# AvMed Individual Health

## Application for Coverage

## I. Enrollment Information

What Kind Of Coverage Are You Applying For?

☐ New Coverage ☐ Change my current AvMed Plan
☐ Reapply ☐ Add dependent(s) to my Plan
Current AvMed Member ID #: ______________________

Requested effective date of coverage (mo/day/year): _____/ _____/ _________

*NOTE: Your effective date must be within 60 days from the date the application was signed or a new application will be required. (If no continuous prior coverage, effective date may be later than requested.)*

## A. Applicant Information

***If applying for child-only coverage, please enter the youngest child as the primary applicant and all additional children, if any, in Part B. Family Members, below. All of the information you provide is for application and quoting purposes only and will be kept confidential.***

| **Primary Applicant Name (Last, First, MI)** | Gender ☐ M ☐ F | Birthdate / / | Height | Weight |
|---|---|---|---|---|
| Home Address (Not P.O. Box) | City | State | | Zip Code |
| *Mailing address if different from home address* | *City* | *State* | | *Zip Code* |
| Home Phone Number ( ) - / Daytime Phone Number ( ) - | Email Address (if over age 18) | Social Security number - - | | Marital Status |

| If translation service is needed, please indicate language preference: | Policy owner name if different than Primary Applicant: | Relationship to Primary Applicant: |
|---|---|---|

***Complete this section if Primary Applicant is under 18 years of age - Legal Guardianship court order must be submitted at time of application:***

| **Custodial Parent or Legal Guardian Name (Last, First, MI)** | Social Security # - - | Birthdate / / | Marital Status |
|---|---|---|---|
| Home Address (Not P.O. Box) | City | State | Zip Code |

| Email address | Relationship to child(ren): |
|---|---|

## B. Family Members

***Complete the following information for each of your family members applying for coverage. If more space is needed please attach another application and complete just the information for those additional family members. Applicable Court Ordered Legal Guardianship papers or Certificate(s) of Adoption must be provided at time of application.***

| First Name, MI, Last Name | Relationship to Applicant | Adoption or Legal Guardianship? | Birthdate (Mo/Day/Year) | Social Security # | Gender | Height | Weight |
|---|---|---|---|---|---|---|---|
| | SPOUSE | N/A | / / | - - | | | |
| | | | / / | - - | | | |
| | | | / / | - - | | | |
| | | | / / | - - | | | |
| | | | / / | - - | | | |
| | | | / / | - - | | | |
| | | | / / | - - | | | |

***If dependents have different last name(s) than that of the Primary Applicant, Custodial Parent or Legal Guardian, please explain:***

| Dependent Name: | Explain: |
|---|---|
| | |
| | |
| | |

***If dependents have different address(es) than that of the Primary Applicant, Custodial Parent or Legal Guardian, please provide:***

| Dependent Name: | Address: |
|---|---|
| | |
| | |
| | |

## I. Enrollment Information (continued)

### C. Employment Status

**1. Primary Applicant:** ☐ Employed ☐ Self-Employed ☐ Not Employed* ☐ Student ☐ Retired / Date (mo/year) _____ /______ ☐ Retired Early (Under Age 55)*

*Please explain:

*Are you seeking employment? ☐ No ☐ Yes Explain:

| Name of Employer/Company or School (if Student) | Occupation / Title | Annual Income | Employment Date / |
|---|---|---|---|
| Employer or School Address | Type of Business and Specific Duties | | |

**2. Spouse:** ☐ Employed ☐ Self-Employed ☐ Not Employed* ☐ Student ☐ Retired / Date (mo/year) _____ /______ ☐ Retired Early (Under Age 55)*

*Please explain:

*Are you seeking employment? ☐ No ☐ Yes Explain:

| Name of Employer/Company or School (if Student) | Occupation / Title | Annual Income | Employment Date / |
|---|---|---|---|
| Employer or School Address | Type of Business and Specific Duties | | |

## II. Plan Selection

**1. Please indicate your choice of AvMed Individual Health coverage:**

**AvMed Plus Plan**
- ☐ AvMed Plus 500
- ☐ AvMed Plus 1000
- ☐ AvMed Plus 2500
- ☐ AvMed Plus 5000

**AvMed Value Plan**
- ☐ AvMed Value 2500
- ☐ AvMed Value 5000

**AvMed HSA Qualified Plan**
- ☐ AvMed HDHP 2500
- ☐ AvMed HDHP 5000

**2. Optional Coverage –to select the optional coverage available for your plan, please indicate your choice below:**

Prescription Drug Benefit ☐ Yes ☐ No
- Prescription Drug 250 ☐
- Prescription Drug 500 ☐
- Prescription Drug 1000 ☐

