

**CONTINENTAL GENERAL INSURANCE COMPANY**

8901 Indian Hills Drive • PO Box 247007 • Omaha, NE 68124-7007 • 402-397-3200 • www.continentalgeneral.com

INSURANCE APPLICATION

Requested Effective Date: _____

Please check appropriate box.

 New Enrollee Change to existing certificate # _____ Adding Dependent Reinstatement of Coverage Remove Coverage Exclusion Rider Increase Benefits to: _____**Section I. Primary Applicant/Member Information (When applying for child-only coverage, Section I should be completed for the person who will be responsible for the coverage.)**

LAST NAME		FIRST NAME			M.I.	OCCUPATION/JOB DUTIES		ANNUAL INCOME			
SOCIAL SECURITY NUMBER		DATE OF BIRTH / /		GENDER (M or F)	HT	WT	HOME PHONE NUMBER ()		WORK PHONE NUMBER ()		
HOME ADDRESS (P.O. Box not acceptable)					STREET	CITY	ST	ZIP	EMAIL ADDRESS		
BILLING ADDRESS					STREET	CITY	ST	ZIP	MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
DRIVER'S LICENSE NUMBER/STATE											

TERM LIFE INS. BENEFICIARY, IF APPLICABLE: INCLUDE GUARDIAN IF UNDER AGE 18. N/A FOR CHILD ONLY. SEE SECTION III.	LAST		FIRST		MI	SS#		RELATIONSHIP			
	STREET		CITY		STATE	ZIP	COUNTRY OF CITIZENSHIP				

Section II. Child(ren)/Dependent Information (if applying for insurance)

	FIRST NAME, MI (LAST NAME IF DIFFERENT)	RELATIONSHIP	FULL-TIME STUDENT		DATE OF BIRTH	SOCIAL SECURITY NUMBER	RESIDES WITH PRIMARY APPLICANT/MEMBER?*		OCCUPATION/JOB DUTIES	GENDER		HT	WT
			YES	NO			YES	NO		M	F		
Spouse		Spouse					<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
1			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
2			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
3			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
4			<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		

*If no, provide name and telephone number of custodial parent: _____

Section III. Child-Only Coverage (This section must also be completed when applying for child-only coverage.)

PARENT'S/GUARDIAN'S NAME (IF OTHER THAN PRIMARY APPLICANT/MEMBER)						SOCIAL SECURITY NUMBER								
PARENT'S/GUARDIAN'S HOME ADDRESS (IF DIFFERENT THAN PRIMARY APPLICANT/MEMBER)						STATE						ZIP		
PARENT'S/GUARDIAN'S HOME ADDRESS (IF DIFFERENT THAN PRIMARY APPLICANT/MEMBER)						STATE						ZIP		
HOME PHONE NUMBER ()			WORK PHONE NUMBER ()			EXT.			EMAIL ADDRESS					
LAST		TERM LIFE BENEFICIARY (IF APPLICABLE)		M.I.		SOCIAL SECURITY NUMBER				RELATIONSHIP				
		FIRST												

Section IV. Plan Selection and Method of Payment

Plan Name: _____	Optional Benefits: _____
PPO Network Name: _____	_____
In-Network Benefit Selected: _____	_____
Deductible: _____ Benefit Percentage/OOP: _____	_____
Association package (if applicable): _____	Other: _____

 I am a HIPAA Eligible Individual as defined on form AEF-0600, HIPAA ELIGIBLE INDIVIDUAL DETERMINATION, but elect to be underwritten and waive my right as an Eligible Individual. I understand I will be subject to a preexisting condition exclusion.

 I am applying as a HIPAA Eligible Individual and understand the rates for this plan will be substantially higher than underwritten-plan rates. (Please attach your certification of creditable coverage or other proof of coverage.) Coverage for Eligible Individuals through CGI is not required in the States of AL, AZ, NE, PA, or SC. Refer to the state-specific brochure insert for information on coverage availability.

Method of Payment:

Estimated Monthly Amount Due including administration fee and association dues.

