



## MDwise, Inc. Healthy Indiana Plan Buy-In Individual Enrollment Application

As used in this application, "MDwise" means MDwise, Inc. and other persons or organizations performing business or legal services in connection with this application.

### YOU ARE ELIGIBLE TO APPLY FOR THIS COVERAGE ONLY IF YOU MEET ALL OF THESE REQUIREMENTS:

1. You are at least 19 years of age and less than 65 years of age; and
2. You are an Indiana resident; and
3. You are a citizen of the United States; and
4. You are not eligible for health insurance coverage through your employer. If you declined coverage during your employer's open enrollment period, you are not eligible to apply for this coverage; and
5. You have been without health insurance for at least six consecutive calendar months; except that if you have exhausted your COBRA continuation coverage, or have lost your Medicaid eligibility in the previous six months, this requirement does not apply; and
6. You are not eligible nor enrolled in the Medicare or Medicaid programs; and
7. You are not covered by any other group or individual health plan.

You will be notified of actions taken within 45 days after the date of your application or be given the reason for the delay.

To be filled out personally by the applicant. PLEASE PRINT IN BLUE OR BLACK INK

### Section 1: Applicant Information *(dependents are not eligible for this coverage)*

#### 1. NAME:

\_\_\_\_\_

Last

\_\_\_\_\_

First

\_\_\_\_\_

M.I.

MARITAL STATUS: single married

SOCIAL SECURITY NUMBER: --

DATE OF BIRTH: --  
(MM-DD-YY)

SEX: male female

HEIGHT: \_\_\_\_\_

WEIGHT: \_\_\_\_\_

#### 2. APPLICANT'S PRIMARY RESIDENT ADDRESS (P.O. Boxes are not accepted):

\_\_\_\_\_

Street Address

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip code

#### 3. PHONE NUMBERS:

\_\_\_\_\_

Home

\_\_\_\_\_

Other

\_\_\_\_\_

Best number and times to call

EMAIL ADDRESS: \_\_\_\_\_

#### 4. YOUR OCCUPATION:

YOUR EMPLOYER: \_\_\_\_\_

DATE HIRED: --  
(MM-DD-YY)

PRIOR EMPLOYER (if within 2 years): \_\_\_\_\_

## Section 2: Provider Selection

5. PRIMARY MEDICAL PROVIDER (PMP):

|                |       |       |          |
|----------------|-------|-------|----------|
| _____          | _____ | _____ | _____    |
| Last           | First | M.I.  |          |
| _____          |       | _____ | _____    |
| Street Address | City  | State | Zip code |

Choice of delivery system is limited to actual participation by your selected PMP. If PMP does not participate in your selected delivery system one will be chosen for you.

6. DELIVERY SYSTEM SELECTION: \_\_\_\_\_

7. REQUESTED EFFECTIVE DATE:   -   -

(MM-DD-YY)

(coverage effective dates must be first of the month. If approved, the earliest effective date will be the first of the month following the date your application is approved subject to monthly enrollment processing timeframes)

## Section 3: Other Coverage

8. Within the last 6 months, have you **been covered** by any type of **medical** insurance? .....  Yes  No  
If yes, complete below:

POLICY/ CERTIFICATE NUMBER: \_\_\_\_\_

TYPE:  individual  employer group  short term  COBRA  Medicaid  Medicare  other

INSURANCE COMPANY NAME: \_\_\_\_\_

TERMINATION DATE:   -   -    
(MM-DD-YY)

**Your signature on this document indicates your agreement to terminate any existing coverage listed above as being replaced.**

9. Have you ever had a health application or policy voided, declined, postponed, rated, or charged an extra premium, or had coverage modified (including medical exclusion riders) by any health or life insurer? .....  Yes  No  
If yes, complete below:

INSURANCE COMPANY: \_\_\_\_\_

ACTION TAKEN: \_\_\_\_\_

DATE:   -   -    
(MM-DD-YY)

REASON FOR ACTION: \_\_\_\_\_

10. I have applied for the Healthy Indiana Plan and received a letter from the State saying I am not eligible (please include letter with application) .....  Yes  No

## Section 4: Medical History

### Health history questions must be answered by you.

All Questions Must Be Answered or The Application Will Be Returned.

