

Quality Health Insurance Company

Application Instructions for CIGNA Healthcare of Arizona

INSTRUCTIONS

- 1) To apply for coverage, fill out the application completely, and sign and date it.
 - 2) Each family applying for coverage will need to select a Primary Care Physician. You can search their provider directory online by clicking on the following link: [Provider Directory](#)
 - 3) **There is a \$15 non-refundable fee due with each application.** Please make check payable to CIGNA Healthcare. An application sent in without this fee will result in a delay. You do not need to send in a check for the first month's premium. Once approved, CIGNA will send you a billing invoice.
 - 4) You will need to select: **Primary Care Physician** (for each applying member)
Requested Effective Date (available only on the 1st of each month).
 - 5) Mail completed application to: **Quality Health Insurance/ Attn: Jay McLaughlin**
10480 E. Clinton St. Scottsdale, AZ 85259.
 - 6) If you need assistance with completing this application, or if you have any question, please contact us at **(480)580-4927**.
- » **Child only coverage is available for children that are 3 months or older. To apply, complete the application for each child for whom you are requesting coverage. Sign and date as Parent/Guardian or Authorized Representative.**



ALL QUESTIONS MUST BE COMPLETED
PLEASE PRINT

CIGNA HealthCare of Arizona

**INDIVIDUAL & FAMILY PLAN
MEDICALLY UNDERWRITTEN ENROLLMENT APPLICATION**

APPLICATION FOR:	SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> CHILD ONLY <input type="checkbox"/> CHILD(REN) ONLY <input type="checkbox"/>		
ENROLLING FOR:	NEW MEMBERSHIP <input type="checkbox"/>	EXISTING MEMBER, ADDING DEPENDENT(S) <input type="checkbox"/>	PROPOSED EFFECTIVE DATE
<input type="checkbox"/> PHOENIX AREA <input type="checkbox"/> TUCSON AREA			

INFORMATION REGARDING THE APPLICANT

LAST NAME		FIRST NAME			MI	SOCIAL SECURITY NO.	
DATE OF BIRTH	AGE	MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/>	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	HEIGHT	WEIGHT	HOME PHONE NO. () -	
HOME ADDRESS					UNIT NO.	WORK PHONE NO. () -	
CITY	STATE	ZIP CODE	PRIMARY CARE PHYSICIAN NO.			EXISTING PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	

COMPLETE THE FOLLOWING INFORMATION FOR EACH PERSON TO BE CONSIDERED FOR ENROLLMENT. IF YOU HAVE MORE THAN TWO CHILDREN ATTACH AN ADDITIONAL SHEET WITH THE SAME COMPLETE INFORMATION. WHEN ADDING A DEPENDENT TO YOUR EXISTING COVERAGE, LIST ONLY THE DEPENDENTS TO BE ADDED.

SPOUSE	LAST NAME		FIRST NAME			MI	PLEASE SELECT YOUR PCP	
	DATE OF BIRTH	AGE	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	HEIGHT	WEIGHT	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN NO.	EXISTING PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
DEPENDENT CHILDREN	LAST NAME		FIRST NAME			MI	PLEASE SELECT YOUR PCP	
	DATE OF BIRTH	AGE*	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	HEIGHT	WEIGHT	RELATIONSHIP	PRIMARY CARE PHYSICIAN NO.	EXISTING PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/>
	SOCIAL SECURITY NO.							
	LAST NAME		FIRST NAME			MI	PLEASE SELECT YOUR PCP	
DATE OF BIRTH	AGE*	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	HEIGHT	WEIGHT	RELATIONSHIP	PRIMARY CARE PHYSICIAN NO.	EXISTING PATIENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
SOCIAL SECURITY NO.								

*IF YOU HAVE LISTED A DEPENDENT AGE 19 OR OLDER, YOU MUST PROVIDE VERIFICATION OF FULL-TIME STATUS FROM THE SCHOOL'S REGISTRAR'S OFFICE.

Are you or is any person to be enrolled Medicare eligible or currently covered under any type of health benefit plan or insurance? Yes No
If yes, complete the following:

Persons Covered: _____ Health benefit plan/insurer: _____ EFFECTIVE DATE _____ TERMINATION DATE _____

Is any applicant currently, or has any applicant ever been, enrolled in a plan offered or administered by a CIGNA company? Yes No

Persons: _____ Subscriber# _____ Medical Record # _____

I acknowledge and agree that coverage shall become effective only after (a) this Application has been accepted upon review of the health history I have provided and any medical information reviewed by CIGNA, and (b) a Service Agreement has been issued by CIGNA HealthCare of Arizona.

