GERD <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Hiatal Hernia / Abdominal Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No	11. Gallbladder Disease / Cholecystitis <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Colon Polyps <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Pancreatitis <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diverticulitis / Diverticulosis <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Crohn's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Liver Cyst(s) or Abscess <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Irritable Bowel Syndrome / IBS <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Gastric Bypass / Lap Band / Weight Loss Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Ulcerative Colitis <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Enlarged Liver / Elevated Liver Enzymes (ALT/LFT) <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Hemorrhoids <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Cirrhosis of Liver <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Esophageal Stricture <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Other Conditions of the Digestive System. <input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions listed in Section 7 - D, please explain below and provide full details.**

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				



Primary Applicant First Name	MI	Last
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**Section 7 - E Kidney / Urinary**

**During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?**

1. Cystitis / Bladder Infections / UTI	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Birth Defects of Kidney / Ureter / Bladder	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Blood / Protein in Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Kidney Transplant or Dialysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Interstitial Cystitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Chronic Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Urinary / Stress Incontinence	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Nephrectomy / Surgical Removal of Kidney	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Urethral Stricture	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Renal Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Elevated Prostate-Specific Antigen (PSA)	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Kidney Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Enlarged Prostate / Benign Prostatic Hypertrophy (BPH)	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Kidney Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Chronic or Recurring Prostatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Polycystic Kidney	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Other Kidney / Urinary Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions listed in Section 7 - E, please explain below and provide full details.**

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

**Section 7 - F Reproductive**

**During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?**

FEMALE			
1. Irregular Menstrual Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Breast Implants: <input type="checkbox"/> Silicone <input type="checkbox"/> Saline <input type="checkbox"/> Other	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Abnormal PAP Smear	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Pregnancy Complications	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Sexually Transmitted Disease (STD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Endometriosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Herpes Simplex Virus (HSV)	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Uterine Fibroids	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Human Papilloma Virus (HPV) / Genital Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Polycystic Ovaries / Ovarian Cyst	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Abnormal Mammogram / Ultra Sound / Breast Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Hysterectomy: <input type="checkbox"/> Partial <input type="checkbox"/> Complete	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Breast Biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Hormone Replacement Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
MALE			
15. Hydrocele / Varicocele / Spermatocele	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Sexually Transmitted Disease (STD)	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Undescended Testicle	<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Herpes Simplex Virus (HSV)	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Hormone Replacement Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Human Papilloma Virus (HPV) / Genital Warts	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions listed in Section 7 - F, please explain below and provide full details.**

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From: To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				



Primary Applicant First Name	MI	Last
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**Section 7 - G Musculoskeletal**

**During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?**

1. Amputations / Birth Defects / Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Bone Spurs	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Osteoarthritis / Degenerative Joint Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Bunion / Hammertoe	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Plantar Fasciitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Elevated or Positive Antinuclear Antibody (ANA)	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Osteoporosis / Osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Gout, Gouty Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Temporal Mandibular Joint Dysfunction (TMJ)	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Psoriatic Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Joint Dislocation / Joint Replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Reiter's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Spina Bifida / Spina Bifida Occulta	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Bursitis / Tendinitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Back or Neck Injury / Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Carpel Tunnel syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Herniated Disc / Ruptured Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Fibromyalgia	<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Sciatica / Sacroiliitis / Radiculitis/ Spinal Stenosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Systemic Lupus Erythematosus (SLE)	<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Scoliosis / Curvature of the Spine	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Connective Tissue Diseases of any type	<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Degenerative Disc Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
25. Any chiropractic treatment? If "Yes," please specify: <input type="checkbox"/> For symptoms of pain or discomfort? <input type="checkbox"/> For wellness or maintenance only?			<input type="checkbox"/> Yes <input type="checkbox"/> No
26. Hip pain, injury, or other conditions of the hip? If "Yes," specify which: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both (List details below)			<input type="checkbox"/> Yes <input type="checkbox"/> No
27. Knee pain, injury, or other conditions of the knee? If "Yes," specify which: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both (List details below)			<input type="checkbox"/> Yes <input type="checkbox"/> No
28. Ankle / Foot pain, injury or other conditions of the Ankle / Foot? If "Yes," specify which: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both (List details below)			<input type="checkbox"/> Yes <input type="checkbox"/> No
29. Shoulder pain, injury, or other conditions of the shoulder? If "Yes," specify which: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both (List details below)			<input type="checkbox"/> Yes <input type="checkbox"/> No
30. Elbow / Wrist pain, injury or other conditions of the Elbow / Wrist? If "Yes," specify which: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both (List details below)			<input type="checkbox"/> Yes <input type="checkbox"/> No
31. Joint internal / external fixations, screws, plates, or rods? If "Yes," specify location and type in space provided below.			<input type="checkbox"/> Yes <input type="checkbox"/> No
32. Physical Therapy or Steroid Injections for any type of injury, inflammation or pain?			<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions listed in Section 7 - G, please explain below and provide full details.**

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From:            To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From:            To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From:            To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

Question #	Applicant's Name:	Diagnosis, condition, or illness:	Duration (MM/YY): From:            To:	Doctor's Name:
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				



Primary Applicant First Name

MI

Last

Section 7 - H

Brain / Neurological / Behavioral

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

Table with 4 columns: Question #, Applicant's Name, Diagnosis, condition, or illness, Duration (MM/YY), and Doctor's Name. Contains 28 medical conditions for brain/neurological/behavioral issues.