GIVE COMPLETE DETAILS in the "MEDICAL HISTORY DETAILS" section FOR ALL QUESTIONS ANSWERED "YES".

**NOTICE:** You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition.

We have the right to review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, do not assume we will review all of your medical records before approving your application.

If we issue coverage to you and later discover that you misrepresented or omitted information you knew in response to a question we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage, you must fully disclose and answer all medical history questions.

11. Are you pregnant or an expectant mother? .....  Yes  No
12. Is English your primary language? .....  Yes  No  
If no, what is your primary language? \_\_\_\_\_
13. In the last 6 months, have you been advised to take medication or received medical advice or treatment of any kind?.....  Yes  No
14. Within the last 5 years, have you had any diagnosis or treatment of any disease or disorder of the:
- a. bones, joints or spine? .....  Yes  No
  - b. eyes, ears, or nose? .....  Yes  No
  - c. mouth, tongue, throat, or jaw? .....  Yes  No
15. Within the last 5 years, have you been diagnosed as having or been treated for any disease or disorder of the:
- a. gallbladder? .....  Yes  No
  - b. pancreas or liver? .....  Yes  No
  - c. kidney? .....  Yes  No
16. In the last 5 years, have you had any diagnosis or treatment of:
- a. high blood pressure? .....  Yes  No
  - b. chest pain? .....  Yes  No
  - c. headaches? .....  Yes  No
  - d. paralysis? .....  Yes  No
  - e. arthritis? .....  Yes  No
  - f. convulsions, seizures or epilepsy? .....  Yes  No
  - g. sexually transmitted disease or infection? .....  Yes  No
  - h. chronic pain not identified above? .....  Yes  No
  - i. tumor, cyst, polyp, lump, or growth of any kind? .....  Yes  No
17. In the last 5 years, have you been diagnosed as having or been treated for:
- a. elevated cholesterol? .....  Yes  No
  - b. diabetes or sugar in the blood or urine? .....  Yes  No
  - c. stroke? .....  Yes  No
  - d. mental, emotional, or behavioral disorder? .....  Yes  No
18. In the last 5 years, have you:
- a. been hospitalized, had surgery, or been advised to have surgery? .....  Yes  No
  - b. been diagnosed as having or been treated for cancer? .....  Yes  No
19. In the last 5 years, have you:
- a. had a complicated pregnancy or delivery? .....  Yes  No
  - b. consulted a mental health professional? .....  Yes  No
20. In the last 5 years, have you had, or in the last 5 years, have you been diagnosed as having or been treated for; any disease, disorder or abnormality of the:
- a. heart or circulatory system? .....  Yes  No
  - b. nervous system? .....  Yes  No
  - c. digestive system including stomach? .....  Yes  No