Maternity Benefit ☐ Yes ☐ No

Maternity Benefit ☐ Yes ☐ No

Maternity Benefit ☐ Yes ☐ No

**Please check below if you do not wish to enroll in a Health Savings Account (HSA) for your High Deductible Plan:**

☐ **I do not wish to enroll in a Health Savings Account** (administered by HealthEquity)

## III. General Eligibility

***Please answer for all individuals applying for coverage:***

**1.** Has either the applicant or spouse used tobacco products in any form (e.g., cigarettes, cigars, pipes, snuff or chewing tobacco) in the past 12 months? ☐ No ☐ Yes

**a.** If "Yes", please identify person: ☐ Applicant ☐ Spouse

**2.** In the past 5 years has anyone applying for Life, Disability Income or Health coverage, including AvMed coverage, been declined, postponed, changed, rated-up, ridered or withdrawn? ☐ No ☐ Yes

**a.** If "Yes", please supply the following:

**i.** Name of Person: ________________________________________ ☐ Declined ☐ Postponed ☐ Changed
Reason: ______________________________ Carrier:_________________________ ☐ Rated-up ☐ Ridered ☐ Withdrawn

**ii.** Name of Person: ________________________________________ ☐ Declined ☐ Postponed ☐ Changed
Reason: ______________________________ Carrier:_________________________ ☐ Rated-up ☐ Ridered ☐ Withdrawn

**3.** Are you and anyone applying for coverage permanent residents of the state of Florida, and reside in an AvMed Service area at least 6 continuous months of the year? ☐ Yes ☐ No

**a.** If "No", please provide details: ____________________________________________________________

## III. General Eligibility (continued)

**4.** Are you or anyone applying for coverage a United States Citizen? ☐ Yes ☐ No

**a.** If "No", please provide name(s): ______________________________

**b.** If "No", are you or anyone applying for coverage a permanent legal resident and have you resided in the U.S. for the past 12 months? ☐ No ☐ Yes

**c.** If "Yes", please attach a copy of your Resident Alien Card (green card) or unexpired VISA in force through the next 18 months.

**5.** Does anyone applying for coverage plan to travel outside the United States within the next 4 months, or plan to spend more than 3 months outside the United States during the next year? ☐ No ☐ Yes

**a.** If "Yes", please provide name(s) of person(s) traveling and details including location: ______________________________

______________________________

**6.** Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Worker's Compensation or disability income benefits due to sickness or injury? ☐ No ☐ Yes

**a.** If "Yes", please provide name(s) and details: ______________________________

______________________________

## IV. Lifestyle

***In the past 10 years, has anyone applying for coverage:***

**1.** Had any Driving Under the Influence (DUI) conviction, drunken driving conviction or driving license revocation? ☐ No ☐ Yes

**2.** Used or is now using barbiturates, amphetamines, marijuana, cocaine, heroine, or other narcotics, except as prescribed by a physician? ☐ No ☐ Yes

**3.** Been treated for the use of alcohol or drugs? This includes but is not limited to seeking advice, taking medication for, or receiving counseling for alcohol or drug use? ☐ No ☐ Yes

**4.** Been diagnosed as alcohol or chemically dependent? ☐ No ☐ Yes

**5.** If the answer is "Yes" to any questions listed above, please provide the following details:

Question Number __________ Name of Person ______________________________

Date of Occurrence(s), Diagnosis or Treatment (mo/year) _____/_____ Reason/Type drug, as applicable:______________________________

## V. Prior Health Coverage

***If additional space is needed please attach additional pages, each page must be signed and dated. IMPORTANT: Do not cancel any existing coverage until you receive notification from AvMed Health Plans of acceptance for coverage.***

**1.** Has anyone applying for coverage ever had group or individual coverage through AvMed Health Plans? ☐ No ☐ Yes

**a.** If "Yes", please supply the following information for all applicants on the policy:

| Name | AvMed Member ID #: | Effective Date | Termination Date |
|---|---|---|---|
| | | / / | / / |
| | | / / | / / |
| | | / / | / / |
| | | / / | / / |
| | | / / | / / |

**2.** Has anyone applying for coverage had any group or individual health plan coverage within the last 24 months? ☐ No ☐ Yes

