# Group Short Term Medical Plan Application

Underwritten by: Companion Life

**Please submit completed applications with payment to:**

Insurance Benefit Administrators
Administrator for Companion Life Ins. Co.
PO Box 2943, Shawnee Mission, KS 66201-1343
844-630-7500

Please complete this application entirely. Failure to provide complete information may delay processing.

## Personal Details

Please provide the following details for all individuals to be covered.

| Name (First and Last) | Date of Birth | Gender | Contact Information | | |
|---|---|---|---|---|---|
| Primary<br>SSN# | | ☐ Male<br>☐ Female | Address | | |
| Spouse<br>SSN# | | ☐ Male<br>☐ Female | City | State | Zip |
| Child 1 | | ☐ Male<br>☐ Female | Phone Number | | |
| Child 2 | | ☐ Male<br>☐ Female | E-mail Address | | |

## Plan Options

| |
|---|
| **Deductible** |
| **Coinsurance** |
| **Out of Pocket Maximum** |
| **Coverage Period Maximum** |
| |

**Payment Option**

☐ Monthly – 90 day plan
☐ Monthly – 180 day plan
☐ Monthly – 364 days pan
☐ Single Up Front (please specify termination)
Specify Term Date _____
Number of days (max 90) _____
**Requested Effective Date** _____

## Medical Questions

Please answer the questions below as they apply to all family members applying for coverage.

1. Will any applicant have other health insurance in force on the policy effective date or be eligible for Medicaid? ☐ Yes ☒ No

2. Have/Are you, or any applicant: ☐ Yes ☒ No
   a. Been denied insurance due to any health reasons for a condition that is still present? (Does not apply to residents of MO)
   b. Now pregnant, in process of adoption or undergoing infertility treatment?
   c. Over 300 pounds if male or over 250 pounds if female?
   d. Been advised by a medical professional to have diagnostic testing, treatment, surgery that has not yet been completed?

3. Within the last 5 years has any applicant had a diagnosis, symptoms, an abnormal test result or received treatment, medication or consultation for: cancer or malignant melanoma; atrial fibrillation or abnormal heart rhythm, heart disorders, angina, heart attack or heart failure; stroke; uncontrolled hypertension; diabetes except gestational (does not apply to residents of DC); hepatitis C or liver or kidney disorders; organ transplant; chronic obstructive pulmonary disease (COPD) or emphysema; rheumatoid arthritis or degenerative disk disease; hemophilia, leukemia or blood disorders; multiple dystrophy or sclerosis; alcohol or drug abuse or misuse; bipolar, schizophrenia; or eating disorders? ☐ Yes ☒ No

4. Within the last 5 years has any applicant been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?(Residents of WI do not need to disclose HIV test results.) ☐ Yes ☒ No

5. If all persons to be insured are United States citizens, please answer "No" to this question. If any person to be insured is not a United States citizen, has that person resided outside the United States at any time during the prior 12 months? ☐ Yes ☒ No

6. Has any person applying for coverage been covered under a nonrenewable Short Term Medical policy during the past 64 days by Companion Life Insurance company? ☐ Yes ☒ No

**If you have answered "Yes" to questions 1 through 6, coverage cannot be issued. Thank you for your interest.**

**For product information or assistance with this application, please contact:**

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844-630-7500

## Payment Information

Please provide complete payment information. Applications without payment cannot be processed.

☐ Check/Money Order (Single Up-Front Payment Only)
☐ MasterCard ☐ VISA
☐ Discover ☐ American Express

Check or Money Orders should be made payable, in US dollars, to Companion Life Insurance Company.
If paying by credit card, I authorize Companion Life to debit my Discover, VISA, MasterCard or American Express account for the applicable premium. If I have selected a monthly plan, I hereby request and authorize Companion Life to debit my Credit Card account for the proper installment amounts on the due dates of the installments. This authorization will remain in effect for the duration of the Coverage Period elected or until revoked by me in writing. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

| Credit Card Number | Exp Date |
|---|---|
| | |

Name on Card

Phone #

Billing Address (including city, state and zip)

| Cardholder Signature | Date |
|---|---|
| | |

## Authorization

I hereby request coverage under the insurance issued to the Communicating for America, Inc. and underwritten by Companion Life Insurance Company (Companion Life). I understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Penalty and other restrictions and exclusions. I agree that coverage will not become effective for me or any dependent whose medical status, prior to the effective date, has changed and therefore results in a "yes" answer to any of the medical questions on this Application. If my medical status changes in this way, coverage will be declined for all individuals included on this application. I understand that if I have elected the Monthly Payment option, my credit card will be charged each month on the due date of the premium. I understand that I may terminate the scheduled payments by notifying Companion Life in writing at least one business day prior to the next scheduled payment date. I understand that this coverage is not renewable or extendable. I understand that the information contained herein is a summary of the coverage offered in the Certificate of Insurance and that I may obtain a complete copy of the Certificate of Insurance upon request to Companion Life. I understand that Companion Life, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I understand and agree that the insurance agent/broker, if any, assisting with this Application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned represents his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned represents his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant. If I am not already a member of the Communicating for America, Inc., I hereby request to be enrolled as a member. I will receive a membership packet after my membership fees are received.

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your Certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your Certificate might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

**Fraud Warning**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

| Applicant Signature | Date | Spouse Signature | Date |
|---|---|---|---|
| | | | |

| Signed by Companion Life Appointed Agent: | Agent Number: | Plan Administrator Use Only: | |
|---|---|---|---|
| | | | |

**WARNING: Any person who knowingly: Arizona and Arkansas:** presents a false or fraudulent claim for payment of a loss or benefit is subject to criminal and civil penalties, or **specific to AR:** presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Louisiana, New Mexico and Texas:** presents a false or fraudulent claim for the payment of a loss or benefit (or **specific to LA and TX:** who knowingly presents false information on an application for insurance) is guilty of a crime and may be subject to fines and confinement in state prison, (or **specific to NM:** to civil fines and criminal penalties.) **Kentucky and Pennsylvania:** and with intent to defraud any insurance company or other person files an application for insurance, or files a statement of claim, containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, **specific to PA:** subjects such person to criminal and civil penalties. **Ohio:** with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Oklahoma:** and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurer or insurance company for the purpose of defrauding the insurer or insurance company. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **Alabama and District of Columbia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison (or **specific to AL**: any combination thereof). **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.