

HOW TO APPLY FOR PACIFICARE INDIVIDUAL PLANS

Terms and Conditions

1. I understand that all health care services under the HMO Coverage options must be provided or arranged for by PacifiCare, except for Emergency or Urgently Needed Services.
2. I certify that the answers in any part of this application are true and complete. I acknowledge that the discovery of facts known and not disclosed may result in the rescission of my PacifiCare Individual Plan Agreement. I alone am responsible for the accuracy and completeness of the application and related documents. I understand that neither I, nor my Dependents, will be eligible for benefits if any known material information is false or incomplete, and that coverage may be rescinded based on such a finding. If rescinded, the contract will be deemed to never have existed, and I will be financially responsible for any cost incurred while under the plan.
3. I understand that if I choose to enroll in a PPO health plan there will be a twelve (12)-month waiting period before coverage for pre-existing medical conditions will begin, for either myself, and/or my dependents who have these medical conditions, even if I am, or my Dependents are, on another PacifiCare plan, unless Guaranteed Availability is applied for and approved.
4. I understand that there is no coverage unless an application is approved by either PacifiCare of Nevada, Inc. or PacifiCare Life Assurance Company Underwriting Department. PacifiCare and PacifiCare Life Assurance Company (PLAC) are not liable for bills incurred before the effective date of coverage. PacifiCare and PacifiCare Life Assurance Company are not liable for the cost in obtaining medical records or the cost of special tests such as, but not limited to, X-rays, EKGs, or mammograms that may be required to determine eligibility.
5. If this application is approved, the date coverage begins will be provided to me by the PacifiCare or PLAC Underwriting Department.
6. The agent selling PacifiCare health coverage does not have the authority to approve my application and cannot change any terms of the PacifiCare Individual Plan Agreement or waive any requirements.
7. I understand that I am responsible for reporting to PacifiCare or PacifiCare Life Assurance Company any changes in the health status which occur before the effective date of the PacifiCare Individual Plan Agreement. This applies to every person listed on the application.
8. I understand that any applicant listed herein may be required to undergo a basic physical and/or basic laboratory testing as part of the application process.

Authorization for disclosure of personal information

9. I hereby authorize any health care facility, Physician or surgeon, or any other health care professional, to disclose to PacifiCare of Nevada, Inc., or any of its parents, subsidiaries, or affiliates, their agent or employees, all information from my medical records pertaining to any past or future examination or treatment, including treatment for substance abuse and mental or emotional disorders furnished to me or my Dependents who are also applying for this coverage, and to any illness, injury or condition that I or these Dependents have had at any time in the past or in the future, up until the expiration of this authorization. I understand that this information is collected in connection with the evaluation and processing of an application for coverage, to determine continuing eligibility for benefits and to process claims. This authorization also includes PacifiCare or PacifiCare Life Assurance Company disclosing any medical information that they may have in their files to the same entities in connection with the advance consideration of providing services or subsequent payment for such services. This authorization is valid for eighteen (18) months from the date inserted below. A photocopy or other reproduction of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this form. I understand that I may revoke this authorization at any time before I become a PacifiCare Member, except for instances that PacifiCare has already taken action based on the authorization, by mailing my written revocation to:

**PacifiCare Individual Plans
Individual Underwriting
M/S # CY24-155
P.O. Box 3069
Cypress, CA 90630-9962**

**HMO Questions? Call the Customer Service Department at 1-800-347-8600.
POS Questions? Call the Customer Service Department at 1-800-459-3224.
PPO Questions? Call the Customer Service Department at 1-866-316-9776.
SDHP Questions? Call the Customer Service Department at 1-866-867-0700.**

You Are Now Ready to Apply

Here are the steps to follow to ensure your application is processed as quickly as possible.

1. Complete the Enrollment Application

Be sure to answer all questions completely and provide all the requested information. Incomplete information may result in a processing delay.