**a.** If "Yes", please supply the following information for each applicant for the last 24 months:

| Name | Type of Coverage | Policy ID # | Effective Date | Termination Date |
|---|---|---|---|---|
| | | | / / | / / |
| | | | / / | / / |
| | | | / / | / / |
| | | | / / | / / |
| | | | / / | / / |

**3.** If anyone applying for coverage has any existing group or individual health plan coverage, do you agree to terminate this existing coverage if approved for the coverage being applied for? ☐ No ☐ Yes

## VI. Medical History

**A. Please answer the following questions for all individuals applying for coverage:**

**1.** Within the past 3 years had a complete examination (including annual check-up or Gyn exam)?............ ☐ No ☐ Yes

**2.** Within the past 5 years had or been advised to have any of the following: electrocardiogram and/or other cardiac work up, x-ray, lab tests, or other medical test such as blood tests, urinalysis, MRI, CT scan, PET scan, stress test, blood pressure check, etc.?............ ☐ No ☐ Yes

**3.** Within the past 5 years had or been advised to have any inpatient or outpatient surgery or observation that has been completed or yet to be completed, or have not been released from a physician's care?............ ☐ No ☐ Yes

**4.** Within the past 5 years been hospitalized or treated in a hospital Emergency Room, or Urgent Care Center?............ ☐ No ☐ Yes

**5.** Within the past 5 years had a cardiac catherization or angioplasty?............ ☐ No ☐ Yes

**6.** Within the past 5 years had any fixation device, prosthesis or prosthetic device including but not limited to pins, plates, screws, rods, wires, joint replacement or implants, including breast implants?............ ☐ No ☐ Yes

**7.** Are you or any person applying for coverage (male or female) an expectant parent?............ ☐ No ☐ Yes

**8.** Have you ever been tested positive for the HIV infection or been diagnosed or received treatment for Acquired Immune Deficiency Syndrome (AIDS), or an AIDS-related complex or other sickness or condition derived from this infection or other immune system disorder?............ ☐ No ☐ Yes

**9.** In the past year, has your weight decreased by more than 10 pounds for reasons other than a weight loss program?............ ☐ No ☐ Yes

***In the past 10 years, has anyone applying for coverage been treated for, had symptoms of, taken medication for, been advised that they have or may have had any of the following:***

**10. Eyes, Ears, Nose or Throat Condition**

- ☐ **a.** Disorder of the eyes, Cataracts or Glaucoma
- ☐ **b.** Disorder of the Ear, Ear Infections or Tubes In Ears
- ☐ **c.** Meniere's Disease, Labyrinthitis or Vertigo
- ☐ **d.** Disorder of the Nose, Deviated Septum or Sinus Infections
- ☐ **e.** Disorder of the Throat, Tonsils or Adenoids
- ☐ **f.** Other
- ☐ **No to all Eye, Ear, Nose, or Throat Conditions**

**11. Muscular Skeletal Disorder**

- ☐ **a.** Back, Spine or Disc Disorder including chiropractic care
- ☐ **b.** Bone, Joint, Muscular, Neuromuscluar Disorder or Injury
- ☐ **c.** Arthritis, Bursitis, Tendonitis or Gout
- ☐ **d.** Fibromyalgia
- ☐ **e.** Muscular Dystrophy, Amyotrophic Lateral Sclerosis (ALS)
- ☐ **f.** Systemic Lupus or Connective Tissue Disorder
- ☐ **g.** Other
- ☐ **No to all Muscular Skeletal Disorders**

**12. Blood or Circulatory Disorder**

- ☐ **a.** Elevated Cholesterol and/or Triglycerides
- ☐ **b.** Anemia
- ☐ **c.** Leukemia
- ☐ **d.** Varicose veins, Deep Vein Thrombosis, or Phlebitis
- ☐ **e.** Edema, Blood clot or Aneurysm
- ☐ **f.** Other
- ☐ **No to all Blood or Circulatory Disorders**

**13. Cardiovascular or Heart Disorder**

- ☐ **a.** High Blood Pressure or Hypertension
- ☐ **b.** Angina or Heart Attack
- ☐ **c.** Chest Pain
- ☐ **d.** Heart Murmur
- ☐ **e.** Mitral Valve Prolapse
- ☐ **f.** Irregular Heartbeat or Palpitations
- ☐ **g.** Valve Disorder
- ☐ **h.** Coronary Artery Disease
- ☐ **i.** Congestive Heart Failure
- ☐ **j.** Congenital Heart Disorder
- ☐ **k.** Other
- ☐ **No to all Cardiovascular or Heart Disorders**

