

SECTION E: HEALTH INFORMATION (*This information is only required for underwriting purposes.*)

1	Have you or any of your dependents had medical expenses in excess of \$5,000, or received inpatient or outpatient hospital care, within the last 12 months? (<i>If yes, please complete Section F</i>)	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
2	Are you or any of your dependents currently disabled? (<i>If yes, please complete Section F</i>)	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
3	Are there any conditions diagnosed or treated in the last 5 years?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
4	In the last 5 years, have you had any abnormal test or physical results, tests/treatment/surgery advised, pending test results, referral to a specialist or condition?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No
5	Do you or any of your dependents take any medicine(s), drugs or pills or require shots?	<input type="checkbox"/> Yes*	<input type="checkbox"/> No

6 Within the last 10 years, have you or any dependent listed on this application ever been diagnosed with or treated for any conditions of the body systems listed below:

___ **None of the conditions listed below**

Brain/Nervous ___ Alzheimer's ___ Cerebral Palsy ___ Headaches ___ Migraines ___ Multiple Sclerosis ___ Paralysis ___ Parkinson's ___ Seizures/Epilepsy ___ Other: _____ Bones/Muscular ___ Arthritis ___ Rheumatoid Arthritis ___ Osteoporosis ___ Lupus ___ Back/Neck Pain or Disorders ___ Bulging/Herniated Disk ___ Joint Pain ___ Muscular Dystrophy ___ Other: _____ Cancer/Tumor ___ Brain ___ Breast ___ Colon ___ Leukemia ___ Liver ___ Lung ___ Lymphoma ___ Melanoma ___ Prostate ___ Skin ___ Uterine/Cervical/Ovarian ___ Other: _____	Digestive ___ Crohn's ___ Gallbladder ___ Gastric/Peptic Ulcer ___ Hernia Type: _____ ___ Liver Disorder ___ Cirrhosis ___ Hepatitis A ___ Hepatitis B ___ Hepatitis C ___ Irritable Bowel/Colon Disorder ___ Pancreatitis ___ Reflux/GERD ___ Ulcerative Colitis ___ Weight Loss Surgery ___ Other: _____ Endocrine/Metabolic ___ Diabetes Type I or Type II Last A1C Reading: _____ ___ Thyroid ___ Other: _____ Eyes/Ears/Nose/Throat ___ Allergies ___ Cataracts ___ Glaucoma ___ Retinopathy ___ Other: _____ Heart/Circulatory ___ Aneurysm ___ Angioplasty/Stent ___ Bypass	___ Congestive Heart Failure ___ Elevated Cholesterol ___ Heart Attack Date: _____ ___ Heart Disease ___ Heart Murmur ___ Heart Valve ___ High Blood Pressure ___ Irregular Heartbeat ___ Stroke ___ Other: _____ Immune/Blood Disorder ___ AIDS/HIV ___ Anemia ___ Lupus ___ Other: _____ Lung/Respiratory ___ Asthma ___ Chronic Bronchitis ___ COPD ___ Emphysema ___ Pneumonia ___ Sleep Apnea ___ Tuberculosis ___ Other: _____ Mental Health/Substance Abuse ___ Alcoholism ___ Anxiety/Depression ___ Attention Deficit Disorder ___ Bipolar/Manic Depression ___ Drug Abuse/Illegal Drug Use ___ Eating Disorder ___ Inpatient/Residential Treatment ___ Other: _____	Reproductive ___ Abnormal Pap Date of last abnormal: _____ Treatment: _____ ___ Abnormal Uterine Bleeding ___ Breast Disorder ___ Current Pregnancy Due Date: _____ ___ Past/Current Complications ___ Multiples Expected ___ Previous C-Section ___ Endometriosis ___ HPV/Condyloma ___ Ovarian Conditions ___ Sexually Transmitted Disease ___ Uterine Fibroids ___ Other: _____ Transplant ___ Past Transplant(s) Organ: _____ ___ Possible Future Transplant Organ: _____ Urinary/Kidney ___ Kidney Stones ___ Polycystic Kidney Disease ___ Prostate Disorder ___ Renal Failure ___ Bladder Disorder ___ Other: _____ Other conditions/treatments not listed: _____ _____
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IF YES INDICATED TO ANY OF THE CONDITIONS LISTED ABOVE - PLEASE COMPLETE SECTION F

SECTION F: HEALTH INFORMATION CONTINUED (*Please provide full details for any conditions checked or questions answered "Yes" in Section E above. Use additional paper if necessary. Please sign and date all pages.*)

LEGAL NAME (Last, First, MI)	DIAGNOSIS/CONDITION	DATE LAST TREATED OR INDICATE 'ONGOING'	TREATMENT RECEIVED/EXPECTED TO RECEIVE

SECTION G: MEDICATION INFORMATION: (*Please provide full details for any medications currently taken*)