- **Print clearly using black ink.** Please don't type on your form. You, as the applicant, must complete the application in your own handwriting.
- **Select the date you wish coverage to become effective.** PacifiCare allows effective dates beginning on the 1st or the 15th of the month. Please submit your application by the 20th of the month to be considered for the 1st of the following month, or by the 5th to be considered for the 15th of the same month. Actual effective dates are determined by the Company. **Do not cancel any existing coverage until you are notified by PacifiCare or PacifiCare Life Assurance Company that you have been accepted.**
- **Select your method of payment for your first month and recurring monthly payments.** Determine the amount of your initial premium by referring to the Rate Card enclosed with this form.
 - If you and your Spouse are both applying, price yourselves individually and then add the two premiums together. Please add any Dependents, if applicable.
 - Select the premium payment option for your initial premium – either check or credit card.
 - Be sure to include your first premium payment check or credit card authorization with this application.
 - Determine your recurring payment option – either monthly bill or Easy Pay automatic deduction.
- **Complete the Primary Applicant Information section.** Please list yourself as the Primary Applicant and, if married, include your Spouse as a Dependent (if the Spouse is also applying). If the parent/guardian is applying for a child-only plan, list the child's name as the Primary Applicant. If applying for coverage of multiple children, list the youngest child as the Primary Applicant. Dependent children age 19 or older who are not full-time students must apply for their own policy.
- **Complete the Enrollment Information section and list each family Member applying.** All PacifiCare SignatureValue® (HMO) applicants must select a Primary Care Physician from the *PacifiCare SignatureValue (HMO) Provider Directory* or www.pacificare.com.

2. Complete the Health Questionnaire

Answer every question in full. Otherwise, your application may be returned to you, resulting in a delay in processing.

- **Be sure to disclose all health history on the Health Questionnaire for all family members listed on the application.** Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination of your coverage.
- **Include all requested details and explanations.** If you need to include additional information or explanations, simply attach an extra sheet.
- If you do not meet the standard PacifiCare underwriting requirements for the plan you have applied for, you may be offered a different option. You are under no obligation to enroll.

3. Send Your Completed Enrollment Application to PacifiCare

- **Review your application to be sure it is complete.**
- **Sign and date your application.** You, your Spouse (if applying) and any listed dependent age 18 or over, must sign and date the application.

▪ Mail your application to:

**PacifiCare Individual Plans
Individual Underwriting
M/S # CY24-155
P.O. Box 3069
Cypress, CA 90630-9962**

Before sealing the envelope, be sure to enclose:

- Your completed Enrollment Application
- Your first premium check or credit card payment authorization form

Please note: Coverage does not become effective under any circumstances until an application has been underwritten and approved by PacifiCare of Nevada, Inc. for HMO plans, and PacifiCare Life Assurance Company for PPO and SDHP plans. All plan documents are available for inspection prior to enrollment upon request.

**HMO Questions? Call the Customer Service Department at 1-800-347-8600.
POS Questions? Call the Customer Service Department at 1-800-459-3224.
PPO Questions? Call the Customer Service Department at 1-866-316-9776.
SDHP Questions? Call the Customer Service Department at 1-866-867-0700.**

Requested Effective Date: _____
Subject to Approval

Type or print with a black ball-point pen. Incomplete information will delay processing. Application must be signed to be valid.

For Office Use Only Date _____ Group # _____
 Effective Date _____ Appr/ Den by _____

1. Application, Plan and Payment Information

- Application for:**
- New Individual Plan Membership
 - Existing PacifiCare Individual Plan Member – adding Dependent
 - New Child(ren)-only Plan
 - Current PacifiCare Member applying for Individual Plan or child(ren) only
 - Guaranteed Availability (HIPAA)

Note: Applicants/Dependents who are eligible for Medicare Benefits (or over age 64) are not eligible for Individual Plan. Please submit Certificates of Creditable Coverage if available with application.