**14. Endocrine, Pituitary, Thyroid or Lymph Node Disorder**

- ☐ **a.** Diabetes, or High Blood Sugar
- ☐ **b.** Thyroid or Glandular Disorder
- ☐ **c.** Lymph Node Disorder
- ☐ **d.** Other
- ☐ **No to all Endocrine, Pituitary, Thyroid, or Lymph Node Disorders**

**15. Digestive Disorder**

- ☐ **a.** Gastro esophageal Reflux Disease (GERD) or Heartburn
- ☐ **b.** Irritable Bowel Syndrome (IBS), Colitis or Crohn's Disease
- ☐ **c.** Ulcer, Hernia or Gastritis
- ☐ **d.** Diverticulitis, Diverticulosis, or Hemorrhoids
- ☐ **e.** Colon Polyps
- ☐ **f.** Gallblader Disorder
- ☐ **g.** Cirrhosis
- ☐ **h.** Hepatitis
- ☐ **i.** Other disorders of the Stomach, Gastrointestinal tract, Colon, Rectum, Liver, Pancreas or Spleen
- ☐ **No to all Digestive Disorders**

## VI. Medical History (continued)

**16. Genitourinary Disorder**

- ☐ **a.** Bladder Infection, Cystitis or Bladder Disorder
- ☐ **b.** Kidney infection
- ☐ **c.** Kidney Disorder
- ☐ **d.** Renal or urinary calculus or Kidney Stones
- ☐ **e.** Other disorders of the Urinary Tract
- ☐ **No to all Genitourinary Disorders**

**17. Brain or Nervous System Disorder**

- ☐ **a.** Epilepsy
- ☐ **b.** Seizures or Convulsions
- ☐ **c.** Stroke or Transient Ischemic Attack (TIA)
- ☐ **d.** Migraines or Headaches; recurrent or severe
- ☐ **e.** Dizziness or Fainting
- ☐ **f.** Concussion, Brain Injury or Head Trauma
- ☐ **g.** Alzheimer's, Dementia or Memory Loss
- ☐ **h.** Multiple Sclerosis
- ☐ **i.** Paralysis
- ☐ **j.** Cerebral Palsy
- ☐ **k.** Parkinson's
- ☐ **l.** Other
- ☐ **No to all Brain or Nervous System Disorders**

**18. Mental or Nervous Disorder**

- ☐ **a.** Anxiety, Depression, Stress, Nervous breakdown or Panic Disorder
- ☐ **b.** Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ **c.** Autism
- ☐ **d.** Eating Disorder
- ☐ **e.** Bipolar Disorder or Schizophrenia
- ☐ **f.** Counseling - Psychiatric or Psychological
- ☐ **g.** Other
- ☐ **No to all Mental or Nervous Disorders**

**19. Respiratory Disorder**

- ☐ **a.** Allergies
- ☐ **b.** Asthma
- ☐ **c.** Bronchitis
- ☐ **d.** Emphysema
- ☐ **e.** Pneumonia
- ☐ **f.** Sleep Apnea
- ☐ **g.** Chronic Obstructive Pulmonary Disease (COPD)
- ☐ **h.** Cystic Fibrosis
- ☐ **i.** Tuberculosis
- ☐ **j.** Other
- ☐ **No to all Respiratory Disorders**

**20. Female Reproductive Disorder**

- ☐ **a.** Abnormal pap smears
- ☐ **b.** Menstrual Disorder
- ☐ **c.** Menopausal Disorder
- ☐ **d.** Endometriosis or Pelvic Inflammatory Disease
- ☐ **e.** Uterine Fibroids
- ☐ **f.** Cervical, Ovarian, Uterine or Vaginal Disorder
- ☐ **g.** Cesarean Section or Complications due to pregnancy or childbirth
- ☐ **h.** Infertility
- ☐ **i.** Disorder of the Breast or Abnormal Mammogram
- ☐ **j.** Other
- ☐ **Not Applicable or No to all Female Reproductive Disorders**

**21. Male Reproductive Disorder**

- ☐ **a.** Penile or Testicular Disorder
- ☐ **b.** Prostate Disorder
- ☐ **c.** Infertility or Sexual Dysfunction
- ☐ **d.** Other
- ☐ **Not Applicable or No to all Male Reproductive Disorders**

**22. Sexually Transmitted Disease**

- ☐ **a.** Human Papilloma Virus (HPV)
- ☐ **b.** Chancroid or Chlamydia
- ☐ **c.** Condylomata, Condyloma or Genital Warts
- ☐ **d.** Herpes Simplex II or Genital Herpes
- ☐ **e.** Gonorrhea or Syphilis
- ☐ **f.** Other
- ☐ **No to all Sexually Transmitted Diseases**

