Individual HMO Plans

RECEIVED DATE
OFFICE USE ONLY

All Applications must be submitted to:
Vista Healthplan of South Florida, Inc.
Individual Underwriting Processing Unit
300 S. Park Road
Hollywood, Florida 33021
Phone: (954) 965-3424
Toll Free: (866) 342-4968

Enrollment Application

As a courtesy, this enrollment application allows family members that are applying for Individual HMO coverage to apply using one enrollment application. Coverage provided by Vista Healthplan of South Florida, Inc. is provided under an Individual policy. Each family member (Applicant) accepted for coverage will be contracted with Vista Healthplan of South Florida individually.

Section I – Important Instructions

1. You, the Applicant, must accurately **COMPLETE ALL INFORMATION REQUESTED**.
2. Please **ANSWER ALL QUESTIONS IN FULL** to avoid a delay in processing.
3. Please type or **PRINT** clearly in **BLACK INK** using a ball point pen and initial all corrections.
4. For non-HIPAA eligibles, this **APPLICATION MUST BE RECEIVED WITHIN 30 DAYS FROM THE DATE OF SIGNATURE**.
5. For HIPAA eligibles this application must be received within 63 days from the date previous qualifying coverage was terminated.
6. If you need help completing this form, please call your Agent or Vista Healthplan of South Florida.
7. No statement, except a fraudulent misstatement, will be used to void the policy or deny a claim after coverage has been in effect for two years.
   Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Section II – Important Information

1. **APPLICATIONS RECEIVED BY THE 19TH OF THE MONTH** will be considered for the 1st of the following month.
2. The actual effective date will always be no sooner than the first of the month following approval by Vista Healthplan of South Florida.
3. Submit the completed application and your personal check for one month's premium made payable to Vista Healthplan of South Florida's Individual Underwriting Processing Unit at the above address.
4. **Vista Healthplan of South Florida will notify you in writing of your effective date.**
5. Applicants eligible for guarantee issue coverage under HIPAA are subject to additional requirements and must complete an additional questionnaire.
6. **Those Applicants accepted for coverage under the provisions of Substandard Risk, will pay a higher monthly premium than those Members of the same age, sex and county of residence that are not determined to be Substandard Risk. The underwriting criteria set forth to determine Substandard Risk is at the sole discretion of Vista Healthplan of South Florida.**

Section III – Agent Information *(To be completed by Agent)*

Agent's Name (Printed): ______________________________

Social Security Number: ______________________________

Phone: ______________________________

Address: ______________________________

City: ______________________________

State: ______________________ Zip Code: __________

General Agent Number: ______________________________

Agent's Email Address: ______________________________

General Agent Name: ______________________________

Agent's Fax Number: ______________________________

A. TELL US WHO IS APPLYING FOR COVERAGE AND SELECT THE PRODUCT(S)

I AM APPLYING FOR: ❑ Self Only ❑ Self and Spouse ❑ Child(ren) Only ❑ Self and Additional Applicants

Attached is my deposit for the 1st month's premium in the amount of : $ ______ Check No.: ______

Billing Options	HMO Coverage Provided by Vista Healthplan of South Florida, Inc.
❑ Monthly Electronic Funds Transfer (No Administrative Fee). *Complete EFT Authorization Section C below and attach a separate "void" check.*	**Plan Selection:** ______ **❑ Maternity Rider ❑ Dental Rider ❑ Prescription Drug Rider**
❑ Billed Monthly (Subject to Administrative Fee of $5 per person)	Please note that Plan FN does not include Prescription Drugs, Excel Choice does not include Maternity, Plans ED and EN do not include Dental. **REQUESTED EFFECTIVE DATE:** ______

B. PERSONAL INFORMATION

Primary Applicant's Last Name	First Name	MI	State of Birth
Home Address			Home Phone Number ( )
City	State	ZIP	County
Applicant's Occupation	Applicant's Employer		Business Phone No. ( )
Spouse's Occupation	Spouse's Employer		Business Phone No. ( )