Medical Plan Options: (choose one)

- PacifiCare SignatureValue® (HMO) Plan 4B – \$10/\$25/\$100 per day
- PacifiCare SignatureValue® (HMO) Plan 5B – \$25/\$50/\$200 per day
- PacifiCare SignatureOptionsSM (PPO) Plan 1 – \$30/80-50/\$1,500
- PacifiCare SignatureOptionsSM (PPO) Plan 2 – \$20/80-50/\$500
- PacifiCare SignatureOptionsSM (PPO) Plan 3 – \$30/70-50/\$2,000
- PacifiCare SignatureFreedomSM (SDHP) Plan 1 – 70-50/\$3,000

HIPAA Eligible

- PacifiCare SignatureValue® (HMO) HIPAA Basic \$25/\$300 per day
- PacifiCare SignatureValue® (HMO) HIPAA Standard \$10/\$100 per day
- PacifiCare SignatureOptionsSM (PPO) HIPAA Basic \$20/70-50/\$1,500
- PacifiCare SignatureOptionsSM (PPO) HIPAA Standard \$10/80-60/\$500

Dental Plan Options:

- PacifiCare SignatureValue® (HMO) Dental 350
- Dentist Name: _____
- Dentist ID Number: _____

Payment Options

Choose your payment method for:
 1. First month payment; and
 2. Recurring monthly

First Month Payment (please select one option)

- Check enclosed: amount of \$ _____
- Credit card (for this payment method you must enclose your completed Credit Card Payment Authorization Form – payment will be deducted only if application is approved)

Recurring Monthly Payment (please select one option. Credit card payment is not available for recurring monthly payments)

- Monthly Bill
- Monthly Easy Pay (For this payment method, you must enclose your completed Easy Pay form)

2. Primary Applicant Information

Important: Indicate yourself as the Primary Applicant and if married, include your Spouse as a Dependent (if the Spouse is also applying for coverage). If the parent/guardian is applying for a child-only plan, list the child's name as the Primary Applicant. If covering multiple children, list youngest child as Primary Applicant.

Primary Applicant's Name _____ Married Single
Last First MI

Home Address _____
P.O. Box not acceptable Street Apt./Suite # City County State ZIP

Work Address _____
Street Apt./Suite # City County State ZIP

Mailing Address for Premium for Medical Information for Both
If different from home address _____
Street Apt./Suite # City County State ZIP

Home Phone _____ Work Phone _____

Applicant's Occupation _____ Spouse's Occupation _____

Ethnicity (optional) Caucasian Black or African-American Hispanic or Latino Asian, Native Hawaiian, other Pacific Islander
 American Indian or Alaskan Native Not provided by member

Preferred Language (optional) English Spanish

3. Enrollment Information (Attach a separate piece of paper for additional information)

List yourself and all eligible family members applying for coverage. **Each applicant applying for HMO plan must select a Primary Care Physician.** You may choose the same or a different Primary Care Physician for each family member, using the number shown in the network pages of the *Provider Directory*. If covering multiple children, list youngest child as Primary Applicant.

| Relationship | Last Name | First Name | MI | Gender | Social Security Number | Height | Weight | Birth Date Mo/Day/Yr | Primary Care Physician (PCP) Name HMO only | PacifiCare Provider # HMO only | Network (PMG) |
|-------------------|-----------|------------|----|--|------------------------|--------|--------|----------------------|--|--------------------------------|---------------|
| Primary Applicant | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | | |
| Spouse | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | | |
| Child | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | | |
| Child | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | | |
| Child | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | | | | |

Do all applying family members reside with applicant? Yes No If no, please indicate name and mailing address of Dependent(s) below.

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

Please note: If the Subscriber is not applying for coverage for his or her eligible Dependents, all future applicants, including newborns who are not enrolled within 31 days of birth, will be required to submit Evidence of Insurability, which is subject to approval by PacifiCare.

Important Notice: PacifiCare or PacifiCare Life Assurance Company will use the information provided in this application to make its determination about coverage for all persons named on the application. Read the application and the instructions very carefully. **If any material information about any applicant's medical background is misstated or omitted, it may result in rescission of the contract. If your contract is rescinded, it will be deemed never to have been in effect. A rescinded application will result in the applicant being billed for any expenses incurred while under the Plan.**

4. Health Questionnaire

You must disclose any and all medical information regarding any of the general categories listed below. If you are not sure whether the information is relevant, include it so PacifiCare or PacifiCare Life Assurance Company can make a determination. The information you provide will not necessarily cause a denial, but underwriting may depend on the items noted and medical information submitted by your doctor(s). **Note: Any illness, condition or change in health status of any applicant that may occur or be discovered between the date of this application and the effective date of coverage must be reported. Please notify any changes in writing to the PacifiCare Individual Plans Individual Underwriting, Mail Stop CY38-224, P.O. Box 3069, Cypress, CA 90630-9962. An unreported illness, condition or change will be treated as a nondisclosure and may result in rescission of coverage.**

Check "Yes" or "No" for each category below. Do not write N/A or leave any blanks. You must check "Yes" if any person named on this application has been aware of or has been evaluated, diagnosed, treated or received advice related to the following categories from any type of health care professional within the last ten (10) years prior to this application.