This amount is subject to acceptance by Underwriting: \$ _____

One-time application fee: \$ _____

Total initial amount-due: \$ _____

Premium Payment Options:

Initial Payment:

- EFT
- Check Check #: _____
- Credit Card

Subsequent Payments:

- EFT
- Direct Bill (not available with monthly billing mode)

Billing Mode Options:

- Monthly
- Quarterly
- Semi-annually
- Annually

Draft Date Desired (Draft date cannot be the 29th, 30th, or 31st): _____

ELECTRONIC FUNDS AUTHORIZATION: Name of Account Owner (Name must match bank records exactly.): _____

Name of Bank (Enter name of bank where account is maintained.): _____

Location of Bank (City, State): _____ Type of Account: Checking Savings

Account Number: _____ Routing Number: _____

To the above-named Financial Institution:

I request that you pay and charge my account, debits drawn on my account by CGI to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advance written notice to me and CGI. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

CREDIT CARD AUTHORIZATION: Name as it appears on the Credit Card: _____

Credit Card: _____ Account Number (no dashes): _____ Expiration Date: _____

To complete either of the above authorizations, please sign your name exactly as listed above, including middle initial (if any):

Account Owner: _____ **Date:** _____

Section V. General Information

A. **Are all persons proposed for coverage U.S. citizens?** (If "No", provide details below including name of non-U.S. citizen, country of citizenship, green-card number and number of years the individual has resided in the U.S.) Yes No

B. **Does any person proposed for coverage participate in any hazardous activities in the performance of a job or through sports or hobbies (i.e., racing, rock climbing, scuba diving, hang gliding or ATV riding)?** (If "Yes", list who, activity and frequency of participation.) Yes No

C. **Has any person proposed for coverage used tobacco or tobacco-cessation products during the past 12 months?** (If "Yes", list who, types of tobacco/cessation products and the frequency of usage.) Yes No

D. **Has any person proposed for coverage used any illegal or controlled substance during the past 12 months?** (If "Yes", list who, illegal substance and frequency of usage.) Yes No

E. Has any person proposed for coverage:

1. within the last 7 years, been diagnosed as having, or had any treatment or counseling for, alcohol, chemical or drug abuse or addiction or been advised by a doctor to discontinue or decrease alcohol consumption or drug use, or been convicted of driving while intoxicated ("DWI") or driving under the influence ("DUI")? (If "Yes", indicate who, substance, treatment, amount, date of last use, and date of DWI/DUI.) (In PA, disregard the word "counseling".) Yes No

2. within the last 5 years, been convicted of a felony, or is any person proposed for coverage currently incarcerated, on probation, or on parole? (If "Yes", indicate who, type and date of conviction, and sentence.) Yes No

Section VI. Other Coverage

Is any person proposed for coverage covered by another plan? Yes No
 If "Yes", check all that apply: group health coverage; other plan with similar benefits; dental coverage; Medicare/Medicaid; or other coverage: _____

Will the plan(s) applied for replace the existing coverage(s)? Yes No
 Effective date of other coverage(s): _____

Paid-to-date(s) or expected termination date(s) of last/other coverage(s):

Name(s), policy number(s) and telephone number(s) of other carrier(s):

Does any person proposed for coverage have any condition which involves Workers' Compensation? Yes No

If "Yes", provide the proposed insured's name and condition: _____

Has any person proposed for coverage ever been declined, postponed, charged an extra premium or had a portion of coverage excluded for any life, disability or medical insurance or had such coverage rescinded? (If "Yes", please provide the reason.) Yes No

Section VII. Health Questionnaire

A. **Are you or your dependent spouse or children, whether or not applying for coverage, currently pregnant, an expectant parent or in the process of adopting a child?** Yes No

B. **Is any person proposed for coverage currently disabled or confined in a healthcare facility?** (If "Yes", indicate who and explain.) Yes No

C. **When was the last time any person proposed for coverage had a routine physical exam?** List who, date(s), and indicate any abnormal findings, and/or follow-up care recommended as a result of the exam: _____

D. **Has any person proposed for coverage:**
 1. **ever** been treated or diagnosed by a physician or a licensed medical professional as having AIDS or ARC (AIDS-related complex) or tested positive for the AIDS (HIV) virus? (If "Yes", indicate who.) Yes No

2. **ever** experienced any of the following: loss of appetite, unexplained weight loss, chronic fatigue, fever, oral thrush, skin rashes, chronic diarrhea, unexplained infections, with no known cause? (If "Yes", indicate who, provide details and date[s].) Yes No

3. **within the last 5 years** been advised, or is contemplating, to have an operation or treatment which has not yet been performed? (If "Yes", explain.) Yes No

E. **Does any person proposed for coverage:**
 1. **currently** have any fixation/prosthetic devices present including, but not limited to, plates, screws, pins, artificial joints, implants (including breast implants), shunts, pacemakers or valve replacements? (If "Yes", indicate who and explain.) Yes No