1. Have any applicants been declined, had an exclusion imposed, postponed, had a waiver applied or been charged an extra premium for any life, disability, or health insurance or had such insurance rescinded or terminated? If yes, provide applicants' name, insurance company's name and a brief explanation. ❑ Yes ❑ No ______
2. Have any applicants had previous coverage with any other health insurance within the last 63 days? If so, please provide name of the insurer and the effective and termination dates of coverage. ______
3. Are any applicant's HIPAA eligible? ❑ Yes ❑ No If yes, check the box below:
   ❑ I choose to apply for a HIPAA Eligible medical plan. If approved for coverage, the pre-existing clause will not apply.

C. ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION

Please attach a voided check here.
All withdrawals will be on the first of the month.

Account Holder's Name ______ Account Number ______

Bank's Name ______ Bank's Address ______

I hereby authorize Vista Healthplan of South Florida and the bank named above to initiate entries to my checking or savings account. This authority will remain in effect until (i) I notify Vista Healthplan of South Florida in writing; (ii) Vista Healthplan of South Florida receives such notice to cancel electronic funds transfers; and (iii) Vista Healthplan of South Florida has reasonable opportunity to act on termination of the electronic funds transfers. I understand that if the necessary funds are not available in my account on the first of the month to execute the automatic entry, I will be terminated effective the first of the month in which there are insufficient funds available following the 10-day grace period. I also understand that any changes or cancellations to my account require a 15-day written notice to Vista Healthplan of South Florida. I acknowledge and agree that I shall be financially responsible for any health services received after the termination date of my coverage.

Signature of Account Holder ______ Date ______

D. PRIMARY CARE PHYSICIAN (PCP) SELECTION

LIST YOURSELF AND ALL FAMILY MEMBERS (APPLICANTS) THAT WISH TO APPLY

You must select a Primary Care Physician (PCP) for yourself and each applicant. Choose from the list of PCPs. You may choose the same or a different PCP for each applicant that is applying for coverage. If you need assistance in selecting a PCP, call our Customer Service Department at 1-800-441-5501.

NOTE: All applicants must apply for the same plan on the same application.

Primary Applicant

Last Name		First Name		MI	Premium
Date of Birth	Sex	Height Ft. In.	Weight lbs.	Social Security Number	$
PCP Last Name		First Name		Current Patient? ❑ Yes ❑ No (list current doctor's name) Name:	
PCP Number		PCP Office Location (city)			

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UW Initials

Applicant 2 (Spouse of Primary)

Last Name		First Name		MI	Premium
Date of Birth	Sex	Height Ft. In.	Weight lbs.	Social Security Number	$
PCP Last Name		First Name		Current Patient? ❑ Yes ❑ No (list current doctor's name) Name:	
PCP Number		PCP Office Location (city)			

OFFICE USE ONLY
APPROVAL
UW Initials

Applicant 3 (Child Under Age 18)

Last Name		First Name		MI	Premium
Date of Birth	Sex	Height Ft. In.	Weight lbs.	Social Security Number	$
PCP Last Name		First Name		Current Patient? ❑ Yes ❑ No (list current doctor's name) Name:	
PCP Number		PCP Office Location (city)			

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UW Initials

Applicant 4 (Child Under Age 18)

Last Name		First Name		MI	Premium
Date of Birth	Sex	Height Ft. In.	Weight lbs.	Social Security Number	$
PCP Last Name		First Name		Current Patient? ❑ Yes ❑ No (list current doctor's name) Name:	
PCP Number		PCP Office Location (city)			

OFFICE USE ONLY
APPROVAL
UW Initials

Applicant 5 (Child Under Age 18)

Last Name		First Name		MI	Premium
Date of Birth	Sex	Height Ft. In.	Weight lbs.	Social Security Number	$
PCP Last Name		First Name		Current Patient? ❑ Yes ❑ No (list current doctor's name) Name:	
PCP Number		PCP Office Location (city)			

OFFICE USE ONLY
APPROVAL
UW Initials

IF ADDITIONAL SPACE NEEDED, PLEASE COMPLETE ADDITIONAL ENROLLMENT APPLICATION(S).

