

MyPrioritySM Application

Instructions:

Thank you for your interest in MyPriority. To help us process your application for you and your dependents, please review the information below. The information you provide will determine whether you are eligible for MyPriority insurance.

- Priority Health must receive your application within 30 days after you sign and date the application.
- Coverage is not guaranteed. All applications are reviewed with a medical underwriting process.
- Priority Health will let you know if they are eligible for coverage.
- Please do not cancel any current insurance coverage they have until you receive a written notice from Priority Health to tell them that you have been approved for MyPriority coverage.
- If you are already a MyPriority member but you would like to either add a spouse or dependent or upgrade your plan, please check the box in Section 1.
 - If you are adding a spouse or dependent(s) please make sure to complete sections 2 and 3 as it would apply to them.
 - If you are upgrading your plan you will need to complete sections 2 and 3 for everyone you would like covered on the plan.

Eligibility requirements:

MyPriority has eligibility requirements for you and your dependents.

A. Subscriber (primary applicant)

You may apply for coverage as the subscriber (also called primary applicant) if the following statements are true.

1. You are a Michigan resident and you have lived in Michigan for six months in a row before the effective date you are requesting.
2. You are not eligible for or enrolled in any governmental health insurance public financial assistance program other than Medicaid. This includes Medicare, Children's Special Health Care Services, VA Benefits and CHIP programs. This includes prescription drug coverage.

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Notice to Applicant

3. You are between the ages of 18 and 64 ½ if applying for a My**Priority** PPO plan, or My**Priority** HSA plan or between the ages of 18 and 30 if applying for the My**Priority** U31 plan.
4. You are not in detention or incarcerated in a facility such as a jail, prison or youth home. You are also not in the custody of any law enforcement officer or on release for the sole purpose of receiving medical treatment.

B. Eligible dependents

You may apply for your spouse and/or eligible dependents if the following statements are true.

1. The subscriber (primary applicant) and the spouse are legally married and not older than age 64 ½.
2. The dependent child(ren) meet all of the following criteria:
 - The child(ren) are between the ages of 15 days and 26 years as of the effective date of coverage.
 - Dependents are not eligible for or enrolled in any governmental health insurance or public financial assistance program other than Medicaid. This includes Medicare, Children's Special Health Care Services, VA Benefits and CHIP programs. This also includes prescription drug coverage.
 - Dependent(s) are not in detention or incarcerated in a facility such as a jail, prison or youth home. Dependents are also not in the custody of law enforcement officer or on release for the sole purpose of receiving medical treatment.

Section 1 – Subscriber information

Please use only blue or black ink

Last name		First name		MI	Social Security Number	
Street address		Gender		Birth date		Age
City		County	State	ZIP	Height	Weight
Primary phone	Work phone	Occupation	Best time to call		e-mail address	

Marital Status
 Single Married

Plan changes:
 I am already a MyPriority member
 I am adding a spouse or dependent
 I am upgrading my plan
 (see instructions for details).

Plan options:
MyPriority PPO
 \$1,000 single/\$2,000 family deductible – 80% coinsurance
 \$1,000 single/\$2,000 family deductible – 70% coinsurance
 \$2,500 single/\$5,000 family deductible – 80% coinsurance
 \$2,500 single/\$5,000 family deductible – 70% coinsurance
 \$3,500 single/\$7,000 family deductible – 80% coinsurance
 \$5,000 single/\$10,000 family deductible – 80% coinsurance
 \$7,500 single/\$15,000 family deductible – 80% coinsurance
 \$10,000 single/\$20,000 family deductible – 80% coinsurance
 Accident rider

MyPriority U31
 \$1,000 deductible – 70% coinsurance
 \$3,000 deductible – 70% coinsurance
 Accident rider

MyPriority HSA
 \$2,000 single/\$4,000 family deductible
 \$4,000 single/\$8,000 family deductible
 \$5,000 single/\$10,000 family deductible
 Accident rider

Priority Health Member number (as shown on ID card) _____ Requested Effective Date of Coverage (date you would like coverage to begin) _____

Please list your spouse and all eligible dependent(s) who are applying for coverage under your policy. If you have more than four (4) dependents complete an additional application and include it with this application.