2. **currently** have any restrictions on the job or in daily living activities due to sickness and/or injury? (If "Yes", indicate who and provide details.) Yes No

F. **Has any person proposed for coverage EVER had any signs, symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for any of the following or had the following treatment performed?** (In PA, disregard the words "consultation" and "counseling".) Check all that apply and explain all "Yes" answers in Section VIII:

	YES	NO		YES	NO		YES	NO
Circulatory Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Heart/Valve Disorder/Heart Attack/ Congestive Heart Failure/Coronary Artery Disease/Stroke/Transient Ischemic Attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis: B <input type="checkbox"/> C <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transplants	<input type="checkbox"/>	<input type="checkbox"/>
Gastric By-Pass/Stapling/Lap Band Procedure	<input type="checkbox"/>	<input type="checkbox"/>	Internal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis/Crohn's Disease/ Regional Ileitis	<input type="checkbox"/>	<input type="checkbox"/>
						Vascular Disorder	<input type="checkbox"/>	<input type="checkbox"/>

G. In the PAST 5 YEARS, has any person proposed for coverage had any signs, symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for any of the following or had the following treatment performed? (In PA, disregard the words "consultation" and "counseling".) Check all that apply and explain all "Yes" answers in Section VIII:

	YES NO		YES NO		YES NO
Abnormal/Irregular Heart Beat/Mitral Valve Disorder/Murmur/Palpitations	<input type="checkbox"/> <input type="checkbox"/>	Endocrine/Hormonal Disorders	<input type="checkbox"/> <input type="checkbox"/>	Meniere's Disease/Vertigo	<input type="checkbox"/> <input type="checkbox"/>
Abnormal Test Results	<input type="checkbox"/> <input type="checkbox"/>	Epilepsy and /or Seizure	<input type="checkbox"/> <input type="checkbox"/>	Menstrual Disorder/Reproductive Organs Disorder/Endometriosis/Infertility Testing and/or Treatment	<input type="checkbox"/> <input type="checkbox"/>
Allergies/Asthma/Bronchitis/Respiratory Disorder	<input type="checkbox"/> <input type="checkbox"/>	Gallbladder Disorder	<input type="checkbox"/> <input type="checkbox"/>	Mental, Nervous, Emotional Disorder	<input type="checkbox"/> <input type="checkbox"/>
Amputations	<input type="checkbox"/> <input type="checkbox"/>	Gastritis/Heart Burn/Esophageal Reflux/Digestive Disorder/Ulcers	<input type="checkbox"/> <input type="checkbox"/>	Neurological Disease	<input type="checkbox"/> <input type="checkbox"/>
Anemia/Blood Clots/Blood Disorders	<input type="checkbox"/> <input type="checkbox"/>	Headaches/Migraines	<input type="checkbox"/> <input type="checkbox"/>	Osteoporosis/Bone Thinning	<input type="checkbox"/> <input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/> <input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Pancreatic Disorder	<input type="checkbox"/> <input type="checkbox"/>
Arthritis	<input type="checkbox"/> <input type="checkbox"/>	Hernia	<input type="checkbox"/> <input type="checkbox"/>	Prostate/Rectal Disorder	<input type="checkbox"/> <input type="checkbox"/>
Back/Muscle/Disc or Joint Disorder	<input type="checkbox"/> <input type="checkbox"/>	High Blood Pressure/Hypertension (last three readings and dates taken	<input type="checkbox"/> <input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/> <input type="checkbox"/>
Bone Disease/Deformity	<input type="checkbox"/> <input type="checkbox"/>	_____)		Skin Cancer/Disorders	<input type="checkbox"/> <input type="checkbox"/>
Breast Disorder/Fibrocystic Breast Disease	<input type="checkbox"/> <input type="checkbox"/>	High Cholesterol/Triglycerides (last reading and date taken	<input type="checkbox"/> <input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/> <input type="checkbox"/>
Carpal Tunnel Syndrome	<input type="checkbox"/> <input type="checkbox"/>	Intestinal Disorder/Colitis/Spastic Colon/Irritable Bowel	<input type="checkbox"/> <input type="checkbox"/>	Spinal Disorder/Back/Neck Strain	<input type="checkbox"/> <input type="checkbox"/>
Complications of Pregnancy/Miscarriage/C-Section	<input type="checkbox"/> <input type="checkbox"/>	Kidney Disorder/Kidney Stones	<input type="checkbox"/> <input type="checkbox"/>	Temporomandibular Joint (TMJ)	<input type="checkbox"/> <input type="checkbox"/>
Congenital Disorder	<input type="checkbox"/> <input type="checkbox"/>	Liver/Spleen Disorder	<input type="checkbox"/> <input type="checkbox"/>	Thyroid or Goiter/Graves Disease	<input type="checkbox"/> <input type="checkbox"/>
Ear/Eye/Sinus/Throat Disorders	<input type="checkbox"/> <input type="checkbox"/>	Lung Disorder	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>
Eating Disorder/Anorexia/Bulimia	<input type="checkbox"/> <input type="checkbox"/>	Lupus/Systemic or Discoid	<input type="checkbox"/> <input type="checkbox"/>	Tumors/Cysts/Polyps/Growths	<input type="checkbox"/> <input type="checkbox"/>
				Urinary Tract or Bladder Disorders/Cystitis/Urinary Tract Infection	<input type="checkbox"/> <input type="checkbox"/>

