

# Tele-App Part 1 Enrollment for Medical Insurance for Individuals and Families



## Agent Information

**Agency Name** \_\_\_\_\_ **Agency Number** \_\_\_\_\_  
**Agent Name** \_\_\_\_\_ **Agent Number** \_\_\_\_\_  
**Agent Fax Number** \_\_\_\_\_ **Agent Phone Number** \_\_\_\_\_  
**Agent E-mail Address** \_\_\_\_\_

## Person(s) To Be Insured

Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number
(Primary)						
1.						
(Spouse)						
2.						
3. Dependent Children						
Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number

4. Resident Address (Street, City, State and ZIP code. No P.O. Boxes)

\_\_\_\_\_  
 Street City State ZIP  
 5. Home Phone Number \_\_\_\_\_ 6. E-Mail Address: \_\_\_\_\_

7. Are any of the proposed insureds covered by, or has application been made for, any type of medical insurance?  
 Yes (complete section below)  No

Proposed Insured's Name	Company Name	Company Phone Number	Group (G)/ Individual (I)	Type of Coverage	Effective Date	Term Date

8. Were all proposed insureds covered under the prior plan listed above?  Yes  No (If no, list those not covered)

9. Will this proposed coverage replace or change any existing health insurance?  Yes  No

10. Are any of the proposed insureds covered by Medicaid?  Yes  No

11. Will any proposed insured become eligible for any other form of medical insurance in the next six months?  Yes  No

## Billing

**Check-O-Matic** (Complete form on the next page)  **Quarterly**  **Semi-Annual**  **Annual**  
 Send premium notices to:  Insured or  Alternate Payor

\_\_\_\_\_  
 Name  
 \_\_\_\_\_  
 Address  
 \_\_\_\_\_  
 City State ZIP

I (we) hereby authorize Fortis Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account.

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
 Signature of Payor Date Signed

## REMEMBER TO FAX PAGES 1 & 2 ONLY!

## Authorization for Check-O-Matic Billing

Choose the following option that applies:

**To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day: (1-28): \_\_\_\_\_

Bank Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

**To add this policy to an existing Check-O-Matic:**

Existing COM Number \_\_\_\_\_

Associated Policy Number \_\_\_\_\_

Jane Doe 2139 S. 33 St. AnyTown, USA 12345	*(Transit Number) 1234	
		Date _____
Pay to the order of _____		\$ _____
		_____ Dollars
BANK NAME _____		
Memo _____		
*(Routing Number)	*(Account Number)	(Check Number)

\*Routing & Transit Numbers \_\_\_\_\_ \*Account Number \_\_\_\_\_

**Don't send in a voided check – just complete the routing and account information for Check-O-Matic!**

## Authorization To Obtain Medical Records and Attestation

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Fortis Insurance Company (or any consumer-reporting agency authorized by Fortis Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

**I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded personal health history, Part 1 and any amendments shall be the basis for the contract. I also agree that:**

**(1)** I must call Fortis Insurance Company and complete the telephone portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto. **(2)** I understand that if at any time through the enrollment process any of the previous information provided becomes inaccurate or is updated, I have an obligation to contact Fortis Insurance Company and advise of such change. **(3)** Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Fortis Insurance Company. **(4)** Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Fortis Insurance Company, will be in force only when issued by Fortis Insurance Company and accepted by me. **(5)** I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. **(6)** If any of these conditions are not met, Fortis Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

\_\_\_\_\_  
Signature of Primary Proposed Insured  
(Circle one)  
A.M. / P.M.

\_\_\_\_\_  
Signature of Spouse or Other Insured (if proposed to be insured)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Time Signed

\_\_\_\_\_  
City & State

\_\_\_\_\_  
Requested Policy Effective Date

**Conditional Receipt Given?**     **Yes**     **No**

## Health Advocates Alliance Membership Application

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the right to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure, form 26588.

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association. If participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association-sponsored programs or benefits.

\_\_\_\_\_  
Member Name (Please print)

\_\_\_\_\_  
Member Signature

**REMEMBER TO FAX PAGES 1 & 2 ONLY!**

## Conditional Receipt

This Conditional Receipt is received from \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ month \_\_\_\_\_ year.

The proposed insured has authorized either an electronic transfer of funds or money in the sum of \$\_\_\_\_\_ for the necessary amount of premium and/or any administrative processing fees, that will be paid in connection with completing a medical insurance enrollment form with Fortis Insurance Company.