A. General Health Questions

- | | |
|---|---|
| <p>1. Alcoholism, Alcohol Abuse, DUI/DWI <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Allergies, Asthma, Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Arthritis, Gout, Bone/Joint Condition, TMJ, Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Anorexia, Bulimia, Eating Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Attention Deficit Disorder (ADD)/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Autism and other pervasive developmental disorders . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Back, Neck, Spine, Disc Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Birth/Physical Defect, Deformity, Congenital Disorder . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Blood Disease, Blood Condition (past 10 years), Leukemia, Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Blood Vessel/Circulation Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Breast Disease, Implants (Silicone or Saline) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Broken Bones, Bone Disease or Infections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Colon, Rectal or Bowel Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Concussion, Head Injury <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Ear, Nose, Throat (Diseases, Infections) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Epilepsy, Seizure Disorder, Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Eyes (Cataracts, Glaucoma, Strabismus, Crossed Eyes) . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Female Organs, Abnormal Pap, Menstrual Disorder, Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Fibromyalgia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Gallbladder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Heartburn/Gastroesophageal Reflux Disease (GERD) . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Heart Conditions of Any Kind <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>25. Hemorrhoids <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>26. Hepatitis (A, B, C or other), Liver Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>27. Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>28. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, last reading _____</p> | <p>29. High Blood Cholesterol and/or Triglycerides <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, last reading _____</p> <p>30. Hormonal/Endocrine (Thyroid, Pituitary) Disorder . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>31. Illicit Drug Use/Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>32. Immune System Disorder, AIDS/HIV+, AIDS Related Complex (ARC), Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>33. Intestinal/Stomach, Colitis, Crohn's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>34. Kaposi's Sarcoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>35. Kidney/Urinary Tract/Bladder (Stones/Infections) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>36. Liver Conditions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>37. Lung Conditions, Chronic Obstructive Pulmonary Disease, Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>38. Male Sex Organs, Prostate, Impotence <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>39. Nervous System Conditions, Multiple Sclerosis, Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>40. Mental/Nervous, Anxiety, Depression, Psychiatric Counseling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>41. Schizoaffective Disorder, Bipolar Disorder, Major Depressive Disorder, Panic Disorder, Obsessive-Compulsive Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>42. Migraines/Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>43. Muscle/Tendon Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>44. Non-Hodgkin's Lymphoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>45. Phlebitis or Blood Clot <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>46. Prosthetic Implants, Artificial Limb <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>47. Reconstructive/Cosmetic Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>48. Sexually Transmitted Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>49. Skin Disorders, Lesions, Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>50. Steroid Use (Anabolic, Prednisone) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>51. Stroke/Transient Ischemic Attacks (TIA) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>52. Stomach or Abdominal Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>53. Thyroid Condition <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>54. Tumors, Cysts, Polyps, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>55. Ulcers, Digestive Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>56. Weight Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|---|

B. Give details for ALL "YES" ANSWERS indicated above in Section A. If you need more space for explanation, please attach a separate piece of paper.

| Condition # | Family Member Name | Condition Description | Date First Diagnosed and/or Treated | Date of Most Recent Dr. Visit | Duration of Condition | Treatment/Medication | | Name, Address & Phone # of Physician |
|-------------|--------------------|-----------------------|-------------------------------------|-------------------------------|-----------------------|----------------------|-------------------|--------------------------------------|
| | | | | | | Type/Name | Date Discontinued | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

C. Has any applicant listed on this application seen a Physician, for any reason, in the past two (2) years? Yes No

If yes, please provide details below:

| Applicant(s) Name | Physician Name | Address/Telephone | Date | Reason/Result and Treatment/Recommendation |
|-------------------|----------------|-------------------|------|--|
| | | | | |
| | | | | |
| | | | | |

D. Has any applicant received any alternative, complementary, holistic or natural therapies within the last twelve (12) months? Examples include acupuncture, ayurveda, biofeedback, chelation therapy, chiropractic, herbal medicines, homeopathy, imagery, reiki, shiatsu and visualization.