**23. Skin Disorder**

- ☐ **a.** Shingles
- ☐ **b.** Acne or Rosacea
- ☐ **c.** Discoid Lupus
- ☐ **d.** Eczema, Dermatitis, Keratosis or Psoriasis
- ☐ **e.** Other
- ☐ **No to all Skin Disorders**

**24. Cyst or Tumor**

- ☐ **a.** Cyst, Tumor, Growth, Lump, or Mass
- ☐ **b.** Polyp or Papilloma
- ☐ **c.** Cancer, Carcinoma, Malignant Tumors or Malignant Melanoma
- ☐ **d.** Hodgkin's disease
- ☐ **e.** Other
- ☐ **No to all Cysts or Tumors**

**25.** Has anyone applying for coverage been seen by or consulted by a doctor, or any other person providing health care services or had any sign of any physical or mental disorder, symptoms, disease or defect or any other condition, injury, or problems not listed on this application?.......... ☐No ☐ Yes

**26.** Other than listed for the Conditions above, is anyone applying currently taking any medication, herbal supplements or receiving any treatment? .......... ☐No ☐ Yes

**If "Yes", please list all details and medications in B. Medical History Additional Details, on the following page**

## VI. Medical History (continued)

### B. Medical History Additional Details

***Additional information is required for any of the above Questions answered "Yes" or any of the above Conditions that are checked. For each applicant having "Yes" answers and/or checked Conditions please provide the information requested below. If more space is needed please attach another application and complete just the information for those additional family members.***

**1. Name of Person:** ________________________ Question #: _____ Condition/Diagnosis: ________________

Treatment: Start Date: End Date:

______________________ ___ / ___ ___ / ___

______________________ ___ / ___ ___ / ___

Medications Taken for the Condition/Diagnosis: Dosage/Frequency: Start Date: End Date:

______________________ ______________ ___ / ___ ___ / ___

______________________ ______________ ___ / ___ ___ / ___

______________________ ______________ ___ / ___ ___ / ___

Treating Physician(s) Name and Address:

______________ ______________________________

______________ ______________________________

______________ ______________________________

**2. Name of Person:** ________________________ Question #: _____ Condition/Diagnosis: ________________

Treatment: Start Date: End Date:

______________________ ___ / ___ ___ / ___

______________________ ___ / ___ ___ / ___

Medications Taken for the Condition/Diagnosis: Dosage/Frequency: Start Date: End Date:

______________________ ______________ ___ / ___ ___ / ___

______________________ ______________ ___ / ___ ___ / ___

______________________ ______________ ___ / ___ ___ / ___

Treating Physician(s) Name and Address:

______________ ______________________________

______________ ______________________________

______________ ______________________________

## VII. Payment Information

**1. Initial Payment - please select one of the following payment types:**

**a. ☐ Automatic Bank Debit (ACH)**

I authorize AvMed Health Plans to debit my initial monthly approved premium(s) to my (select one): ☐ Checking Account ☐ Savings Account. I understand that my account will be debited when coverage is approved and accepted by me.

| Account Holder's Signature: | Account Number: | ABA9 Digit Routing Number: |
|---|---|---|

| Bank Name: | Bank Address: | Bank Phone Number: |
|---|---|---|

| Name on Bank Account: | Relationship to Primary Applicant: |
|---|---|

[**b. ☐ Credit Card** [☐ VISA ☐ MasterCard ☐ Discover ☐ American Express]

I authorize AvMed Health Plans to charge my initial monthly approved premium(s) to my credit card.

| Cardholder Name: | Card Number: |
|---|---|

| Signature of Authorized User: | Security Code: | Expiration Date: |
|---|---|---|

Cardholder's Billing Address: ]

**2. Ongoing Payment:**

**a. ☐ Authorization For Recurring Payment Of Premiums By Bank Debit**

By checking here I am indicating that, if I am approved and accept coverage, I wish for my monthly premium to be automatically debited on a recurring basis from by bank account as indicated above, in Section 1. Initial Payment. My bank account will be debited on the 1st of each coverage month.