The above statements and/or those on the Evidence of Insurability form are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance into membership of CIGNA HealthCare of Arizona. I acknowledge and agree that any misrepresentation or omission regarding the presence of pre-existing conditions, diseases, or other medical condition of any applicant will render this Service Agreement null and void from its date of issue.

I understand that any illness or condition that may occur or be discovered between the date of my application and the effective date of coverage must be reported to CIGNA HealthCare of Arizona. In such event, I further understand that my application may again be reviewed by CIGNA HealthCare of Arizona to determine final approval.

I have read and understand the authorization on the reverse side of this form.

NOTE: AN EVIDENCE OF INSURABILITY FORM MUST BE COMPLETED AND SUBMITTED TO CIGNA HEALTHCARE OF ARIZONA ALONG WITH THIS ENROLLMENT APPLICATION AND A CHECK FOR THE NON-REFUNDABLE \$15.00 APPLICATION FEE. EXPENSES, IF ANY, ASSOCIATED WITH OBTAINING MEDICAL RECORDS ARE THE APPLICANT'S FINANCIAL RESPONSIBILITY.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THE REVERSE OF THIS FORM, INCLUDING THE PROVISIONS REGARDING THE RELEASE OF MEDICAL INFORMATION.

Signature X _____ DATE _____ Signature X _____ DATE _____
APPLICANT OR PARENT/GUARDIAN SPOUSE (if to be enrolled)

FOR OFFICE USE ONLY			
Approved By _____	Date _____		
Group No. _____	Division No. _____	Eff. Date _____	Rate _____

FOR AGENT USE ONLY	
Agent or Agency Name (please print) <u>William J. McLaughlin</u>	Agent No. <u>F-77</u>
Address <u>10480 E. Clinton Street Scottsdale, AZ 85259</u>	Phone # <u>480-580-4927</u>
Signature _____	

APPLICANT'S NAME

FIRST

MIDDLE INITIAL

1. HAVE YOU OR ANY PERSON TO BE ENROLLED EVER HAD KNOWLEDGE OF OR BEEN DIAGNOSED, TREATED OR EVALUATED FOR ANY OF THE FOLLOWING:

YES	NO	EACH ITEM MUST BE CHECKED	YES	NO	EACH ITEM MUST BE CHECKED	YES	NO	EACH ITEM MUST BE CHECKED	YES	NO	EACH ITEM MUST BE CHECKED
		Abnormal pap smear (within past 12 mos.)			Breast disease, Breast implants			Heart problem, Chest pains			Prostate, Male sex organ problems
		Alcoholism, Drug abuse			Broken bone, Bone disease			Hepatitis (Please specify type)			Psychiatric disorders
		Anemia, Blood disease			Cancer			Hernia (Please specify type)			Seizures, Stroke
		Anxiety, Depression			Cataracts, Glaucoma			High blood pressure			Sexually transmitted disease
		Arthritis, Gout, Bursitis			Concussion, Head Injury			HIV/AIDS			Skin disease, Skin problems
		Artificial limb			Convulsions, Epilepsy			Infertility treatment			Stomach problems, Colitis
		Asthma, Bronchitis			Crossed eyes, Other eye disease			Intestinal problem			Thyroid, Glandular disease
		Attention Deficit Disorder, ADHD			Diabetes, Hypoglycemia			Kidney stone, Kidney problem			Tumor, Cyst
		Back or spine problem			Ear problem, Hearing loss			Liver disease, Cirrhosis			Ulcer (Please specify location)
		Birth defects, Deformity			Emphysema, Lung problem			Menstrual problems, Female disorder			Uterus, Ovarian problems
		Bladder Problems			Gallbladder disease or problem			Paralysis, Nervous system problem			Weight problem
		Brain disease			Headaches, Migraines			Prosthesis, Implants			

2. Yes No Have you or any person to be enrolled ever had an operation? **Give complete details below.**
3. Yes No Have you or any person to be enrolled been advised to have any operation not yet performed? **Give complete details below.**
4. Yes No Has any person to be enrolled visited a physician, clinic or hospital for any reason whatsoever (including physical examination by a Primary Care Physician) within the last five years? **Give details, date and reason seen, complete name and address of doctor below.**
5. Yes No Is any person to be enrolled currently taking medication? **If yes, list medications** _____
6. Yes No Is any male listed on this application currently expecting a child with anyone, either natural or by adoption, even if the mother is not listed on this application?

IF THE ANSWER IS YES TO ANY PART OF QUESTION 1-5 ABOVE, COMPLETE DETAILS MUST BE GIVEN BELOW: Use additional pages if necessary.