If you answered "Yes" to any of the above questions listed in Section 7 - H, please explain below and provide full details.

Form for detailed explanation of a condition from Section 7-H. Includes fields for Question #, Applicant's Name, Diagnosis, Duration, Doctor's Name, and a detailed explanation section.

Form for detailed explanation of a condition from Section 7-H. Includes fields for Question #, Applicant's Name, Diagnosis, Duration, Doctor's Name, and a detailed explanation section.

Section 7 - I

Lung / Respiratory

During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?

Table with 4 columns: Question #, Applicant's Name, Diagnosis, condition, or illness, Duration (MM/YY), and Doctor's Name. Contains 16 medical conditions for lung/respiratory issues.

If you answered "Yes" to any of the above questions listed in Section 7 - I, please explain below and provide full details.

Form for detailed explanation of a condition from Section 7-I. Includes fields for Question #, Applicant's Name, Diagnosis, Duration, Doctor's Name, and a detailed explanation section.

Form for detailed explanation of a condition from Section 7-I. Includes fields for Question #, Applicant's Name, Diagnosis, Duration, Doctor's Name, and a detailed explanation section.



Primary Applicant First Name	MI	Last
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**Section 7 - J Ear / Eye / Nose / Throat**

**During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?**

1. Cholesteatoma / Cyst of Ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Retinal Detachment / Hemorrhage / Tear	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Deafness	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Vertigo / Meniere's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Ptosis / Drooping Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Chronic or Recurring Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Ear Tubes <input type="checkbox"/> Currently in Place <input type="checkbox"/> No Longer in Place	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Cleft Palate / Cleft Lip	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Other Condition or Problem of the Ear(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Chronis / Recurring Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Blindness / Partial Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Deviated Septum	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Vocal Chord Polyps / Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Corneal Implants / Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Other Condition or Problem of the Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions listed in Section 7 - J, please explain below and provide full details.**

<b>Question #</b>	<b>Applicant's Name:</b>	<b>Diagnosis, condition, or illness:</b>	<b>Duration (MM/YY):</b> From:                      To:	<b>Doctor's Name:</b>
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

<b>Question #</b>	<b>Applicant's Name:</b>	<b>Diagnosis, condition, or illness:</b>	<b>Duration (MM/YY):</b> From:                      To:	<b>Doctor's Name:</b>
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

**Section 7 - K Skin**

**During the past ten (10) years, have you, your spouse or any children for whom you are applying, received medical advice or treatment; been medically diagnosed with; or experienced symptoms for any of the conditions or diseases listed below?**

1. Eczema / Rosacea	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Darier's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Psoriasis	<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Abnormal Moles / Abnormal Skin Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Seborrheic Dermatitis / Keratosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Cyst / Tumor of Skin	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Shingles / Herpes Zoster	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Acne	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Biopsy of Skin / Biopsy of Skin Lesion	<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you answered "Yes" to any of the above questions listed in Section 7 - K, please explain below and provide full details.**

<b>Question #</b>	<b>Applicant's Name:</b>	<b>Diagnosis, condition, or illness:</b>	<b>Duration (MM/YY):</b> From:                      To:	<b>Doctor's Name:</b>
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				

<b>Question #</b>	<b>Applicant's Name:</b>	<b>Diagnosis, condition, or illness:</b>	<b>Duration (MM/YY):</b> From:                      To:	<b>Doctor's Name:</b>
<b>Is the Condition still present?</b> <input type="checkbox"/> Yes - Ongoing <input type="checkbox"/> No - Resolved	<b>Was Surgery Performed?</b> <input type="checkbox"/> Yes - (MM/YY) _____ <input type="checkbox"/> No		<b>What medications do you take for this condition or illness?</b>	
<b>Provide a detailed explanation regarding your treatment, any tests you were advised to have completed or tests actually completed and current status:</b>				





Primary Applicant First Name	MI	Last
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**Section 7 - L Miscellaneous Questions**

**When answering the following questions, consider the health of yourself, your spouse and all dependent children for whom you are applying:**