1

Spouse/dependent last name		First name		MI	Gender <input type="radio"/> Male <input type="radio"/> Female	
Social Security Number		Birth date	Age	E-mail address		
Relationship to primary applicant		Occupation	Height / Weight	Primary Care Physician		

2

Dependent last name		First name		MI	Gender <input type="radio"/> Male <input type="radio"/> Female	
Social Security Number		Birth date	Age	E-mail address		
Relationship to primary applicant		Occupation	Height / Weight	Primary Care Physician		

3

Dependent last name		First name		MI	Gender <input type="radio"/> Male <input type="radio"/> Female	
Social Security Number		Birth date	Age	E-mail address		
Relationship to primary applicant		Occupation	Height / Weight	Primary Care Physician		

4

Dependent last name		First name		MI	Gender <input type="radio"/> Male <input type="radio"/> Female	
Social Security Number		Birth date	Age	E-mail address		
Relationship to primary applicant		Occupation	Height / Weight	Primary Care Physician Subscriber initials _____		

Section 2 – Health information

Please give details about any "YES" answers in the section following these questions: In the past 5 years, have you or any person applying for coverage been diagnosed with, advised of, tested for, had or been in need of treatment or surgery for any condition related to the following:

1. Yes No Are you or any family member pregnant, or an expectant parent, or in the process of adoption, whether or not that person is listed on this application? If yes, you or any other family members are not eligible for MyPriority coverage. **Please do not submit an application.**
2. Yes No Any heart or circulatory system disorders including high blood pressure, high cholesterol, anemia, clogged arteries, atherosclerosis, heart attack, chest pain, stroke, TIA, heart valve disorder, irregular heart beat, pacemaker, heart murmur, atrial fibrillation, angioplasty, heart bypass surgery, atrial septal defect, aortic insufficiency, congestive heart failure, cardiomegaly, cardiomyopathy, aneurysm, bleeding or clotting disorder, hemophilia, varicose veins, or heart transplant?
3. Yes No Any respiratory system disorders including lung disease, emphysema, asthma, chronic cough, tuberculosis, cystic fibrosis, chronic obstructive pulmonary disease (COPD), bronchitis, pneumonia, or lung transplant?
4. Yes No Any digestive system disorders including diseases of the pancreas, liver or gallbladder, hepatitis (B, C, D, E, Other), cirrhosis, fatty liver, gastric bypass or banding, eating disorders, GERD, Crohn's disease, gastrointestinal disorder, ulcer, ulcerative colitis, or liver or pancreas transplant?
5. Yes No Any musculoskeletal system disorders including back, spine or neck disorders, arthritis, hip or knee replacement, amputation or prosthesis, lupus, fibromyalgia, or connective tissue disorder?
6. Yes No Any nervous system or mental disorders including psychoses, depression, anxiety, epilepsy, seizure, multiple sclerosis, muscular dystrophy, myasthenia gravis, paralysis, Parkinson's disease, cerebral palsy, schizophrenia, bipolar/ manic depressive disorder, senile dementia, Alzheimer's, amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease)?
7. Yes No Any endocrine and metabolic system disorders including diabetes, elevated blood sugar or presence of any protein, albumin or sugar in the urine, thyroid, adrenal or pituitary disorders?
8. Yes No Any genital, reproductive, or urinary system disorders including blood in urine, infertility, irregular menstruation, ovary disorder, abnormal PAP, cystitis, stones, prostate disorder, sexually transmitted diseases, complications of pregnancy (including caesarean section), kidney stones or disease, end stage renal disease (ESRD), kidney transplant or dialysis?
9. Yes No Any tumors, cysts, birth defects or congenital abnormalities including cleft lip or palate, autism, Down's syndrome, congenital heart defect, mental retardation, or other physical deformities?
10. Yes No Any acquired immune deficiency syndrome disorder (AIDS), chronic fatigue, AIDS-related complex (ARC) or ever tested positive for the human immunodeficiency virus (HIV+) ?
11. Yes No Any cancers, including melanoma, leukemia, Hodgkin's disease, lymph glands/node, bone marrow or stem cell transplant?
12. Yes No Any eyes and ears disorders including glaucoma, cataract, corneal transplant, loss of hearing, chronic ear infections or ear tubes?
13. Yes No Any tobacco or nicotine product use in the last 12 months?
14. Yes No Any alcoholism or alcohol abuse, drug use including cocaine, heroin, and narcotics, chemical dependency or recommended for drug or alcohol counseling, or driving while intoxicated (DUI)?