E. STATEMENT OF HEALTH

OMISSIONS OR FALSE STATEMENTS ON THIS MEDICAL QUESTIONNAIRE SHALL RESULT IN VISTA HEALTHPLAN OF SOUTH FLORIDA'S RECISION OF YOUR COVERAGE TO THE ORIGINAL EFFECTIVE DATE. Please make sure that all of the information contained herein is complete, true and accurate. If accepted for coverage, any material misstatements or omissions in the Medical Questionnaire may result in recision of coverage and the voiding of the contract back to the original effective date. Answer the following health questions for yourself and each family member (applicant) applying for coverage.

For each question, the applicant's initials must be placed in each of the appropriate "Yes" or "No" boxes.
If you answer "Yes" to any questions, provide details in section F - Health History Information.

Question	Yes *(Initials)*	No *(Initials)*
1. Are you or any applicant(s) experiencing any pain or symptoms for which you have not seen a doctor?		
2. Have you or any applying family member consulted a physician for a condition or symptom(s) for which diagnosis has not been established?		
3. Have you or any applicant ever had an Individual or Group plan by Vista Healthplan of South Florida or any of its affiliates (i.e. Foundation Health, Vista Healthplan, Beacon Health Plans or Healthplan Southeast)? If yes, Please provide member number: ______		
4. Is any female applicant listed on this application currently pregnant?		
5. Is any male listed on this application expecting a child with anyone, even if the child's mother is not listed on this application?		
6. In the past ten (10) years have you or any applicant listed ever: a. Had an abnormal physical exam, abnormal laboratory results, abnormal diagnostic tests or been advised to have diagnostic tests, treatment(s), surgery or hospitalization(s)?		
b. Been a patient in a hospital, clinic, emergency room, surgicenter, sanitarium, or any other medical facility as an inpatient or outpatient (**this question includes childbirth**)?		

7. For questions 7A - 7L, have you or any applicant ever had any testing, diagnosis, consultation, counseling or been prescribed medication by a physician for any of the following or any other physical symptoms, structures or organs, illnesses, injuries, diseases or disorders, whether physical or psychological. This list is not all inclusive? **Check appropriate "Yes" or "No" boxes.**

A. Heart and Blood (Circulatory System): Applicant's Initials: ______

YES NO
- ❑ ❑ Chest pain
- ❑ ❑ Palpitations
- ❑ ❑ High / low blood pressure
- ❑ ❑ Arteriosclerosis
- ❑ ❑ Athrosclerosis
- ❑ ❑ Heart murmur
- ❑ ❑ Mitral Valve Prolapse
- ❑ ❑ Heart attack
- ❑ ❑ Stroke
- ❑ ❑ Anemia
- ❑ ❑ Platelet, blood, spleen disorder
- ❑ ❑ Other cardiovascular / circulatory / hematologic disorders______

B. Digestive / Liver / Gallbladder: Applicant's Initials: ______

YES NO
- ❑ ❑ Ulcers
- ❑ ❑ Hernia
- ❑ ❑ Rectum Hemorrhoids
- ❑ ❑ Hepatitis
- ❑ ❑ Irritable bowel syndrome
- ❑ ❑ Intestinal bleeding
- ❑ ❑ Liver, esophagus, gallbladder, or colon polyp(s)
- ❑ ❑ Other gastrointestinal / digestive disorders______

C. Eyes, Ears, Nose, Throat, Skin (Sensory System): Applicant's Initials: ______

YES NO
- ❑ ❑ Neoplasm
- ❑ ❑ Deviated septum
- ❑ ❑ Allergies
- ❑ ❑ Tinnitus
- ❑ ❑ Polyps
- ❑ ❑ Vertigo
- ❑ ❑ Deafness
- ❑ ❑ Blindness
- ❑ ❑ Skin
- ❑ ❑ Other disorder of the sensory system______