LEGAL NAME (Last, First, MI)	DIAGNOSIS/CONDITION	NAME OF MEDICATION	START DATE	FREQUENCY	DOSAGE

SECTION H: TERMS, CONDITIONS, AUTHORIZATIONS, AND OTHER PROVISIONS

1	I declare that I am an employee regularly scheduled to work full time (as defined by employer), year round, for full pay, at my employer's normal place of work and in the employer's normal business and request to be insured.
2	<p>Authorization: I authorize any physician, hospital, clinic, other medical or medically related facility, or insurance company to release to Cox Health Systems Insurance Company ("CHSIC"), its legal representatives or its reinsurers, any information, record or knowledge of the health of any persons proposed for insurance for determination of claims. This consent includes information about drug and alcohol use. I authorize any consumer reporting agency that has any record, public record or knowledge of any persons proposed for insurance to give to CHSIC, its legal representatives or reinsurers, any such record or knowledge for purposes of underwriting insurance. A photographic copy of this consent shall be as valid as the original.</p> <p>I understand that I may revoke this authorization for information by supplying the revocation in writing to the Home Office of CHSIC. I understand that the revocation will not be in effect until it is received at the Home Office. Unless revoked, I agree that, when signed in connection with an application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below.</p>
3	<p>Representation: I hereby declare I have read, or had read to me, the questions and responses on this application. I represent that all information, statements, and answers made on this form, and any attachments, about myself or any dependents' state of health, are complete and true to the best of my knowledge. I understand that they shall be a part of this request for coverage under the group's policy. I realize any false statements, omissions and/or material misrepresentations regarding any information requested on this form, could cause an otherwise valid claim to be denied and/or cause the insurance coverage, if issued, to be cancelled as never effective. For any applicant listed on this form, after coverage has been in effect for two (2) years, no statement will void the coverage or reduce the benefits, unless the statement was material to the risk assumed, fraudulent, and contained on this form.</p> <p>NOTICE: Any person who, knowingly or with intent to defraud any insurance company or other person, files an application of insurance or 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 and subjects such person to criminal and civil penalties.</p>
4	<p>Pre-Existing Conditions: A Pre-Existing Condition exclusion may apply to any employee or dependent enrolling in a CHSIC PPO health plan. This exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than twelve (12) months after your enrollment date. Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within thirty-one (31) days after birth, adoption, or placement for adoption.</p> <p>The Pre-Existing Condition exclusion may be waived if the employee or dependent was covered by a prior qualifying plan in certain situations. These provisions will be described in the Evidence of Coverage issued to the employee and will never be more restrictive than the applicable state and federal law.</p>
5	Important Information: I understand no coverage under this insurance exists unless and until approved by Cox Health Systems Insurance Company, Inc. at its home office in Springfield, Missouri. If at any time prior to such approval, anyone applying for coverage under this application consults a doctor, is hospitalized, or has any change in health, I agree to inform CHSIC and understand that I am responsible for all charges incurred.
6	I understand that no producer, agent, or broker may change or waive any rates, benefits, or provisions of the policy, if issued, without the written approval of an officer of CHSIC.

SIGNATURE REQUIRED	<div style="font-size: 2em; font-weight: bold; margin-bottom: 5px;">X</div> <hr style="border: 0.5px solid black;"/>	<hr style="border: 0.5px solid black;"/>
	Signature of Enrolling Employee*	Date Signed
	* A Group Plan Administrator may sign on behalf of the employee under certain circumstances. Please refer to the "Application Instructions" section for more details.	

SECTION I: WAIVER OF COVERAGE (If you are waiving coverage for any reason, including other coverage, you must complete this section, Section A, read Section H, then sign and date this form.)

1	<p>I am declining coverage for:</p> <input type="checkbox"/> Myself <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child(ren) <input type="checkbox"/> Myself and all dependents	<p>Declining coverage due to existence of other coverage:</p> <input type="checkbox"/> COBRA or State Continuation * <input type="checkbox"/> Medicaid <input type="checkbox"/> Coverage under Spouse's group plan * <input type="checkbox"/> Medicare or Champus (Tri-Care) <input type="checkbox"/> Individual Health Plan * <input type="checkbox"/> Other: _____ <input type="checkbox"/> I (we) have no other coverage at this time
2	<p>* If you are waiving due to other coverage, you must provide a copy of your insurance card or list your information below: Insurance Company Name: _____ Policy #: _____</p> <p>Waiving Coverage: If you are declining enrollment for you or your dependents, you must wait until the next open enrollment period for your group to enroll unless you meet the special enrollment rules described below: Rule #1: Eligibility for coverage under other employer sponsored group health plan ends; except for failure to pay premiums or termination for cause. Rule #2: Loss of coverage as a result of exhaustion of COBRA benefits, eligibility for coverage including legal separation, divorce, death, termination of employment, reduction of hours, or your employer contributions for coverage were terminated. Rule #3: Newly acquired dependent as a result of marriage, birth, adoption, or placement for adoption, and a court or administrative order stating the employee shall provide insurance for dependent child(ren). The eligible covered employee or dependent will have a special enrollment period of thirty-one (31) days within which to submit the required forms to enroll, that begins on the date of the qualifying event.</p>	
	<div style="font-size: 2em; font-weight: bold; margin-bottom: 5px;">X</div> <hr style="border: 0.5px solid black;"/>	<hr style="border: 0.5px solid black;"/>
	Signature of Employee Waiving Coverage (sign only if waiving coverage)	Date Signed