If yes for DUI, please provide driver's license number here. _____
15. Yes No Does anyone applying for coverage have any medical or physical impairment or take any medications or receive medical treatment for any conditions not already mentioned?
16. Yes No Has anyone applying for coverage had any testing, surgery, treatment, therapy, medications, or hospitalization recommended or advised and not yet completed? Or treatment for any other condition not already disclosed on this application?
17. Yes No Has anyone applying for coverage participated in any activity such as : automobile, motorcycle, or powerboat racing, rodeo, sky diving, scuba diving, rock or mountain climbing, hang gliding, or ultra light flying?
18. Yes No Any history of breast implants or internal fixations (plates, screws, pins, shunts, stents, etc.)?

Please provide details to any "YES" answers in the following section. Please include full details including person, condition, treatment, prescription drugs, hospitalization, dates, and current condition. If additional space is needed, please continue on another page (please sign and date that page.)

Question #	Applicant name	Condition	Date diagnosed	Date last treated	Treatment, including medication names with dosage, how-often taken, and doctor name

Section 3 – Other information.

1. Yes No Has anyone applying for coverage ever been covered by Priority Health insurance?
If yes, please provide details including: name, dates covered, employer name:

2. Yes No Is anyone applying for coverage currently covered by, or has applied for coverage, for any type of medical insurance? If Yes, please give details including: name, name of insurance company, dates covered, type of coverage (employer or individual) and whether or not current coverage will be replaced by Priority Health, should this Priority Health application be approved:

3. Yes No Have you or any person applying for coverage ever been declined, postponed, or had conditions excluded or charged an additional premium for any health, life or disability insurance coverage?
If "yes", please provide details: name, when, and why

4. Yes No Is anyone, or has anyone applying for coverage been disabled, hospitalized, confined, or unable to work due to a medical condition? If yes, please provide details:

5. Yes No Is anyone applying for coverage currently submitting an application for a Priority Health Short-term plan?
If yes, please provide details:

Subscriber initials _____

Section 4 – Payment information

If your application is accepted, Priority Health will notify you by e-mail or letter the exact amount of your monthly premium and when your policy will start (your "effective date"). Priority Health collects health insurance premiums by electronic fund transfer.

First payment

Your first payment will be debited from the following bank/other financial institution:

Name of financial institution	ABA / routing number (9 digits on the bottom of check for a checking account)
Account number	Account type <input type="radio"/> Checking <input type="radio"/> Savings
Print name	
Account holder's signature	Date

We must receive all required information to enroll you in coverage. If your application is approved, your coverage will be effective on the requested effective date or the underwriting approval date, whichever is the later. Once approved, your ID card will be mailed to you. Please allow 7 to 10 business days to receive your ID card, after you have received written notice of approval.

If you have additional questions on the automatic bill payment plan, please call Customer Service at 800 528-8762.

After your first payment is made through the account designated above you can choose from the following options for ongoing payments.

- Choose one:
- | | |
|---|--------------------------------------|
| <input type="radio"/> Electronic Funds Transfer | <input type="radio"/> Mail me a bill |
| <input type="radio"/> Monthly | <input type="radio"/> Quarterly |
| <input type="radio"/> Quarterly | <input type="radio"/> Semi-annual |
| <input type="radio"/> Semi-annual | <input type="radio"/> Annually |
| <input type="radio"/> Annually | |

1. On the third business day of the month, we will automatically debit the checking or savings account that you name above for the amount of your monthly/quarterly/semi-annual/annual premium. If your account does not have enough money to pay your premium we will get a "non-sufficient funds" (NSF) notice from your account, and we will charge you an extra \$50.
2. If we don't receive and post your premium payment by the last day of the month in which the premium is due, we will end your policy as of the last date your policy was paid in full.
3. You must notify Priority Health of any changes to your designated account at least five business days before the last day of the month.

Acceptance of payment terms

When my application is approved, I authorize Priority Health to deduct from the account listed above my first premium payment which may include: (1) the first partial month of coverage (depending on the effective date) AND (2) the first premium period (monthly, quarterly, etc.) I indicate below. I understand my account will be debited on or about the third business day of every month in which a payment is due. If at any time I decide to discontinue automatic electronic fund transfer payments, I will notify Priority Health in writing 30 days before discontinuing.

If you have questions on the automatic bill payment plan, please call Customer Service at 800 528-8762.

Section 5 – Important authorization and verification information. Please read, sign, and date as indicated.