D. Genitourinary (Kidney, Urinary Tract, Reproductive Organs): Applicant's Initials: ______

YES NO
- ❑ ❑ Urinary incontinence
- ❑ ❑ Prostate
- ❑ ❑ Bladder
- ❑ ❑ Kidney
- ❑ ❑ Penis / scrotum pain
- ❑ ❑ Pelvic pain
- ❑ ❑ Abnormal uterine bleeding
- ❑ ❑ Fibrocystic breast
- ❑ ❑ Endometriosis
- ❑ ❑ Other disorder of the genitourinary or reproductive system______

E. STATEMENT OF HEALTH *(continued)*

E. Lung and Airway: Applicant's Initials: ___________

YES NO
- ❑ ❑ Shortness of breath
- ❑ ❑ Chronic cough
- ❑ ❑ Tuberculosis
- ❑ ❑ Asthma
- ❑ ❑ Sleep apnea
- ❑ ❑ Emphysema
- ❑ ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ ❑ Other disorder of the respiratory system___________________________

F. Bone, Joint, Muscle, and Connective Tissue: Applicant's Initials: ___________

YES NO
- ❑ ❑ Polio
- ❑ ❑ Bursitis
- ❑ ❑ Arthititis
- ❑ ❑ Torticollis
- ❑ ❑ Gout
- ❑ ❑ Fracture
- ❑ ❑ Internal fixations (i.e. pins, plates, screws)
- ❑ ❑ Joint replacement
- ❑ ❑ Sprains / strains
- ❑ ❑ Temporomandibular joint syndrome (TMJ)
- ❑ ❑ Dislocations
- ❑ ❑ Weakness or injury of any bone, joint, tendon, ligament, muscle, disk, back, neck, spine
- ❑ ❑ Prosthesis
- ❑ ❑ Other disorder of connective tissue or musculoskeletal system ___________________

G. Brain and Nervous System: Applicant's Initials: ___________

YES NO
- ❑ ❑ Speech defect / delay
- ❑ ❑ Dizziness
- ❑ ❑ Fainting
- ❑ ❑ Convulsions
- ❑ ❑ Epilepsy
- ❑ ❑ Headache
- ❑ ❑ Migraines
- ❑ ❑ Amnesia
- ❑ ❑ Ataxia
- ❑ ❑ Tremors
- ❑ ❑ Muscular Dystrophy
- ❑ ❑ Tics
- ❑ ❑ Head injury
- ❑ ❑ Brain
- ❑ ❑ Neuritis
- ❑ ❑ Paralysis
- ❑ ❑ Other disorder of the nervous / neurological system ___________________________

H. Nutrition / Metabolism / Hormonal / Endocrine: Applicant's Initials: ___________

YES NO
- ❑ ❑ Diabetes
- ❑ ❑ Pituitary
- ❑ ❑ Thyroid
- ❑ ❑ Parathyroid
- ❑ ❑ Adrenal gland
- ❑ ❑ Hypoglycemia
- ❑ ❑ Hyperlipidemia
- ❑ ❑ Pancreas
- ❑ ❑ Lymph node(s)
- ❑ ❑ Other disorders of the endocrine/metabolic system ___________________________

I. Mental / Nervous System: Applicant's Initials: ___________

YES NO
- ❑ ❑ Anxiety
- ❑ ❑ Depression
- ❑ ❑ Panic attack
- ❑ ❑ Sleep disorders
- ❑ ❑ Chronic fatigue syndrome
- ❑ ❑ Eating disorders
- ❑ ❑ Alcoholism
- ❑ ❑ Substance abuse
- ❑ ❑ Other mental or psychiatric disorder ___________________________

J. Cancer / Tumor: Applicant's Initials: ___________

YES NO
- ❑ ❑ Lymphoma
- ❑ ❑ Lupus
- ❑ ❑ Immune disorder
- ❑ ❑ Cysts
- ❑ ❑ Malignant/benign growth
- ❑ ❑ Other form of tumor ___________________________