Yes No If yes, please explain:

| Applicant(s) Name | Physician Name | Address/Telephone | Date | Reason/Result and Treatment/Recommendation |
|-------------------|----------------|-------------------|------|--|
| | | | | |
| | | | | |
| | | | | |

E. Please complete the following for ALL applicants listed on this application.

Incomplete information will result in a processing delay

If you need more space for explanation, please attach a separate piece of paper.

1. In the event one or more applicant(s) listed on this application is denied coverage, should PacifiCare or PacifiCare Life Assurance Company continue the underwriting and enrollment process for the remaining eligible family members? Yes No

2. Has surgery (major/minor, inpatient/outpatient) been performed for any applicant within the last ten (10) years? Yes No
If yes, please explain:

3. Has surgery (major/minor, inpatient/outpatient) been advised but not performed for any applicant within the last ten (10) years? Yes No
If yes, please explain:

4. Has any applicant been aware of, evaluated, diagnosed, treated or advised regarding any other conditions or injuries not listed within the last ten (10) years? . Yes No
If yes, please state individual's name(s) and explain (include date):

5. Have you or any person applying used tobacco products within the last ten (10) years? Yes No
If yes, please provide the following information:

| | | |
|--|---------------------------------|-------------------------------|
| NAME | How many packs per day? | How many years? |
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Cigars | <input type="checkbox"/> Pipe |
| <input type="checkbox"/> Other: _____ | | |
| Has the person(s) quit? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ | | |

6. Does any applicant listed on this application presently consume alcoholic beverages? Yes No
If yes, please provide the following information:

| | | | |
|------|---|---|--|
| NAME | <input type="checkbox"/> 0 - 1 drinks per day | <input type="checkbox"/> 2 - 3 drinks per day | <input type="checkbox"/> 4+ drinks per day |
| NAME | <input type="checkbox"/> 0 - 1 drinks per day | <input type="checkbox"/> 2 - 3 drinks per day | <input type="checkbox"/> 4+ drinks per day |

7. Does any applicant listed on this application use narcotics, hallucinogenics, amphetamines, barbiturates, or other illegal drugs, or has used drugs other than in accordance with the instructions or prescription for use within the last ten (10) years?
 Yes No If yes, state name(s) and explain (include date and duration): _____

8. Does any applicant listed on this application currently take prescription drugs? Yes No If yes, list applicant's name(s), drug name(s), dosage and date started:

| | | |
|------|------|---------------------|
| NAME | DRUG | DOSAGE/DATE STARTED |
| NAME | DRUG | DOSAGE/DATE STARTED |

9. Has any applicant listed on this application been hospitalized, been seen in an emergency room or been in therapy/counseling (mental, physical or emotional) within the last ten (10) years?
 Yes No If yes, state applicant's name(s) and explain (include date and duration): _____

10. Is any applicant currently receiving any type of physical or mental disability insurance benefits? Yes No
If yes, state name(s) and explain:

| | | |
|------|--|-----------------|
| NAME | NATURE OF DISABILITY (specify body part) | % OF DISABILITY |
| NAME | NATURE OF DISABILITY (specify body part) | % OF DISABILITY |

11. Has any application for a policy of life or health insurance on any applicant been declined, postponed, modified or required an extra premium within the last ten (10) years? Yes No

| | |
|------|-------------------|
| NAME | TYPE OF INSURANCE |
| DATE | INSURANCE CARRIER |
| | REASON |

12. Will this coverage for which you are applying replace any other coverage you have? Yes No

| | | |
|-------------------|------|-------------------|
| TYPE OF INSURANCE | DATE | INSURANCE CARRIER |
| EXPIRATION DATE | | REASON |

13. Do you or any other person applying have or ever had PacifiCare coverage? Yes No
If yes: a. You should understand that this is not a conversion or extension of that coverage. Yes, I understand.
b. You should understand that there may be a lapse in coverage, new waiting periods, new copayments and each listed member may be accepted or denied. Yes, I understand.

