



## Your Individual Application Kit is enclosed

### WHO CAN APPLY?

You are eligible to apply for Significa Individual health care coverage if you:

- are NOT eligible for or enrolled in either Part A or Part B of Medicare, and
- are NOT covered by any other health care insurance, including a hospital service plan, health care service plan, health maintenance organization or a health and welfare plan.

### HOW DO I APPLY?

There are two ways to apply for Significa coverage:

1. Online at [www.significa-ins.com](http://www.significa-ins.com) under the Insureds tab from our home page. You can answer all questions online to expedite your application process.
2. On paper using the enclosed application.  
Send your completed paper applications with your first month's premium to:  
Significa Insurance Group, Inc.  
P.O. Box 7777  
Lancaster, PA 17604

### CHECKLIST

Here is a checklist of a few items that are commonly overlooked and are mandatory in processing your application:

- Legibly complete all questions and sections of the application with blue or black ink
- Indicate your requested effective date
- Provide information, including dates and identification numbers, of your current and previous coverage  
Attach any Certificate of Creditable Coverage(s)
- Provide any and all medical conditions for you and any dependents applying for coverage  
Attach additional paper if necessary to fully answer all questions
- Select your preferred billing method
- Review the Terms and Conditions
- Sign and date the application
- Include your payment of \$10 for the NON-REFUNDABLE application fee which is applied to the first month's premium, upon approval. (Application fee applies to credit card payments only).

If you need assistance filling out this application, please contact your agent.

### HIPAA-Eligible Coverage

If you do not qualify for our regular plan because of your health condition(s), you might still qualify as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Individuals who qualify for HIPAA-Eligible coverage are guaranteed acceptance if they meet these seven (7) criteria:

1. had eighteen (18) months of prior creditable coverage;
2. were most recently covered under an employer group health plan, governmental plan or church plan;
3. elected and exhausted COBRA or similar state continuation of benefits coverage if available;
4. are not eligible for any other group coverage, Medicare or Medicaid;
5. do not have other health insurance;
6. had no more than a sixty-three (63) day break in coverage; and
7. did not have previous coverage terminated for fraud of non-payment of premium.

If you think you may qualify for this coverage under HIPAA, you can contact your agent for further information.

# Significa Insurance Group, Inc.

## Individual Application for Coverage

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

| Last Name  |   |                        | First Name                 |                         |           | MI  | Social Security Number |                 |                  |
|--|---|------------------------|----------------------------|-------------------------|-----------|---|------------------------|-----------------|------------------|
| Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>   |   |                        |                            |                         |           | E-mail Address  |                        |                 |                  |
| Permanent Residence / Street Address   |   |                        |                            | Birth Date (MM/DD/YYYY) | Sex (M/F) | Height  | Weight                 | Tobacco?<br>Y N | Disabled?<br>Y N |
| City   | State   | Zip Code               | Best Contact Number<br>( ) |                         |           | Primary Language<br>English <input type="checkbox"/> Spanish <input type="checkbox"/> |                        |                 |                  |
| Reason for Application:<br><input type="checkbox"/> Applying for new coverage <input type="checkbox"/> Applying for change to current coverage <input type="checkbox"/> Adding dependent <input type="checkbox"/> Applying for HIPAA-Eligible coverage |   |                        |                            |                         |           |   |                        |                 |                  |
| Dependents   | First Name, MI<br>(and Last Name, if different) | Social Security Number | Birth Date<br>MM/DD/YYYY   | Sex<br>M/F              | Height    | Weight  | Tobacco<br>User?       | Student?        | Disabled?        |
| Spouse   |   |                        |                            |                         |           |   | Y N                    | Y N             | Y N              |
| 1  |   |                        |                            |                         |           |   | Y N                    | Y N             | Y N              |
| 2  |   |                        |                            |                         |           |   | Y N                    | Y N             | Y N              |
| 3  |   |                        |                            |                         |           |   | Y N                    | Y N             | Y N              |
| 4  |   |                        |                            |                         |           |   | Y N                    | Y N             | Y N              |
| 5  |   |                        |                            |                         |           |   | Y N                    | Y N             | Y N              |
| 6  |   |                        |                            |                         |           |   | Y N                    | Y N             | Y N              |
| 7  |   |                        |                            |                         |           |   | Y N                    | Y N             | Y N              |
| 8  |   |                        |                            |                         |           |   | Y N                    | Y N             | Y N              |