K. Congenital Disorder: Applicant's Initials: ___________

YES NO
- ❑ ❑ Deformity
- ❑ ❑ Congenital defect
- ❑ ❑ Mental retardation
- ❑ ❑ Cleft lip/palate
- ❑ ❑ Developmental delay

L. Other: Applicant's Initials: ___________

YES NO
- ❑ ❑ Any other medical condition not listed above. Please specify. ___________________________

For each question below, the applicant's initials must be placed in each of the appropriate "Yes" or "No" boxes.
If you answer "Yes" to any questions, provide details in section F - Health History Information.

Question	Yes *(Initials)*	No *(Initials)*
8. Have you or any applicant ever tested positive for Human Immunodeficiency Virus (HIV) or been diagnosed as having Aids Related Complex / Conditions (ARC), Acquired Immunodeficiency Syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency?		
9. Have you or any applicant listed ever had or been treated for Herpes, Human Papilloma Virus (HPV), Syphilis or any sexually transmitted disease?		

E. STATEMENT OF HEALTH *(continued)*

For each question, the applicant's initials must be placed in each of the appropriate "Yes" or "No" boxes.
If you answer "Yes" to any questions, provide details in section F - Health History Information.

Question	Yes *(Initials)*	No *(Initials)*
10. Are you or any applicant listed currently taking or have taken any prescribed medication within the past two years? If "Yes", list the prescriptions in **Section H – Prescription Medication Information**.		
11. Do you or any applicant have any cosmetic implants and/or complications/symptoms related to the implants? If yes, explain: ______		
12. Are you or any applicant receiving or received treatment for infertility within the past three (3) years?		
13. Do you or any applicant listed currently use or have used tobacco within the past five (5) years? (i.e. cigarettes, cigars, pipes, chewing tobacco, etc.) If yes, how often?______		
14. Do you or any applicant listed currently use or have used recreational/illegal drugs in the past five (5) years?		
15. Have you or any applicant ever had a mammogram (including males)?		

If yes, date of last mammogram: (Month/Day/Year:) _____/_______/______

Results of exam: ❑ Normal ❑ Abnormal (explain in **Section F**)

Referring Doctor/Facility Name ______________________ Phone Number ________________

Address ____

16. **FEMALES ONLY** (**Applicable to all females listed on application**)

Question	Yes *(Initials)*	No *(Initials)*
A. Do you currently menstruate? Start date of last menstrual period: (Month/Day/Year:) _____/_______/______		
B. During the previous 90 days, has any female applicant performed a home pregnancy test which has reacted positive?		
C. Have you ever had a pelvic/pap smear exam?		

Date of last pelvic/pap smear exam: (Month/Date/Year:) _____/_______/______

Results of exam: ❑ Normal ❑ Abnormal (explain in **Section F**)

Referring Doctor/Facility Name ______________________ Phone Number ________________

Address ____

F. HEALTH HISTORY INFORMATION

If you have answered "Yes" to any questions in **Section E – Statement of Health**, please provide complete details below.

QUESTION #	NAME OF APPLICANT	CONDITION, INJURY, SYMPTOM OF ILL HEALTH OR FINDINGS OF EXAMINATION (IF SURGERY PERFORMED/TYPE)	ONSET DATE (MO./YR.)	DATE OF LAST TREATMENT (MO./YR.)	DEGREE OF RECOVERY	NAME AND ADDRESS OF HOSPITAL AND ATTENDING PROVIDER

G. PHYSICIAN INFORMATION

Give names and addresses of all physicians seen within the last two (2) years for all applicants that wish to be covered including doctor visits and physical examinations.

NAME OF APPLICANT	PROVIDER NAME /ADDRESS /PHONE	DATE OF SERVICE	REASON FOR CONSULTATION

H. PRESCRIPTION MEDICATION INFORMATION

List all prescribed medications taken within the last two (2) years by all applicants that wish to be covered.