No insurance will become effective prior to contract issue and acceptance by the proposed insured, except, insurance may become effective prior to the contract issue if and when each and every condition contained in this receipt is met. No agent or broker of the company is authorized to alter or waive any of the following conditions:

1. The proposed insured(s) must be, on the effective date, as hereinafter defined, a risk acceptable to the company under its rules, standards and practices for the exact contract and premium applied for, without any modification.
2. The amount of payment received with Part 1 or the actual withdrawal of funds by means of electronic transfer is an amount equal to the amount of the first full premium payment selected.
3. The proposed insured(s) must call Fortis Insurance Company and complete the telephone portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto.
4. The contract is issued exactly as applied for within 30 days from the date of commencement of the enrollment process. If the contract is not issued within 30 days from the date of commencement of the enrollment process, there will be no coverage provided under the terms of this Conditional Receipt. Any coverage provided by the Conditional Receipt ends when the contract is delivered and accepted by you.
5. Proposed insured(s) completes all forms and provides all information required through the application and enrollment process.
6. Part 1 is submitted by an insurance agent or broker appropriately licensed to do business with the company and in the appropriate state jurisdiction.
7. Proposed insured(s) understands that if at any time through the enrollment process any of the previous information provided becomes inaccurate or is updated, he or she has an obligation to contact Fortis Insurance Company and advise of such change. Failure to do so may result in claim denial or rescission/revocation of coverage.
8. Within 30 days of policy issue, the proposed insured must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning the signed acceptance to Fortis Insurance Company.

If each of the above conditions is fulfilled, then the insurance as provided by the terms and conditions of the contract applied for will become effective on the effective date prior to the contract delivery. "Effective Date" as used herein means the later of a) the date of commencement of the enrollment process, or b) the requested effective date. If one or more of the conditions are not met, Fortis Insurance Company may rescind its offer of coverage and its liability shall be limited to the return of the sum received.

\_\_\_\_\_  
Proposed Insured Signature

\_\_\_\_\_  
Agent Signature



# BUILD CHART

Male		Female	
Height (ft, in)	Weight (lbs)	Height (ft, in)	Weight (lbs)
5'0"	98 - 152	4'10"	90 - 138
5'1"	101 - 155	4'11"	92 - 140
5'2"	103 - 159	5'0"	94 - 143
5'3"	105 - 162	5'1"	96 - 146
5'4"	107 - 166	5'2"	98 - 150
5'5"	110 - 171	5'3"	101 - 153
5'6"	112 - 175	5'4"	104 - 158
5'7"	115 - 181	5'5"	107 - 163
5'8"	118 - 186	5'6"	109 - 168
5'9"	121 - 191	5'7"	112 - 173
5'10"	124 - 197	5'8"	115 - 178
5'11"	126 - 203	5'9"	117 - 185
6'0"	129 - 208	5'10"	119 - 192
6'1"	132 - 215	5'11"	122 - 197
6'2"	135 - 220	6'0"	123 - 202
6'3"	139 - 226	6'1"	126 - 207
6'4"	143 - 232	6'2"	130 - 213
6'5"	146 - 240	6'3"	134 - 219

**HIPAA ELIGIBILITY FORM  
FOR INDIVIDUAL MEDICAL**



In order to determine whether or not an applicant is an Eligible Individual as defined by the Health Insurance Portability and Accountability Act (HIPAA), please complete the following questions.

- 1) Do you have 18 months of previous (continuous) creditable coverage\*?  Yes  No
- 2) Was the most recent creditable coverage a group health plan, governmental plan or church plan?  
(A one man trust product does not qualify as a group plan)  Yes  No
- 3) Have you had no gap in coverage or a gap of 63 days or less during the past 18 months?  
 Yes  No
- 4) Was your most recent coverage terminated due to nonpayment of premiums or fraud?  
 Yes  No
- 5) Are you currently eligible for any other health insurance coverage?  Yes  No
- 6) Are you eligible for Medicare or Medicaid?  Yes  No
- 7) Was coverage under COBRA or a state continuation plan made available to you?  Yes  No
- 8) If YES, did you elect coverage under COBRA or state continuation and exhaust such coverage?  
 Yes  No If yes, when will coverage terminate? \_\_\_\_\_
- 9) If NO, please briefly explain why COBRA or state continuation was not made available to you.

**Please provide prior employer's name and telephone number for verification purposes:**

*Along with this form, please submit a certification from your previous group carrier. If a certification is not available, please submit a copy of your previous carrier's ID card, a copy of your previous carrier's specification page or summary plan document, and a copy of your latest bill. These requirements are necessary for each person applying for coverage.*

I represent that all of the above answers are correct to the best of my knowledge and belief. I understand that any misrepresentations or fraudulent statements could result in rescission of my contract.

\_\_\_\_\_  
Signature of applicant

\_\_\_\_\_  
Date

\*Creditable Coverage: A group health plan, including HMO's, Health insurance coverage, Medicare/Medicaid, A medical care program of the Indian Health Service/Tribal Organization, State risk pool, A public health plan, A health benefit plan under the Peace Corp. Act, CHAMPUS (Civilian Health and Medical Program for Uniformed Services (a federal program), TRICARE program.