My signature below indicates that I have read and understand the contents of this application. I declare that the answers and information presented on this application are complete and true for all applicants to the best of my knowledge and belief, and will be used as the basis for underwriting and issuing coverage. I understand that the application and any amendments become part of the insurance contract and that if any information and answers are incomplete, incorrect or untrue, Priority Health may have the right to rescind (cancel) coverage, adjust premium, and/or reduce benefits. Coverage is not guaranteed, and I understand that I should not cancel any current coverage until I receive written notice of approval from Priority Health.

I understand that any person who, knowingly and with intent to defraud any insurance company or other person, files an application for 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 when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties. I understand the coverage under the plan I am applying for will not take effect until issued by Priority Health. Priority Health requires proper handling of personal health information for applicants and members, and details of confidentiality policies and procedures are available to me upon my written request to Priority Health.

I understand that this coverage is not an employer group health plan and is not intended to be an employer-sponsored health insurance plan. I certify that my employer will not contribute any funds toward the cost of this coverage.

I agree that I, along with any dependents, will accept and receive member material online (via priorityhealth.com).

Subscriber (primary applicant) signature Date

Spouse/dependent (if age 18 or older) signature Date

Dependent (if age 18 or older) signature Date

Dependent (if age 18 or older) signature Date

Dependent (if age 18 or older) signature Date

Section 6 - For agent: if an agent assisted with the sale or completion of this application, the agent is required to complete the following information:

Agent last name

Agent first name

Rick Young & Associates
Agency name

Agent number

E-mail address

Primary phone

Fax phone

Quoted premium

Rick Young & Associates
General agency

A00828
General agency ID

Agent signature

Date

Checklist of required forms:

Please ensure that all medical questions and forms are completed and answered with full details provided for the following:

- Completed health information and details given for all "Yes" answers (Section 2 and Section 3)
- Signatures provided (Section 4 and Section 5)
- Payment Information provided (Section 4)

Applications can be mailed or faxed.

- Mail all required forms using either the enclosed business reply envelope, or address to:
Priority Health
Individual Market Underwriting MSFH10
34505 West Twelve Mile Road
Farmington Hills, MI 48331
- Fax all forms to: 248 324-2973

Authorization for release of personal and health information:

Name

Street address

City/State/ZIP code

Phone number

Priority Health requires proper handling of individually identifiable health information for applicants and members, and details of confidentiality policies and procedures are available to me upon my written request to Priority Health.

I understand that the following parties may need to provide or collect information on me or my dependent applicants in regard my proposed application for insurance: Priority Health and its reinsurers, any insurance support organization, related Business Associates, any consumer reporting agency, physicians, hospitals, clinics, and all persons authorized to represent these organizations for this purpose. I authorize any health care provider, hospital or medically related facility, pharmacy, or pharmacy related facility, consumer reporting agency, insurance or reinsurance company, having information about me or any of my dependent applicants to provide all such information as requested to Priority Health or its Business Associates or Agents.

I authorize that the following information may be disclosed to or by Priority Health: any and all individually identifiable health information, including but not limited to medical records, medical benefit histories, prescription drug benefit histories, medical reports, pharmaceutical records, diagnostic testing, and lab work results. Those parties that may need to collect information may disclose information to the following: other insurers to which I have applied or may apply, reinsurers, pharmacy benefit managers, physicians, hospitals, Business Associates, clinics or other medically related facilities, health care clearing houses, or persons who perform business, professional, or insurance tasks for Priority Health. The parties may disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information to make eligibility, underwriting and risk rating determinations and includes any and all information regarding diagnosis, treatment, and prognosis or medical conditions including physical, mental, psychiatric, drug, alcohol, and prescription history. Unless revoked earlier, this authorization will be valid for a period of thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to Priority Health at: 1231 E Beltline, NE, MS 1175, Grand Rapids, MI 49525. 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 this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the persons to whom information is disclosed under this Authorization may possibly re-disclose the information in which case it may no longer be protected by federal rules governing privacy and confidentiality.

I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above.

Subscriber (primary applicant) signature Date

Spouse/dependent (if age 18 or older) signature Date

Dependent (if age 18 or older) signature Date

Dependent (if age 18 or older) signature Date

Dependent (if age 18 or older) signature Date

Authorized representative signature (parent, legal guardian, personal representative, power of attorney)

Relationship Date

Note: This form cannot be used for psychotherapy notes. If you seek to authorize the use of disclosure of psychotherapy notes, you will need to use a separate form.

Please return this completed form with the application.