NAME OF APPLICANT	MEDICATION / DOSAGE FREQUENCY (i.e. *Lopressor / 100mg / daily*)	ILLNESS FOR WHICH THE MEDICATION IS PRESCRIBED	DATE PRESCRIBED (MO/DAY/YR)	DATE DISCONTINUED (MO/DAY/YR)	NAME AND PHONE NUMBER OF DOCTOR OR HOSPITAL

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

_____ Number of sheets attached.

I. CONDITIONS OF ENROLLMENT

GENERAL CONDITIONS

Initials

Vista Healthplan of South Florida reserves the right to reject any application for enrollment. There is no coverage unless this Application is accepted by Vista Healthplan of South Florida's Underwriting Department and a Notice of Acceptance is issued to you even though you sent Vista Healthplan of South Florida a check for the first month's premium. If yours or any applicants' Application is rejected, your money will be returned to you or applied to other family applicants.

No other department, officer, agent or employee of Vista Healthplan of South Florida is authorized to grant enrollment. An agent cannot grant approval, change terms or waive requirements. We may require that you provide medical records or have a medical examination and you will be responsible for the cost. If so, these become a part of the Plan Contract.

The applicant understands that it is his/her responsibility to provide Vista Healthplan of South Florida with any changes in the health status of the applicant and/or his/her dependent(s) prior to the effective date of coverage. You must notify Vista Healthplan of South Florida of any additional or different information regarding your and / or your dependents health from the date you sign this Application until the date that you are notified by Vista Healthplan of South Florida regarding its coverage decision. Your failure to provide this additional information may be cause for Vista Healthplan of South Florida to rescind coverage back to the effective date and to proceed to recoup any amounts paid for covered services as a result of such nondisclosure. In that event, Vista Healthplan of South Florida shall have no liability for the provision of coverage under the contract.

Any intentional or unintentional non-disclosure or misstatement of fact in application materials is cause for disenrollment and rescission of the Plan Contract/Policy/Certificate and Vista Healthplan of South Florida may recoup any amounts paid for Covered Services obtained as a result of such non-disclosure or misstatement of fact. In the event of disenrollment or rescission of the Plan Contract, Vista Healthplan of South Florida shall have no liability for the provision of coverage under the Plan Contract or Policy/Certificate.

PAYMENT OF PREMIUM

Initials

Please note that this coverage is not to be sold as a commercial group policy. The applicant and/or family members are responsible for the initial premium as well as any future payments if accepted for coverage.

If funds are drawn from a business account, I certify by initalling above that I am the business owner and the payments are for myself and/or immediate family member(s) as individuals and not as employees. I understand that payments from a business account are not for employees or others outside the immediate family. Refund of premiums is only payable to the member.

MEDICAL INFORMATION BUREAU (MIB)

Initials

Information regarding your insurability will be treated as confidential. Vista Healthplan of South Florida or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

Vista Healthplan of South Florida, or its insurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

OMISSIONS CLAUSE

Initials

I represent that all statements and answers made in this document, by whomsoever written including its reverse side and on any attached papers, are complete, true and correct. I agree that this shall be the basis of my acceptance of membership with Vista Healthplan of South Florida. I realize that any misrepresentation or omission, for any reason, regarding the presence or history of pre-existing conditions may result in rescission of my coverage.

DECLINATION CLAUSE

Initials

If Vista Healthplan of South Florida denies your request for coverage, you will be notified in writing. Vista Healthplan of South Florida will not provide reasons for the denial unless a written request from the applicant is obtained. Upon written request, Vista Healthplan of South Florida will provide a reason for the denial only if the denial was based on information provided on the enrollment application. We will provide you with such reason for denial within 60 business days of receipt of the written request. Denials based on information related to medical reasons may only be provided to a physician. Such denials will be processed quicker if you include the name and address of a physician to whom we may respond directly.