**Requested Effective Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (for coverage to begin)

### Section 2: PRODUCT SELECTION

**A. Select a SIGNIFICA PPO PLAN to meet your needs:**

DEDUCTIBLE (Individual, In-Network):

Copay Plans\*  \$500     \$1000  
 \$1500     \$2500     \$5000

HSA-Compatible Plans  \$1500     \$2500/100     \$2500/80  
 \$5000

\*OPTIONAL Maternity Coverage (Copay Plans only):  
 Yes     No

**B. Or, select a HIPAA-Eligible Plan if you meet the specific requirements to qualify for this coverage.**

*Note: You can contact your agent for further information regarding the selection of HIPAA-Eligible plans.*

BASIC PLAN  
 STANDARD PLAN

**C. Select a PPO NETWORK:**

Medical Mutual of Ohio

### Section 3: OTHER HEALTH INSURANCE COVERAGE

**A. Is ANY PERSON TO BE COVERED currently covered by or eligible for Medicare? Yes  No**

If yes, this person(s) is NOT eligible for Significa coverage. Please state name(s): \_\_\_\_\_.

**B. Is ANY PERSON TO BE COVERED currently insured by another health plan or was insured within the last sixty-three (63) days? Yes  No**

If yes, this person(s) may be eligible for pre-existing condition credit upon proof of creditable coverage. Creditable coverage is defined as prior health coverage from: a group health plan, health insurance coverage, Medicare, Medicaid, Champus, the Indian Health Service medical care program, a State health benefits risk pool, Federal Employees' Health Benefits Program, a public program maintained by a state, county, or other political subdivision of a state and Peace Corps health benefit plan or any other plans as may be permitted by HIPAA.

In order to receive pre-existing condition credit you MUST ATTACH the Certificate of Creditable Coverage for any previous health care coverage within the last eighteen (18) months.

| NAME (If entire family, simply write ALL below) | NAME OF INSURANCE COMPANY | CANCELATION DATE | REASON FOR CANCELATION |
|---|---------------------------|------------------|------------------------|
|   |                           |                  |                        |
|   |                           |                  |                        |
|   |                           |                  |                        |

**C. If ANY HEALTH CARE COVERAGE STATED ABOVE IS CURRENTLY ACTIVE OR IN EFFECT, will you cancel any and all active coverage upon approval by Significa? Yes  No**

If no, you are NOT ELIGIBLE for Significa coverage. Please discontinue completion of this application.

**Section 4: MEDICAL HISTORY**

A. Has ANY PERSON TO BE COVERED within the past ten (10) years been treated, diagnosed, hospitalized, had surgery or has been recommended for future surgery, diagnostic testing or medical treatment, or thought they should seek medical advice for any of the following conditions? Each condition must be checked (✓) yes or no.