FEMALES ONLY (including Spouse and Dependents)

14. Is any family member currently pregnant? Yes No
If yes, expected date of delivery: _____

15. List the name of each female applicant and the date of their last menstrual period.

| | | | |
|------|-------|-----|------|
| NAME | MONTH | DAY | YEAR |
| NAME | MONTH | DAY | YEAR |

16. List the name of each female applicant and the date of their last Pap smear and the results: _____

17. Has any female applicant listed on this application been treated in the last ten (10) years for infertility or any other female disorder? Yes No
If yes, state applicant's name(s) and explain (include date and duration): _____

MALES ONLY (including Spouse and Dependents)

18. Is any male applicant listed on this application an expectant father, even if the mother is not listed on this application? Yes No
If yes, state applicant's name: _____

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

If you are applying for Guaranteed Availability, please complete this section.

Health Insurance Portability and Accountability Act (HIPAA) Questionnaire

1. Have you had at least 18 months of Creditable Coverage? Yes No
2. Was your most recent coverage under a (check one):
 Group Plan Government Plan Church Plan
3. Are you eligible for any other coverage, including group, Medicare, Medicaid, etc.? Yes No
 If yes, please explain: _____
4. Was your previous coverage terminated for nonpayment of premium or fraud? Yes No
5. Was Federal COBRA or State mini-COBRA an available option? Yes No
 (If yes, which one?) _____

If yes, did you apply for COBRA? Yes No
 (If yes, which one?) _____

- What was your Qualifying Event? (check one)
- Voluntary termination
 - Involuntary termination
 - Reduction of hours
 - Death of employee
 - Employee's Medicare entitlement
 - Divorce or legal separation
 - Dependent child ceasing to be a Dependent

Provide the dates of coverage under COBRA: _____ to _____

Did you remain on COBRA until it was no longer available? Yes No

If no, please provide details: _____

6. Has there been a gap in coverage of more than 63 days? Yes No

This questionnaire will be used by PacifiCare of Nevada, Inc. or PacifiCare Life Assurance Company in evaluating the applicant's eligibility for guaranteed individual health insurance. It does not constitute an offer of coverage. If you would like detailed information concerning guaranteed availability and renewability of individual coverage, please contact your insurance broker.

PacifiCare compensates Agents/Brokers for the sale of certain products. Your premium is the same if you purchase coverage directly from PacifiCare or if you use an Agent/Broker. Please contact your Agent/Broker, if applicable, regarding the amount of compensation. In addition, you may request information regarding broker commissions attributable to your policy by contacting PacifiCare Membership Accounting.

Agent Information – To be completed by Agent only

| | | | | | | |
|--|------------------------|--------------------|---------------------|---|---|--|
| Agent Name Oleg Skurskiy | | Company Name | | | Agent Number P 22180 | |
| Agent Address 18375 Ventura Blvd # 226 | City Tarzana | State CA | ZIP 91356 | Agent Phone Number 818-987-5000 | Agent Fax Number 818-776-9865 | |

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

5. Sign and Date Application

| | | | |
|---|-------------------------|--|-------------------------|
| SIGNATURE OF APPLICANT OR LEGAL GUARDIAN (required) X | TODAY'S DATE (required) | SIGNATURE OF APPLICANT'S SPOUSE (required if applying) X | TODAY'S DATE (required) |
| SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER (required) X | TODAY'S DATE (required) | SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER (required) X | TODAY'S DATE (required) |
| SIGNATURE OF PERSONAL REPRESENTATIVE OR CUSTODIAN (if applicable) X | TODAY'S DATE (required) | PRINT NAME OF PERSONAL REPRESENTATIVE OR CUSTODIAN (if applicable) X | |

Note: Until you have received written approval of this application, do not cancel any insurance you may have.

**PacifiCare Individual Plans
 Individual Underwriting
 M/S CY24-155
 P.O. Box 3069
 Cypress, CA 90630**

**Individual Sales:
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