QUES. NO.	NAME OF PERSON	DATE TREATMENT BEGAN	REASON FOR VISIT, TYPE OF SURGERY, PROBLEM, NAME OF MEDICATION	DATE TREATMENT ENDED	DOCTOR OR HOSPITAL NAME YOU MUST GIVE THE COMPLETE NAME, STREET ADDRESS, CITY & ZIP CODE		
					NAME	STREET ADDRESS	PHONE
					CITY	STATE	ZIP
					CITY	STATE	ZIP
					CITY	STATE	ZIP
					CITY	STATE	ZIP
					CITY	STATE	ZIP

7. Do you currently have a physician? Yes No If Yes, please provide the COMPLETE name and address for your physician.

NAME ADDRESS CITY STATE ZIP

8. Have you or any person to be enrolled ever used tobacco products? Yes No If Yes, please COMPLETE the following:
- A. Name of person(s) _____ B. Cigarettes Cigars Pipe Chewing tobacco: _____
- C. Identify quantity per day _____ D. For how many years? _____ E. Have the person(s) quit? Yes No If Yes, when? _____
9. Are you or any person to be enrolled disabled, claiming entitlement to or receiving workers' compensation benefits? Yes No If Yes, person? _____
Disability/Handicap/Claim: _____
10. Have you or any person to be enrolled ever been refused health insurance? Yes No If Yes, person: _____
Date refused: _____ Reason refused: _____
11. Are you or is any person to be enrolled currently undergoing treatment or is any treatment or visit to a hospital or a physician anticipated? Yes No
If Yes, person: _____ Treatment/Problem: _____

FEMALES MUST COMPLETE THE FOLLOWING:

12. Is any female to be enrolled now pregnant? Yes No If Yes, expected date of delivery: _____
13. List the name and date of the last menstrual period of each female:
- Name: _____ Last Menstrual Period: _____ Last Pap: _____
- Name: _____ Last Menstrual Period: _____ Last Pap: _____
- Name: _____ Last Menstrual Period: _____ Last Pap: _____

Signature X

APPLICANT or PARENT/GUARDIAN

DATE

Signature X

SPOUSE (if to be enrolled)

DATE

PROVISIONS

1. I understand that Primary Care Physicians may be network-affiliated and that my choice of Primary Care Physician may affect the hospitals, specialty care and other providers to which or whom I am referred.
2. I understand that during the application process and after my enrollment, CIGNA HealthCare of Arizona, Inc. and other direct or indirect subsidiaries of CIGNA Corporation (collectively "CIGNA") may need to obtain and provide Confidential Information to others. For purposes of this Paragraph and Paragraphs 3 and 4 below, "Confidential Information" means Medical Record Information, Personal Information and/or Privileged Information as defined by applicable law; dental, disability, accident or workers' compensation related information, and expressly includes the following: **CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-66, CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.), CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION, AND CONFIDENTIAL GENETIC TESTING INFORMATION (AS DEFINED IN A.R.S. SECTION 12-2801).**
3. I authorize any insurance institution, employer, provider, insurance support organization, health care organization, and their agents and representatives to provide Confidential Information on request by CIGNA to representatives of CIGNA who are authorized by CIGNA to receive such information, to any CIGNA participating provider, or to any other provider, person or entity performing a service for the following purposes: establishing eligibility under the Plan, Plan administration, validating services and benefits payable under the Plan, performance of peer review, utilization management, quality assurance, grievance and appeals, care management, and/or to assess the quality of or access to health care services and supplies. I further authorize CIGNA (through its agents and representatives who are authorized by CIGNA to disclose confidential information) to provide Confidential Information to the persons or entities above when it determines that such disclosure is necessary or appropriate for the purposes specified in this paragraph.
4. I am providing this authorization for myself and as agent or representative of my spouse and any dependent children. I understand that this authorization will remain in effect until I send written notice revoking it to CIGNA or for such shorter period as required by law. I understand that to the extent this authorization applies to information collected in connection with this application for coverage, the authorization is valid for a period of thirty (30) months. I further understand that to the extent this authorization applies to information collected in connection with a claim for benefits under the Plan, the authorization is valid for with respect to services received during the term of coverage under the Plan. Until revoked by me or by operation of law, this authorization remains in effect and may be relied on by CIGNA and other parties.
5. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act and may be subject to civil and criminal penalties.
6. I authorize that payment be made under Part B of Medicare to CIGNA for medical and other services furnished by CIGNA for which it pays or has paid, if applicable.
7. I agree that in the event health services provided are the primary responsibility of Medicare, workers' compensation coverage or automobile medical payments coverage, to fully inform CIGNA and execute such documents and provide such assistance as may be necessary to enable CIGNA to recover the value of services provided or arranged.
8. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.

Signature of Applicant

Date

Please sign and date and return with application.