| CONDITION   | Yes | No | CONDITION  | Yes | No | CONDITION  | Yes | No |
|---|-----|----|--|-----|----|--|-----|----|
| Abnormal Pap Smears   |     |    | Epilepsy or Seizure (Type: Grand Mal <input type="checkbox"/> Petit Mal <input type="checkbox"/> Other _____; Date of Last Seizure: _____) |     |    | Otitis Media (ear infections)                                    |     |    |
| Allergies   |     |    | Fibrocystic Breast Disease   |     |    | Ovarian Cyst/Polycystic Ovarian Disease                          |     |    |
| Alzheimer's Disease   |     |    | Fibromyalgia   |     |    | Pacemaker Implantation   |     |    |
| Anemia (Type: _____)  |     |    | Gallbladder Disease  |     |    | Pancreatitis   |     |    |
| Aneurysm  |     |    | Gastric Reflux (GERD)  |     |    | Paralysis  |     |    |
| Anorexia/Bulimia  |     |    | Gastric Bypass/Banding   |     |    | Parkinson's Disease  |     |    |
| Arthritis (Type: _____)                                     |     |    | Gout   |     |    | Peptic/Gastric Ulcer   |     |    |
| Asthma  |     |    | Graves Disease   |     |    | Peripheral Vascular Disease                                      |     |    |
| Back Sprains/Strains  |     |    | Growth Deficiency  |     |    | Phlebitis/Blood Clot   |     |    |
| Bronchitis  |     |    | Heart Attack   |     |    | Polycystic Kidney Disease  |     |    |
| Bursitis  |     |    | Heart Bypass Grafting  |     |    | Prostate Disorders   |     |    |
| Cancer (Type: _____ & Location: _____)                      |     |    | Heart Murmur   |     |    | Schizophrenia/Bipolar  |     |    |
| Cardiomyopathy  |     |    | Heart Palpitations or Arrhythmia   |     |    | Scleroderma  |     |    |
| Carpel Tunnel Syndrome                                      |     |    | Heart Valve Disorders  |     |    | Seizure Disorder/Epilepsy  |     |    |
| Cataracts   |     |    | Hemorrhoids  |     |    | Sexually Transmitted Disease                                     |     |    |
| Carotid Artery Disease                                      |     |    | Hemophilia   |     |    | Skin Conditions (includes Acne, Psoriasis, Rosacea, Nail Fungus) |     |    |
| Cerebral Palsy  |     |    | Hydrocephalus/Shunt  |     |    | Sleep Apnea  |     |    |
| Cholesterol (High)  |     |    | Hypertension (High Blood Pressure) Last 3 Pressure Readings & Dates:   |     |    | Spina Bifida Cystica / Occulta                                   |     |    |
| COPD or Emphysema   |     |    | 1) _____   |     |    | Spinal Disorders/ Disc Disease                                   |     |    |
| Cirrhosis of the Liver                                      |     |    | 2) _____   |     |    | Stroke   |     |    |
| Colitis (Including Ulcerative)                              |     |    | 3) _____   |     |    | Suicide Attempts/ Psychiatric Admissions                         |     |    |
| Colon Polyps  |     |    | Ileostomy/Colostomy  |     |    | Systemic Lupus   |     |    |
| Congenital Disorders  |     |    | Infertility  |     |    | Tendonitis   |     |    |
| Congestive Heart Failure                                    |     |    | Irritable Bowel Syndrome   |     |    | Thyroid Disorder   |     |    |
| Coronary Artery Disease (Including Angina and Angioplasty)  |     |    | Joint Replacement  |     |    | TMJ  |     |    |
| Coronary Insufficiency                                      |     |    | Kidney Failure   |     |    | Tonsillitis  |     |    |
| Crohns Disease  |     |    | Kidney Stones  |     |    | Transient Ischemic Attacks (TIA)                                 |     |    |
| Cystic Fibrosis   |     |    | Liver Disorders/Hepatitis  |     |    | Varicose Veins   |     |    |
| Cystitis (Chronic or interstitial)                          |     |    | Lou Gehrig's Disease (ALS)   |     |    | Other condition(s) not listed:                                   |     |    |
| Cysts, Tumors or Growths                                    |     |    | Lupus  |     |    |  |     |    |
| Diabetes/ Blood Sugar Disorder Last 3 Blood Sugars & Dates: |     |    | Lymph Node or Gland Disorders  |     |    |  |     |    |
| 1) _____  |     |    | Meningitis   |     |    |  |     |    |
| 2) _____  |     |    | Menstrual Disorders (including Abnormal Cycles/ Uterine Bleeding)  |     |    |  |     |    |
| 3) _____  |     |    | Mental Health Disorders (Including Depression, Anxiety, ADD/ADHD and counseling)   |     |    |  |     |    |
| Diverticulitis/Diverticulosis                               |     |    | Migraines  |     |    |  |     |    |
| Down's Syndrome   |     |    | Multiple Sclerosis   |     |    |  |     |    |
| Drug/Alcohol Abuse (Including Arrests/Convictions)          |     |    | Muscular Dystrophy   |     |    |  |     |    |
| Endometriosis   |     |    | Organ Transplant/Failure   |     |    |  |     |    |
|   |     |    | Osteoporosis   |     |    |  |     |    |

**B. Please complete the following questions (each question must have an answer selected):**

In the past ten (10) years, have you or any dependent listed ever been declined health coverage or accepted contingent upon a higher rate by an insurer? Yes  No