J. APPLICANTS' CERTIFICATION

MINOR AS A SOLE APPLICANT ☐ *Initials*

If the sole Applicant under this Application is under 18 years of age, the Applicant's parent or legal guardian must sign as such. In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information in this Application and for payment of prepayment fees. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with Application.

ACKNOWLEDGMENT AND AGREEMENT ☐ *Initials*

I understand and agree that by enrolling or accepting services under a health plan with Vista Healthplan of South Florida, I and any enrolled dependents are obligated to understand and abide by all terms, conditions and provisions of the Plan Contract. I have read and understand the terms on all pages on this Application including the conditions of enrollment. I understand if this application is accepted it will become part of the Plan Contract. My signature below indicates my acceptance of these terms and that the information entered in this application is complete, true and correct.

MATERNITY SERVICES ☐ *Initials*

Unless I meet the qualifications of a HIPAA eligible, I understand that there is a 15 month waiting period for maternity (obstetrics) benefits under the *Select Choice C2 and/or Preferred Choice F1/FN* benefit plan. No benefits are payable for: pre-natal, delivery and post-natal care provided by a physician, hospital or other medical provider during the first 15 consecutive months of coverage. Benefits will be payable for maternity (obstetrics) benefits provided by Vista Healthplan of South Florida participating providers after 15 consecutive months of coverage under the Select Choice C2 and Preferred Choice F1/FN benefit plans. Maternity benefits are available only when the Maternity Rider has been elected.

PRE-EXISTING CLAUSE ☐ *Initials*

I understand that there are pre-existing condition exclusions and waiting periods for certain conditions and that my coverage and that of any of the applicants identified on the enrollment application shall be subject to those exclusions and waiting periods for any pre-existing conditions as defined by the Plan Contract and the Member Handbook. I also understand that there is a 24 month waiting period on all pre-existing conditions, including medications.

AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION

I, on my behalf and on behalf of any applying family member under the age of 18, do hereby authorize Vista Healthplan of South Florida and its authorized employees, its agents, independent contractors and Participating Providers to release to, or obtain from, any person, health care provider, organization or government agency, any information and records, including patient records of applicants and information on any condition including AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex), which Vista Healthplan of South Florida requires or is obligated to provide pursuant to legal process, federal, state or local law, or otherwise requires to administer the health plan. I hearby authorize any licensed physician, medical practitioner, hospital, clinic, or other health care facility or provider, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to Vista Healthplan of South Florida, or its reinsurers, any such information. A photocopy of this Authorization is considered as valid as the original. You are entitled to make and return a photocopy of this authorization. This authorization shall remain in effect indefinitely unless properly terminated by written notice.

I have read and understand the terms of this Application. My signature below indicates my acceptance of these terms and that the information I have entered on this Application is complete, true and correct. Vista Healthplan of South Florida reserves the right to rescind coverage due to any material misrepresentation on this Enrollment Application. Material misrepresentation is determined at the sole discretion of Vista Healthplan of South Florida.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

X ______________________	________	X ______________________	________
PRIMARY APPLICANT'S SIGNATURE (in ink)	Date Signed	PARENT or LEGAL GUARDIAN (circle) if sole Applicant is under 18 years old	Date Signed
X ______________________	________	X ______________________	________
SPOUSE'S SIGNATURE (in ink)	Date Signed	AGENT'S SIGNATURE (in ink)	Date Signed

K. PRIVACY PROTECTION ACT

Vista Healthplan of South Florida is committed to protecting the privacy of you and your family. However, in order for us to provide you with health insurance products and services, we need to collect certain information. We understand that the confidentiality of this information is very important. This information should explain our policies and practices with respect to personal health information. Please take a moment to read this in full so that you may understand how we collect, protect and use the personal information of you and your covered family members.

Types of Information We Collect and How We Collect It
The information we receive from you and your family members on health insurance applications, claim forms and other various forms, include information such as name, address, date of birth, sex, social security number, medical information and dependent information. In addition, we receive information regarding your transactions, payment history and experiences with us, our business partners and others such as disease management organizations, participating and non-participating physicians and facilities and third party administrators.

