Application to Add to Remove Family Members

Application to: Conseco Health Insurance Company Administrative Office: P.O. Box 1908, Carmel, Indiana 46082-1908

Policyowner/Certificateholder Name *(Please Print: First, Middle Initial, Last)*	Height	Weight	□ Male □ Female	Date of Birth	Social Security Number
Applicant's Name *(If different from above)*	Height	Weight	□ Male □ Female	Date of Birth	Phone ( )
Applicant's Address Number and Street City County State Zip Code					
Account Number(s)			Group Number (if any)		

Instructions

If you want to:

- **remove family members** from your coverage, complete Sections 1 and 3, below.
- **add family members** to your coverage, complete Section 2, Section 3 and the back of this application.

Section 1: Removing Family Members

- What type of coverage do you want to change?

□ Cancer □ Specified Disease □ Sickness □ _____
□ Intensive Care □ Accidental Death & Dismemberment □ Accidental Injury
□ Heart/Stroke □ Hospital Indemnity

- For the above coverage(s), list the names of the persons you want removed and their relationship to the policyowner/certificateowner.

Name	**Relationship to Policyowner/Certificateowner** (example: child, spouse)

- Are you requesting the decrease in coverage because of the death of the policyowner/certificateowner? □ Yes □ No
  If "yes," please forward a copy of the death certificate with this application.
- **Other than yourself**, after removing the person(s) above, are there any of your dependents (spouse, children) who will still remain under your coverage? □ Yes □ No

Section 2: Adding Family Members

- For the coverage(s) you want to change, list the names of the persons you want added, their relationship to the policyowner/certificateowner, their birth dates and complete the back of the application.

Name	**Relationship to Policyowner/ Certificateowner** (example: child, spouse)	**Date of Birth**

Section 3: Applicant's Statement

I have read, or have had read to me, the completed application; all representations are true and complete to the best of my knowledge and belief. I understand that:

- any false statements or misrepresentations may result in loss of coverage;
- the agent has no authority to approve the application, change the coverage or waive any of its provisions;
- the Company will notify me of any adjustment in premium;
- if I am adding a family member to my coverage, the family member will not be covered until this application is approved by the Company, I have paid the appropriate premium, and the family member has met the waiting period, if any, and;
- my existing coverage will remain in effect until the Company issues a new policy/certificate stating the change in coverage and its Effective Date.

Payroll Deduction Authorization if Premium by Payroll Deduction: I authorize the Payroll Department to increase/deduct changes in premium from my salary. I understand that in order to revoke this authorization, I must notify the Payroll Department in writing.

Medical Record Authorization: I hereby authorize any legally licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, and the Medical Information Bureau that has any medical record or knowledge of me, or any members of my family for whom application has been made, to give the Company any such information. This information will be used to determine the insurability of each applicant. This authorization will remain valid for 24 months from the date of signing, and may be revoked anytime subject to the rights of the Company who acted in reliance on the authorization prior to receiving the notice of revocation. I or my authorized representative are entitled to receive a copy of this authorization. A photographic copy of this authorization shall be as valid as the original.

_____ _____
Date Signature of Policyowner/Certificateowner

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company that submits an application for insurance or statement of claim containing any materially false information, or conceals information concerning any fact material thereto for the purpose of misleading, may be committing a crime which is subject to criminal and civil penalties.

Please answer all applicable questions for the type(s) of coverage you want to change. If you answer "yes" to any of the health questions, the person(s) named in the section(s) may be partially or completely excluded from coverage by an Exclusion Rider to be signed by you before we change the coverage. The Company reserves the right to reject an application for coverage based on a person's existing medical condition and records.