If yes, indicate the result: Higher Rating  Decline  Explain reason, date and relationship, below:

| NAME | REASON | DATE | RELATIONSHIP |
|------|--------|------|--------------|
|      |        |      |              |
|      |        |      |              |

In the past ten (10) years, has any person to be covered ever been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS) or any AIDS-related condition or ever had a positive test result on an Human Immunodeficiency Virus (HIV) test? Yes  No

If yes, please complete the following:

| NAME | TYPE | DATE |
|------|------|------|
|      |      |      |
|      |      |      |

Within the past five (5) years, has any person to be covered been treated for, diagnosed by or consulted a physician, psychotherapist, counselor, or any other provider, for any illness, injury or medical abnormality not stated in the previous Section 4.A? Yes  No

If yes, please complete the following:

| NAME | REASON | DATE | RESULTS |
|------|--------|------|---------|
|      |        |      |         |
|      |        |      |         |

Within the past five (5) years, has any person to be covered had abnormal results in any of the following tests: blood work, laboratory results, X-Ray, EKG, blood flow studies, MRI scan, or CAT scan, for conditions you have not already described in this application? Yes  No

If yes, please complete the following:

| NAME | TEST | DATE |
|------|------|------|
|      |      |      |
|      |      |      |

Within the past five (5) years, has any person to be covered had surgery, been confined in a hospital, or been treated in an emergency room for conditions you have not already described in this application? Yes  No  If yes, please complete the following:

| NAME | TREATMENT | DATE |
|------|-----------|------|
|      |           |      |
|      |           |      |

Within the past five (5) years, has any person to be covered currently taking medication or been prescribed medication by a physician?

Yes  No  If yes, please complete the following:

| NAME | MEDICATION / DOSAGE | MEDICAL CONDITION |
|------|---------------------|-------------------|
|      |                     |                   |
|      |                     |                   |

Within the past two (2) years, has any person to be covered had a physical exam? Yes  No  If yes, please complete the following:

| NAME | PHYSICIAN | DATE | RESULTS |
|------|-----------|------|---------|
|      |           |      |         |
|      |           |      |         |

Currently are YOU, your SPOUSE, or any DEPENDENT pregnant, an expectant parent or in the process of adoption (even if not named in this application)? Yes  No  Name/Relationship: \_\_\_\_\_ Due Date: \_\_\_\_\_

Currently, has any person applying for coverage applied for disability or have a condition that is covered by Worker's Compensation? Yes  No

If yes, please complete the following:

| NAME | WORKERS' COMPENSATION NUMBER | MEDICAL CONDITION |
|------|------------------------------|-------------------|
|      |                              |                   |
|      |                              |                   |

C. If you answered YES to ANY questions in this MEDICAL HISTORY Section 4 (A or B), you must provide the following details of each injury, ailment or condition. Attach additional pages as necessary to provide complete medical information.

| Patient's First Name | Physician Name & Telephone (with area code) | Specific Diagnosis | Name & Dosage of Medication or Treatment | Dates of Use or Treatment |             | Was Surgery Performed?              |                          | Description of Surgery/ Procedures & Dates | Current Status of Treatment   |
|----------------------|---|--------------------|--|---------------------------|-------------|-------------------------------------|--------------------------|--|---|
|                      |   |                    |  | Begin mm/yyyy             | End mm/yyyy | YES                                 | NO                       |  |   |
| Susan                | Dr. Mark Green<br>777-777-7777              | Cholesterol (High) | Simvastatin<br>10mg 1x day               | 11/2005                   |             | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Stent inserted<br>3/2006                   | Ongoing <input checked="" type="checkbox"/><br>Ended <input type="checkbox"/> |
|                      |   |                    |  |                           |             | <input type="checkbox"/>            | <input type="checkbox"/> |  | Ongoing <input type="checkbox"/><br>Ended <input type="checkbox"/>            |
|                      |   |                    |  |                           |             | <input type="checkbox"/>            | <input type="checkbox"/> |  | Ongoing <input type="checkbox"/><br>Ended <input type="checkbox"/>            |
|                      |   |                    |  |                           |             | <input type="checkbox"/>            | <input type="checkbox"/> |  | Ongoing <input type="checkbox"/><br>Ended <input type="checkbox"/>            |
|                      |   |                    |  |                           |             | <input type="checkbox"/>            | <input type="checkbox"/> |  | Ongoing <input type="checkbox"/><br>Ended <input type="checkbox"/>            |