1. Has any applicant been rejected for coverage, issued a limited policy or issued a policy with increased premium for life, health, or disability coverage? If "Yes," Applicant name(s): _____ Reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is any applicant currently on disability of any type? If "Yes," Applicant name(s): _____ Reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is any applicant currently covered under worker's compensation? If "Yes," Applicant name(s): _____ Reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is any male applicant expecting a child with anyone, whether or not listed on this application? <i>If "Yes," the completion of a Newborn Waiver is required.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is any female applicant currently pregnant or has any female applicant tested positive using a home pregnancy test? <i>If "Yes," the completion of a Newborn Waiver is required.</i> Applicant name(s): _____ How many months pregnant? _____ What is the current pregnancy weight? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you or anyone for whom you are applying, experienced weight gain or loss of more than 20 pounds in the past 12 months? If "Yes," Applicant name(s): _____ Reason for weight gain or loss: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past 10 years, has any applicant been treated, diagnosed with, or discussed with a physician the need to reduce alcohol, chemical, prescription or substance use or abuse? If "Yes," Applicant Name(s) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past 10 years, has any applicant ever used illegal controlled drugs (prescription medications) or other substances such as marijuana, cocaine, methamphetamine, or intravenous (IV) drugs? If "Yes," Applicant name(s): _____ Type of drug/substance: _____ Date discontinued: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any applicant attended counseling, Alcoholics Anonymous (AA) or support groups for alcohol or drug use within the last 10 years? If "Yes," Applicant name(s) _____ Date started: _____ Date ended: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past 10 years, has any applicant been treated for Chronic Pain with use of pain medications including but not limited to: Oxycontin, Lortab, Morphine, or other pain medications? If "Yes," Applicant name(s): _____ Name of Medication(s) : _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Is any applicant currently being treated or has any applicant been treated through a Pain Management Center? If "Yes," Applicant name(s) _____ Date started: _____ Date ended: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Has any applicant been advised to have surgery / biopsy that has not been completed? If "Yes," Applicant name(s): _____ Type of surgery / biopsy: _____ Explain why the surgery / biopsy has not been completed: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Has any applicant been advised to have testing done that has not been completed? (i.e. blood work, x-ray, CT, MRI, Ultrasound, etc.) If "Yes," Applicant name(s): _____ Type of test(s): _____ Explain why the test has not been completed: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. In the last 3 years, has any applicant been referred to a medical specialist of any kind? (i.e. Cardiologist, Endocrinologist, Oncologist, Neurologist, Pulmonologist, Urologist, etc.) If "Yes," Applicant name(s): _____ Type of Specialist: _____ Doctor's Name: _____ Reason for referral: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. In the last 12 months, has any applicant been seen in the Emergency room? If "Yes," Applicant name(s): _____ Reason: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

**List all medications that are currently being taken or that have been taken in the last three (3) years for you, your spouse, and any children for whom you are applying. If necessary, please add a separate page with additional information.**

Applicant's Name	Name of Medication(s)	What illness or condition is this medication treating?	Is medication currently being taken?	Date Started	Date Stopped



Primary Applicant First Name

MI

Last

**Section 8**

**Acknowledgements and Agreements**

**Please Read Carefully and Initial Below**

I understand and acknowledge:

- Any coverage which may be issued will contain a pre-existing condition waiting period of at least 12 months. **(Please initial here:\_\_\_\_\_)**
- I must immediately notify TRHH when there is any change in the information submitted on this application concerning the eligibility for coverage of any dependent, including my spouse. **(Please initial here:\_\_\_\_\_)**

**IMPORTANT:** The approval of this application is subject to medical underwriting guidelines. If you have current coverage, do not cancel your current coverage until you have been issued coverage by TRHH and upon review, agree to accept the rate, terms and conditions of the contract.

Should this change require re-issuance, your Plan ID card(s) and contract should arrive within a few days of the billing. Please review both the identification card(s) and the contract carefully, as they contain important information. You will have 30 days from the date you receive your contract to decide if you want to continue the coverage.

**Please Read Carefully and Sign Below**

TRHH and the Administrator are entitled to rely solely on the statements made on this application which are complete and correct.

I understand and acknowledge that any coverage which may be issued:

- Will be effective, subject to all the terms and conditions of the contract, on the date indicated with the issuance of the identification card;
- Shall be binding only if each statement included on the application is complete and true; and
- May be transferable to another coverage classification within the TRHH program.

I authorize any doctor, hospital, clinic, provider of health care, insurance or reinsurance company, or any other person or firm having any information necessary to determine the eligibility of each person for whom application is made, to give to TRHH, the Administrator or its affiliates, all such information. I (or my personal representative) may request a copy of this authorization.

I understand the information in this application and any information obtained with this authorization will be used by TRHH and the Administrator to determine eligibility for coverage and that coverage and rates will be affected by this information. Rates resulting from an underwriting determination more than 30 days in advance of the effective date could be subject to change.

I declare that the foregoing statements provided by me in this application in its entirety are true, correct and complete for myself, my spouse and all children for whom I am applying.

I understand it is a crime to knowingly provide false, incomplete or misleading information to TRHH or the Administrator for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of coverage.

**All individuals for whom application is made who are 18 years of age or older must sign and date the application, acknowledging their understanding of and agreement to the conditions listed above.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Spouse Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Dependent Signature  
(age 18 and older)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Dependent Signature  
(age 18 and older)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Dependent Signature  
(age 18 and older)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Dependent Signature  
(age 18 and older)

\_\_\_\_\_  
Today's Date

*A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.*

TRHH is a wholly owned subsidiary of TRH Health Plans. TRH Health Plans is a taxable, not-for-profit, membership organization which promotes health care for Tennesseans by providing a program of benefits to its members and members of the Tennessee Farm Bureau Federation. Members can learn more about the programs and services offered through their local Farm Bureau office.

**\$6 Application Fee (Non-Refundable)**