☐ **Cancer**	**Has anyone to be insured ever been treated for or diagnosed as having:** • cancer in any form? ☐ **Yes** ☐ **No** If "yes," indicate the type of cancer, name(s) of person(s). ☐ non-melanoma skin cancer. Name(s) of person(s):_____ ☐ any melanoma cancer. Name(s) of person(s):_____ ☐ non-melanoma internal cancer. Name(s) of person(s):_____ • within the last 10 years, a pre-leukemic condition, a pre-malignant condition or a condition with malignant potential? ☐ **Yes** ☐ **No** If "yes," indicate name(s) of person(s):_____	
☐ **Intensive Care**	**Has anyone to be insured ever been treated for or diagnosed as having any heart disease; a heart condition, angina or a heart attack; any disorder, disease or abnormality of the coronary arteries; arteriosclerosis; chronic disease of the pericardium; high blood pressure for which medication has been prescribed; transient ischemic attack; stroke, whether or not resulting in paralysis?** If "yes," indicate name(s) of person(s):_____	☐ **Yes** ☐ **No**
☐ **Specified Disease**	**Has anyone to be insured ever been treated for or diagnosed as having any of the following diseases: diphtheria, encephalitis, legionnaire's disease, meningitis, multiple sclerosis, muscular dystrophy, osteomyelitis, poliomyelitis, rabies, scarlet fever, sickle cell anemia, tetanus, toxic shock syndrome, tuberculosis, tularemia, or typhoid fever?** If "yes" to any of the above, indicate name(s) of person(s) and disease(s):_____	☐ **Yes** ☐ **No**
☐ **Accident Injury/Accidental Death and Dismemberment**	**What is your gross monthly income from above employer?_____ per month** **Does anyone to be insured have a physical impairment or deformity?** ☐ **Yes** ☐ **No** If "yes," indicate name(s) of person(s) and explain:_____ **Have you ever requested or received a pension, benefits or payment because of any injury or disability?** ☐ **Yes** ☐ **No** If "yes," explain:_____ **Do you own any other accident, hospital indemnity and/or disability insurance other than Worker's Compensation?** ☐ **Yes** ☐ **No** If "yes," complete the "Other Insurance" section on the bottom of application.	
☐ **Sickness**	**Has anyone to be insured received medical treatment or taken any prescribed medicine or drugs within the last 12 months?** ☐ **Yes** ☐ **No** If "yes," within the last five years, has that person: • been confined to a hospital or other medical facility for at least 24 hours? (Do not include normal pregnancies.) ☐ **Yes** ☐ **No** • consulted with a physician for any illness or for symptoms of undiagnosed origin? (Do not include colds, minor virus infections or minor injuries.) ☐ **Yes** ☐ **No** • had surgery or an operation? ☐ **Yes** ☐ **No** If "yes," complete the "Five-Year Health History" section on the bottom of this application.	
☐ **Hospital Indemnity**	**Has anyone to be insured ever been treated for or diagnosed as having:** • cancer (except non-melanoma skin cancer), stroke, heart disease, heart attack, chronic liver disease, kidney failure or emphysema? ☐ **Yes** ☐ **No** If "yes," indicate name(s) of person(s) and the disease(s) or condition(s):_____ • Alzheimer's disease, senile dementia or insulin-dependent diabetes? ☐ **Yes** ☐ **No** If "yes," indicate name(s) of person(s) and the disease(s) or condition(s):_____ **Has anyone to be insured been treated for or diagnosed within the last 24 months as having:** • a substance abuse problem or alcoholism? ☐ **Yes** ☐ **No** If "yes," indicate name(s) of person(s) and the condition(s):_____ **Is anyone to be insured:** • currently confined to a hospital or nursing home or has such confinement been recommended by a physician? ☐ **Yes** ☐ **No** If "yes," indicate name(s) of person(s) and reason for confinement:_____ • currently pregnant and has experienced complications or been advised that complications are likely? ☐ **Yes** ☐ **No** If "yes," indicate name(s) of person(s):_____ **Does anyone to be insured have other insurance which pays benefits for each day hospitalized?** ☐ **Yes** ☐ **No** If "yes," please complete the "Other Insurance" section on the bottom of this application.	
☐ **Heart/Stroke**	**Has anyone to be insured ever had, been treated for or been diagnosed as having:** • any heart disease; a heart condition; angina or a heart attack; any disorder, disease or abnormality of the coronary arteries; arteriosclerosis; chronic disease of the pericardium; high blood pressure for which medication has been prescribed; transient ischemic attack; stroke, whether or not resulting in paralysis; or, ☐ **Yes** ☐ **No** • for any of the above conditions, within the last year, been advised be a medical practitioner to be hospitalized or to have any diagnostic test or surgery which has not been completed? ☐ **Yes** ☐ **No** If "yes," please indicate name(s) of person(s) and explain:_____	
☐ **All Coverages**	**Has anyone to be added under this coverage ever been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?** If "yes," indicate name(s) of person(s):_____	☐ **Yes** ☐ **No**

Five-Year Health History (Please PRINT and fill out completely.)

Name of Person(s) Receiving Treatment	Nature of Illness/Injury	Date and Duration	Name & Address of Physician or Medical Facility

Other Insurance (Please PRINT and fill out completely.)

Name of Company	Type of Insurance	Monthly Benefit Amount(s)