QUALITY INSURANCE ASSOCIATES L.L.C.

9015 E. Via Linda, Suite 107 PMB-813
Scottsdale, Arizona 85258
Phone: (480)580-4927 Fax: (480)391-3047
e-mail: jay@qualityhealthinsurance.com

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 Insurance Associates L.L.C.
10480 E. Clinton St.
Scottsdale, AZ 85259.

Attn: Jay McLaughlin

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.

CIGNA HealthCare of Arizona

ALL QUESTIONS MUST BE COMPLETED
PLEASE PRINT

INDIVIDUAL & FAMILY PLAN
MEDICALLY UNDERWRITTEN ENROLLMENT APPLICATION

APPLICATION FOR:	SINGLE ☐ FAMILY ☐ CHILD ONLY ☐ CHILD(REN) ONLY ☐	
ENROLLING FOR:	NEW MEMBERSHIP ☐ EXISTING MEMBER, ADDING DEPENDENT(S) ☐	PROPOSED EFFECTIVE DATE
☐ PHOENIX AREA	☐ TUCSON AREA	

INFORMATION REGARDING THE APPLICANT

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

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 ☐ FEMALE ☐	HEIGHT	WEIGHT	SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN NO.	EXISTING PATIENT? YES ☐ NO ☐

DEPENDENT CHILDREN

LAST NAME				FIRST NAME		MI	PLEASE SELECT YOUR PCP
DATE OF BIRTH	AGE*	MALE ☐ FEMALE ☐	HEIGHT	WEIGHT	RELATIONSHIP	PRIMARY CARE PHYSICIAN NO.	EXISTING PATIENT? YES ☐ NO ☐
SOCIAL SECURITY NO.							

LAST NAME				FIRST NAME		MI	PLEASE SELECT YOUR PCP
DATE OF BIRTH	AGE*	MALE ☐ FEMALE ☐	HEIGHT	WEIGHT	RELATIONSHIP	PRIMARY CARE PHYSICIAN NO.	EXISTING PATIENT? YES ☐ NO ☐
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 ELIGILBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THE REVERSE OF THIS FORM, INCLUDING THE PROVISIONS REGARDING THE RELEASE OF MEDICAL INFORMATION.

Signature X ______________________ APPLICANT OR PARENT/GUARDIAN DATE

Signature X ______________________ SPOUSE (if to be enrolled) DATE

FOR OFFICE USE ONLY

Approved By ______________________ **Date** ____________
Group No. ____________ **Division No.** ____________ **Eff. Date** ____________ **Rate** ____________

FOR AGENT USE ONLY

Agent or Agency Name (please print) William J. McLaughlin **Agent No.** F-77
Address 10480 E. Clinton Street Scottsdale, AZ 85259
Signature ______________________ **Phone #** 480-580-4927

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Please Read Reverse Side

CIGNA HealthCare of Arizona

PLEASE PRINT

EVIDENCE OF INSURABILITY

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 PHONE STREET ADDRESS CITY STATE ZIP
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					NAME PHONE STREET ADDRESS 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**

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(INCLUDE ADDITIONAL PAGES AS NECESSARY)

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.