## VIII. Authorization to Obtain and Release Information

I understand that the following parties may need to collect information in regard to the proposed coverage: AvMed and its reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose. In addition, I understand that those parties that may need to collect information may disclose information to the following: other insurers to which the Applicant has applied or may apply; reinsurers, pharmacy benefit managers, physicians, hospitals, clinics or other medically related facilities, health care clearinghouses, the MIB Group, Inc. or persons who perform business, professional, or insurance tasks for them. I understand that there is a possibility of redisclosure of any information provided pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

My spouse, dependents and I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, pharmacy benefit manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc., employer or the Consumer Reporting Agency having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of any and all individually identifiable health information, including medical records, reports, pharmaceutical records, diagnostic testing, lab work, nonpublic personal health information, and any other non-medical information to share any and all such information with AvMed, its reinsurer or its legal representatives, and its affiliates.

I understand that this authorization is needed for the purpose of gathering information to make eligibility, underwriting and risk rating determinations. Unless revoked earlier, this authorization will be valid for thirty (30) months after the date it is signed. I understand that I may revoke this authorization at any time by giving written notice to AvMed; however, I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand that authorizing the disclosure of health information is voluntary. I may refuse to sign this authorization.

**Applicant's Signature:** ______________________________ Date: ____________

**If child is under age 18, parent/guardian's signature and relationship required:**

Parent/Guardian Signature: ______________________________ Date: ____________

Relationship: ____________________

**Spouse's Signature (If proposed for coverage):** ______________________ Date: ____________

**Dependent(s) over 18 years of age and proposed for coverage must sign below:**

Dependent Signature: ______________________ Dependent Signature: ______________________

Dependent Signature: ______________________ Dependent Signature: ______________________

## IX. Agent Information

| | |
|---|---|
| Writing Agent Name (please print): ________________ | Writing Agent Signature: ____________________ |
| Agency Name: ____________________ | Agency Address: __________________________ |
| Agency Telephone Number: (_____) _____-_____ | Agency Code/Agent Code: __________ __________ |

See **Agreement and Signature** page, following.

## VIII. Agreement and Signature:

I hereby apply for individual coverage for myself and eligible dependents under this AvMed Health Plans product. I acknowledge that coverage is contingent upon the complete and accurate disclosure of the information requested in this application**. I understand that AvMed may decline coverage to me, my spouse and/or any of my dependents based upon the information contained in this application and/or a paramedical exam requested at the option of AvMed, and AvMed may offer coverage only to those individuals acceptable to AvMed.**

I understand that this Plan has a 12 month limitation of coverage for services related to pre-existing conditions initially disclosed in this application, and a 24 month limitation of coverage for services related to pre-existing conditions that are otherwise identified. I understand and agree that if the Agreement is issued to me or any of my family members it will not cover benefits for me or any family members covered under this Agreement for any pre-existing condition. A pre-existing condition is defined as any Condition that manifests itself 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 during the 24-month period immediately preceding the Effective Date of this Agreement. I understand that this Plan provides NO coverage for services rendered in conjunction with a non-complicated pregnancy/delivery unless the optional Maternity Benefits Amendment has been purchased.

**Child Only Applications:** In instances where this application is for AvMed Health Plans health coverage benefits which cover only a child, the name of the child to be considered for coverage appears on the application as the "Primary Applicant". By my signature below, I certify that all the statements and answers submitted in this application are entirely true and complete. All statements and descriptions in this application are deemed to be representations and not warranties. As parent or guardian of the applicant, I will be responsible for the payment of Premium on this Agreement.

**If Legal Guardian, Court Ordered Guardianship papers are required and must be attached to this application.**

Coverage will not start unless your application is approved by AvMed Health Plans, an Agreement is issued, accepted by you, the initial premium(s) paid, and the statements in Sections I, III, IV and VI continue to be complete and true as of the effective date of the agreement. No agent can make or change an Agreement or waive any of the company's rights.

I understand that I am applying for a health care plan that is not intended by AvMed to be a small employer health plan.

I have read this application carefully and I represent that the statements and answers I am submitting on this application are entirely true and complete. No information has been withheld or omitted concerning the past and present state of health of myself and any family members applying for this coverage. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree. I understand and agree that any misstatements or omissions may result in denial of benefits and/or termination or rescission of coverage. I understand that if I am accepted for coverage, I will have ten (10) days after my Agreement is received by me to review it and submit any information that is missing or incorrect, including any past medical history which may have been left out of the application.

**Applicant's Signature:** ______________________________ Date: ____________

**If child is under age 18, parent/guardian's signature and relationship required:**

Parent/Guardian Signature: ______________________________ Date: ____________

Relationship: ____________________

**Spouse's Signature (If proposed for coverage):** ______________________________ Date: ____________