



SHORT TERM ESSENTIAL POLICY

A short term medical insurance policy

Primary Health Plan
 800 Park Blvd., Ste. 760
 Boise, ID 83712
 Phone: 1-208-333-1596
 1-800-688-5008 ext. 596
 Fax: 1-208-433-4600
www.primaryhealth.com

Insured's Information

Insured's Name (first, initial, last):		Requested Effective Date:
Address:		
City:	State:	Zip:
Daytime Phone:	Evening Phone:	

List self and family members to be covered. If you need more room, please use an additional application.

Self and Family Member Names (first, initial, last)	Relationship to	Gender	Date of Birth
Insured	Self		
Spouse			
Child 1			
Child 2			
Child 3			
Child 4			

Medical Questions

1. Are you, or any person to be insured, age 65 or older?	<input type="radio"/> Yes <input type="radio"/> No	If YES, this policy cannot be issued
2. Are you, or any person to be insured, eligible for Medicare?	<input type="radio"/> Yes <input type="radio"/> No	If YES, this policy cannot be issued
3. Do you, or any person to be insured, now have any hospital, major medical, group health or medical insurance coverage that will not terminate prior to the beginning of this policy?	<input type="radio"/> Yes <input type="radio"/> No	If YES, this policy cannot be issued
4. With regard to you or any person to be covered, is there reason to believe anyone is an expectant mother or father through birth or adoption?	<input type="radio"/> Yes <input type="radio"/> No	If YES, this policy cannot be issued

Plan Options & Acceptance

Deductible Amount/Family Deductible: \$500/\$1,500 \$1,000/\$3,000 \$2,500/\$7,500

Policy Term (30-181 days) Number of Days: _____

Premium Payment Options: Full payment with application by check Credit/Debit Card— full payment (complete section on page 2)
 Direct Debit—90 days with application and then monthly from checking/savings account (complete section on page 2)

I understand that:

- (1) If my application for coverage is accepted, the Effective Date will be 12:01 a.m. on the later of the day after the postmark date or the requested effective date or the date the application is hand delivered to our home office;
- (2) If my application for coverage is not accepted, any premium I paid will be promptly refunded;
- (3) This is not a continuation of any previous medical plan, including any prior Short Term Medical Plan;
- (4) This policy is not renewable; and
- (5) There is no coverage for Pre-Existing Conditions under this Policy. Pre-Existing Condition means: (1) a condition that would have caused an ordinarily prudent person to seek medical advise, diagnosis, care or treatment during the six months immediately preceding the Effective Date of coverage; (2) a condition for which medical advise, diagnosis, care or treatment was recommended or received during the six months immediately preceding the Effective Date of coverage.
- (6) Under this policy, benefit payments will be made directly to the medical provider.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief, and I understand that the answers to the above questions shall be the basis of any coverage issued, and that any incorrect answer may operate to void this coverage.

INSURED'S SIGNATURE	PARENT/GUARDIAN SIGNATURE	DATE
LICENSED AGENT NAME (Print)	LICENSED AGENT SIGNATURE	AGENT NUMBER

OFFICE USE ONLY *****

Written Notification Received: _____ Start Date: _____ Payment: _____ Number of Members: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize any physician, health care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Primary Health Network, Inc. (PHN) or its representatives health information (including alcohol, chemical dependency, or mental treatment, genetic testing or HIV treatment) pertaining to me and/or my eligible dependents. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan and eligibility for benefits or payment of claims. Health Information may include claim records, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records or progress notes).

If I choose to not sign this authorization, PHN may be unable to enroll my family or me in the health plan or to pay claims that were incurred while we had insurance coverage with PHN.

I may cancel this authorization at any time by sending a written request to PHN. Cancellation of this authorization will not affect any action PHN took before it received this request. If I do not revoke this authorization, it will automatically expire when I am no longer covered under this policy and all claims arising from the policy have been settled, or in 24 months from the date below, whichever comes first. A photocopy of this authorization is as valid as the original.

Federal law requires PHN to tell me that if the party to whom PHN discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, part 2). Federal law prohibits redisclosure of this information without specific written authorization.

SIGNATURE*: _____ **DATE:** _____

NAME: _____ (please print)

*If signature by a personal representative of the Insured, please complete the following:

Personal Representative's Name: _____

Relationship to Insured: Parent Legal Guardian** Holder of Power of Attorney**

**Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney

APPLICANT SPOUSE SIGNATURE: _____ **DATE:** _____

APPLICANT NAME: _____ (please print)

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation)

DISCLOSURE: If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from PHN. Incentives may be based on any of several factors, the products you buy, your broker or agent's volume of business with PHN and the other services your broker or agent provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

CREDIT/DEBIT CARD AUTHORIZATION

Name on credit card: _____ **Type of card:** VISA Mastercard

Billing Address: _____ **State:** _____ **Zip:** _____

Credit Card Number: _____ **Expiration Date:** _____ **3 digit security code:** _____

I authorize Primary Health Network, Inc. to charge my credit card the full amount of \$ _____

Signature: _____ **Date:** _____

DIRECT DEBIT AUTHORIZATION

I hereby authorize **PRIMARY HEALTH NETWORK, INC.** to initiate debit entries to my _____ (checking or savings) account from the depository financial institution named below, hereinafter called DEPOSITORY, and to debit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U. S. Law. I will be responsible for all bank charges associated with insufficient fund fees. **Initial payment of 90 days is required. After 90 days your account will be debited monthly for the duration of coverage.**

****PLEASE STAPLE VOIDED CHECK TO THIS FORM****

Depository Name: _____ **Branch:** _____

Signature: _____ **Date:** _____

NOTE: ALL WRITTEN DEBIT AUTHORIZATIONS MUST PROVIDE THAT THE RECEIVER MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.