**Section 5: BILLING INFORMATION**

**A. FREQUENCY (CHOOSE ONE):**

- Monthly       Semi-Annually
- Quarterly     Annually

**B. PREMIUM BILLING METHOD (CHOOSE ONE):**

- Credit Card (Complete 1 below) Payment automatically taken from credit card. You will not receive an invoice.
- Bank Draft (Complete 2 below) Payment automatically taken from bank account. You will not receive an invoice.
- Invoice Option (Complete 3 below) You will receive an invoice.
  - Email     Post Mail

\* If selecting Invoice Option, you must print this completed application, enclose a check (payable to Significa Insurance Group, Inc.) for the first full month of premium and mail to: *Significa, P.O. Box 7777, Lancaster, PA 17604.*

**1. CREDIT CARD:** Have premium automatically charged to your CREDIT CARD ACCOUNT.

If you wish to charge the premium to your credit card on the second business day of the billing period you selected, please complete the following authorization:

- MasterCard     Visa     Discover

|  |    |                  |                |
|--|----|------------------|----------------|
| CARD HOLDER: First Name  | MI | Last Name        | BANK NAME:     |
| CREDIT CARD NUMBER:  |    | EXPIRATION DATE: | SECURITY CODE: |
| CARD HOLDER BILLING ADDRESS (if different than above)  |    |                  |                |
| CITY   |    | STATE            | ZIP CODE       |
| EMAIL ADDRESS (REQUIRED):  |    |                  |                |
| I authorize Significa Insurance Group, Inc. (Significa) to charge my credit card account for the immediate payment of Significa's non-refundable application fee and for the amount of premium due for my health coverage, if approved by Significa.<br>I understand that the initial and any future premium payments due will be charged to my credit card, subject to the approval of my application. I understand the first premium payment may be deducted after my normal payment due date and may include more than one month's premium.<br>I will notify Significa prior to the next payment due date if I desire to change this method of payment. |    |                  |                |
| CARD HOLDER SIGNATURE:   |    |                  | DATE:          |

**2. BANK DRAFT:** Have automatic premium withdrawals from your FINANCIAL INSTITUTION. If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Significa Insurance Group, Inc. (Significa) to initiate premium deductions from my account, subject to the approval of my application. I also authorize the immediate payment of Significa's non-refundable application fee, if applicable.

This authorization will remain in effect until Significa and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction. I understand the first premium payment may be deducted after my normal payment due date and may include more than one month's premium.

Premiums will be deducted on the second business day of the month from:

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

|                                    |    |           |                 |                         |  |
|------------------------------------|----|-----------|-----------------|-------------------------|--|
| ACCOUNT HOLDER: First Name         | MI | Last Name | ACCOUNT NUMBER: |                         |  |
| STREET ADDRESS:                    |    | CITY:     | STATE:          | ZIP CODE:               |  |
| EMAIL ADDRESS:                     |    |           |                 |                         |  |
| FINANCIAL INSTITUTION / BANK NAME: |    |           | Branch:         | Transit Routing Number: |  |
| ACCOUNT HOLDER SIGNATURE:          |    |           |                 | Date:                   |  |

**3. INVOICE OPTION (CHOOSE ONE):** Have premium billed to the address you designate. *Enclose your check for the first month's premium plus the non-refundable application fee, if applicable.* Upon approval by Significa, all future payments are due on or before the first day of each coverage period.

- HOME (Receive premium billings at Contract Holder's home address)
  - DIFFERENT BILLING ADDRESS (Send premium billings to a different address)
- If your mailing address is different than your permanent address, complete the following:

|                             |    |           |          |           |  |
|-----------------------------|----|-----------|----------|-----------|--|
| CONTRACT HOLDER: First Name | MI | Last Name | Care Of: |           |  |
| STREET ADDRESS:             |    | CITY:     | STATE:   | ZIP CODE: |  |
| EMAIL ADDRESS:              |    |           |          |           |  |
| AUTHORIZED SIGNATURE:       |    |           |          | DATE:     |  |