H. Within the past 5 years, has anyone proposed for coverage had symptoms of ill health other than as listed above or been diagnosed or treated for, or been told that he or she has, any other condition, disorder, disease, injury, or syndrome not listed above? (If "Yes", explain in Section VIII.) Yes No

I. ANSWER THE FOLLOWING TWO QUESTIONS ONLY IF APPLYING FOR CRITICAL PAYMENT BENEFIT:

- Has any person proposed for coverage had more than two immediate family members who have been diagnosed with the same condition before age 55 with heart disease, heart attack, stroke, kidney disorder, insulin dependent diabetes, internal cancer, leukemia, or Hodgkin's Disease? (An immediate family member is a father, mother, brother or sister.) Yes No
- In the past 10 years, has any person proposed for coverage been diagnosed as having or been treated for Alzheimer's Disease, or a pre-cancerous, pre-leukemic or pre-malignant condition? Yes No

Section VIII. Health History

A. Give complete details to questions F through H. Use Section XV of this application entitled "Additional Information", if additional space is needed.

Question	Name of Individual	Diagnosis	Treatment (List medications below in Section B.)	Date(s) of treatment	Prognosis/Recovery	Doctor's Name and Address

B. List all medications currently prescribed or taken by any person proposed for coverage in the past 12 months. Use Section XV of this application entitled "Additional Information", if additional space is needed.

Name of Individual	Medications / Frequency & Dosage	Reason Taken	Length of time on medication?	Date medication was last taken?	Doctor's Name and Address

Section XI. Application Authorization

By signing Section XII, I hereby authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, employer, or, except in AZ, any other organization, institution or person that has my records or knowledge of me or my dependent(s) proposed for coverage, to disclose to CGI, or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by company personnel to determine eligibility for insurance and/or benefits. CGI may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. CGI reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy laws. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask CGI to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of two (2) years from the date signed to determine eligibility for insurance. For determination of benefits, the authorization shall be valid for either the term of coverage of the policy, for health insurance products, or for the duration of the claim, for all other insurance products. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative, may receive a copy of this authorization upon request. This authorization may be revoked at any time, subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, my right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

Section XII. Application Signatures

In order for coverage to be considered, please sign below. If submitting via the Internet, please provide your electronic signature by entering your name exactly as you entered it on the first page, including middle initial. If your electronic signature cannot be provided, your verbal electronic signature will be obtained during telephone verification before coverage will be considered.

Primary Applicant's/Member's Printed Name

Signature of Primary Applicant/Member

Date

Signature of Parent or Legal Guardian required if child is under 18

Date

Signature of Spouse (If applying for coverage)

Date

Signature of Adult Child (If applying for coverage)

Date

Signature of Authorized Representative, if applicable (i.e., Power of Attorney)

Relationship/
Authority to Represent

Date

Authorized Representative's Address

Authorized Representative's Phone Number

Section XIII. Medical Information Bureau (MIB) Authorization

Information regarding your insurability will be treated as confidential. CGI or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

I understand that if I apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such member company, the Bureau, upon request, will supply such member company with the information in its file.

By signing below, I authorize release of my information to MIB and MIB to any member company.

Signature of Applicant
(Signature of Parent or Legal Guardian required if child is under 18)

Date

Signature of Spouse (If applying for coverage)

Date

Signature of Adult Child (If applying for coverage)

Date

Signature of Adult Child (If applying for coverage)

Date

Signature of Adult Child (If applying for coverage)

Date

Signature of Authorized Representative, if applicable (i.e., Power of Attorney)

Relationship/
Authority to Represent

Date

Authorized Representative's Address

Authorized Representative's Phone Number

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