How We Share Your Personal Information
We may provide personal health information we collect to our business partners to accomplish certain functions such as underwriting, processing, utilization management, servicing and marketing. We will not provide this information to any other entity unless we have a written agreement that requires such third party protection and confidentiality of this information.

There may be circumstances when we are required by subpoena or summons of federal, state or local authorities to provide collected personal health information to authorized persons or entities in response to a judicial process or regulatory authority with jurisdiction over our company for examination, compliance or other purposes as required by law.

When we share personal health information as permitted and required by law, we are not required to provide you with an option to restrict the sharing of personal health information.

Protecting the Security of Your Personal Health Information
We take safeguarding your privacy very seriously. We employ industry standard security measures to prevent unauthorized access, protect against loss, maintain data security, and ensure the correct use of such information. Employee access to personal health information is limited to only those employees with a business reason for accessing such information. We educate all our employees about the importance of confidentiality, and we take appropriate disciplinary measures to enforce employee responsibility regarding personal health information.

L. STATEMENT OF ACCOUNTABILITY

To be completed when the applicant cannot complete the application.

I, ________________________________, personally read and completed this Individual Enrollment Application for the applicant because:

❏ Applicant does not read English ❏ Applicant does not speak English ❏ Applicant does not write English

❏ Other (explain)____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: ____

I also translated and fully explained the "Conditions of Enrollment and Applicants' Certification."

X ____ ____________________

Signature of Translator (Required) Today's Date (Required)

M. AGENT'S CERTIFICATION

Are you aware of any information not disclosed in this Application which may have a bearing on this risk? ❏ Yes ❏ No
If yes, please attach explanation.

Did you see the applicant and did you ask each question in this Application exactly as set forth?

❏ Yes ❏ No, explain and attach explanation

I have read the Application and all questions have been answered in full. (Incomplete applications will be returned.)

X____ ______________

Agent's Signature (in ink) Date Signed

ALL APPLICATIONS MUST BE SUBMITTED TO:
Vista Healthplan of South Florida, Inc. Individual Underwriting Processing Unit
300 South Park Road, Hollywood, FL 33021
Toll Free: (866) 342-4968
Phone: (954) 965-3424

N. CONDITIONAL RECEIPT

INDIVIDUAL HMO CONDITIONAL CASH RECEIPT

Check or Money Order MUST accompany application. All checks must be made payable to Vista Healthplan of South Florida.

Received from ______________________________________ on _________________

an initial premium payment of ________________.

1. I/We realize this is an Individual plan and not an employer sponsored group plan. I'm fully responsible for any future premium payment (if approved for coverage) and any nonpayment of premium will subject the coverage to termination.
2. I/We understand that my/our application is subject to an underwriting evaluation and verification of the information provided. The premium submitted along with the application is merely a deposit for the first month's premium and does not entitle me/us to coverage until I/we receive written confirmation from Vista Healthplan of South Florida's Health underwriting department. In the event the application is rejected, the deposit will be returned to me/us.
3. This Plan will hold applications with missing information for up to 30 days. After 30 days, the application will be closed and the deposit will be returned to the applicant.
4. Once approval is confirmed by Vista Healthplan of South Florida, coverage will begin on the effective date designated by Vista Healthplan of South Florida in such confirmation. My/our premium rate will be based on that approved effective date. Vista Healthplan of South Florida is not responsible for the payment or providing services prior to the effective date of my/our enrollment.

Detach after completion and give canary copy to Applicant.

I/We hereby certify that I/we have read this agreement and that I/we fully understand and accept its contents and that no further explanation is required. I/We have received the "Individual HMO Conditional Cash Receipt" and have it in my/our possession.

X ____ ______________
Main Applicant signature (Legal guardian if under 18) Date

X ____ ______________
Spouse's signature Date

X ____ ______________
Agent signature Date

white copy – VISTA Underwriting canary copy – Applicant pink copy – agent

VHPSFL IND-I(4/03)