- LIST BILLING THROUGH EMPLOYER (Available only to employees of a common employer who has agreed to collect the individual premiums on a monthly basis through payroll deduction AND the employer is not paying any portion of the premium)

|                       |  |             |               |           |  |
|-----------------------|--|-------------|---------------|-----------|--|
| EMPLOYER NAME:        |  | OCCUPATION: |               |           |  |
| STREET ADDRESS:       |  | CITY:       | STATE:        | ZIP CODE: |  |
| EMAIL ADDRESS:        |  |             |               |           |  |
| GROUP NUMBER:         |  |             | PHONE NUMBER: |           |  |
| AUTHORIZED SIGNATURE: |  |             |               | DATE:     |  |

**Section 6: TERMS AND CONDITIONS**

I hereby apply for health insurance coverage from Significa Insurance Group, Inc.® as indicated on this Application for Coverage.

1. I authorize release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), government agency or person to Significa Insurance Group, Inc. (Significa) and/or any affiliates or division of Significa: (a) to evaluate this application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize Significa to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.

2. I agree that a medical examination may be required in connection with this Application for health insurance. I further agree that I, as the Applicant, will be responsible to pay for the medical examination and/or the release of any and all medical records on behalf of myself, my spouse, and/or the listed dependents.
3. By signing below, I represent and warrant as follows: (a) I have thoroughly read and understand this Application and the questions asked herein; (b) I have answered each and every question set forth in this Application; (c) all of my answers to each of the questions are accurate, complete and true and (d) I did not sign a blank or partially completed Application. I agree that Significa, in its sole discretion, may rescind my policy at any time on the basis of any untrue, inaccurate or incomplete answer to any question in this Application, or any misrepresentation, omission or concealment on this Application, whether intentional or otherwise. I further agree that if a policy is issued, it will be issued by Significa in full reliance and in consideration of the information, answers and statements contained herein. I understand that this policy will be medically underwritten.
4. I have read and understand the plan benefits, exclusions and limitations. I acknowledge that the preferred provider organization features of this health insurance policy (the networks) have been explained to my satisfaction.
5. **Notice: Certain Pre-Existing Condition limitations will apply.**
6. No issuance, waiver, modification or change of policy or any of Significa's rules or amendments shall be binding upon Significa unless it is in writing and signed by an authorized officer of Significa, as applicable.
7. I also understand that information submitted with this application may require further medical underwriting. If that underwriting discloses additional medical risk I understand that there may be a significant change in the rate charged for this coverage or in certain cases, the coverage may be rescinded. A permanent ID card will be issued following the final review and acceptance of the Application.
8. I understand and agree that I am solely and exclusively responsible for the truth, accuracy and completeness of all of the answers contained in this application. I understand and agree that no agent or broker who may be assisting in the completion of this application has any authority (a) to waive any answer or any portion of any answer to any question on this Application or any information Significa requests, (b) to waive my obligation to disclose any condition of which I am aware concerning my health or the health of any dependent included on the Application, (c) to make any representation concerning health benefits that are inconsistent with, or different from, any written information provided by Significa, (d) to bind Significa in any way by making any statement, promise or representation that is not set out in writing in this Application or regarding eligibility, benefits or issuance of a policy, (e) to answer any questions in, or insert any information on, this Application on my behalf, or (f) to approve coverage.
9. I understand and agree that I am responsible for disclosing all information required by this Application, including but not limited to all health conditions and diagnoses of which I am aware. I understand and agree that Significa has the exclusive right to determine whether a particular condition or diagnosis is significant, that I do not have the right to evaluate whether a condition or diagnosis should or should not be disclosed on this Application and that I am obligated to disclose even those conditions or diagnoses that I do not believe are significant or important.
10. My dependents and I understand and agree that any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to Significa's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by Significa's Privacy Office.

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

|  |      |
|--|------|
| Signature of Applicant                                   | Date |
| Signature of Spouse (if applying for coverage)           | Date |
| Signature of Dependent (if applying and age 18 or older) | Date |

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

|                           |                     |
|---------------------------|---------------------|
| Agent Signature           | Date                |
| Agent Name (please print) | Agent Email Address |
| Agent Number              | Agent Phone Number  |
|                           | Agent Fax Number    |