- d. muscular or skeletal system? .....  Yes  No
- e. respiratory system? .....  Yes  No
- f. male or female reproductive system, including infertility? .....  Yes  No
- g. urinary system? .....  Yes  No
- h. thyroid, breast, or other glands? .....  Yes  No
21. In the last 5 years, have you tested positive for antibodies to the HIV virus or been diagnosed as having or been treated for, Acquired Immune Deficiency Syndrome (AIDS) or any HIV disease or related illness? .....  Yes  No
22. In the last 5 years, have you had any other disease, disorder, injury, or adverse medical finding that we have not asked you about? .....  Yes  No
23. In the last 5 years, have you been diagnosed as having or been treated for any other disease, disorder, injury, or adverse finding, or had any adverse abnormal test result? .....  Yes  No
24. In the last 12 months, have you experienced a weight gain or loss of 15 pounds or more? .....  Yes  No
25. In the last 5 years, have you had any diagnosis or treatment of an alcohol or drug dependency, problem, or abuse; or any alcohol or drug-related arrest? .....  Yes  No
26. In the last 5 years have you been a user of alcoholic beverages in excess of 14 drinks per week? .....  Yes  No  
If yes, show how many drinks per week in "Medical History Details" (one drink equals: 12 oz. of beer; 4 oz. of wine; 1 oz. of hard liquor).
27. In last 12 months have you smoked cigarettes or used tobacco in any form (including smokeless tobacco or nicotine substitute)? .....  Yes  No
28. Do you have implants, prosthesis, or retained hardware (including any joint replacements)? .....  Yes  No
29. List in "Medical History Details" any additional doctors or other health care professionals that you have consulted with or been treated by in the last 5 years, and give full details.

**IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS".**

## Section 5: Medical History Details

If you answered "Yes" to any of the medical history questions, give complete details.

| Questions # (number, letter) | Physician Name, Address & Telephone (include area code) | Indications, Symptoms, Signs, Conditions, or Specific Diagnosis | Treatment, Advice Given, Medications Prescribed, Treatment Results | Current Status |
|------------------------------|---|---|--|----------------|
|                              |   |   |  |                |
|                              |   |   |  |                |
|                              |   |   |  |                |
|                              |   |   |  |                |

Should you need more space to provide complete and accurate information, please use plain or lined paper, sign and date it, and check here

**Prescription Medications — List ALL medications taken within the last 12 months, if not indicated in the Medical History Details above.**

| Illness for which Medication is Prescribed | Medication/ Dosage/ Frequency (e.g. Lopressor/100mg/daily) | Date Prescribed (MM/DD/YY) | Date Discontinued if applicable (MM/DD/YY) | Name, Phone Number of Prescribing Physician |
|--|--|----------------------------|--|---|
|  |  |                            |  |   |
|  |  |                            |  |   |
|  |  |                            |  |   |

## Statement of Understanding

Please read this section carefully before signing the application.

1. I understand that it is mandatory that I notify MDwise, in writing, immediately if I (the applicant) received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date.
2. I understand that any premium quote provided is preliminary. I understand that, to the extent permitted by law, MDwise reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that this completed application, and any supplements or amendments, will be made a part of any policy/ certificate which may be issued. I understand that if my application is denied, my bank account or credit card will not be charged.
3. I am responsible to timely notify MDwise of any change that would make me ineligible for coverage.
4. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between MDwise and myself.
5. I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that I am not receiving, directly or indirectly, any form of reimbursement or compensation for this coverage with respect to premium from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid. I understand that any coverage under this policy will terminate on the date I accept any direct or indirect contribution or reimbursement (through wage adjustment or otherwise), by or on behalf of an employer for any portion of the premium for coverage under this policy, or the date I or any employer treat this policy as part of an employer-provided health plan for any purpose, including tax purposes.
6. I understand that unless MDwise agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury.
7. I acknowledge that I have read the Statement of Understanding, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by MDwise in accepting this application. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).
8. If tobacco use question #27 is answered "NO", I understand that the signature(s) shown on the following page will attest to non-tobacco usage for the past 12 months.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

# Authorization for Use of Protected Health Information & Non-Medical Information

## I understand the following:

- A photocopy of this authorization is as valid as the original;
- I or my authorized representative may obtain a copy of this authorization by writing to MDwise;
- I may request revocation of this authorization as described below;
- MDwise may condition enrollment in its health plan or eligibility for benefits on my refusal to sign this authorization;
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.

I hereby authorize that any provider of health services or supplies, the Medical Information Bureau (MIB), insurance company, organization, or person can release to MDwise medical and insurance information about health-related services and supplies provided to me. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record. In addition, I authorize any employer, insurance company, government agency, consumer reporting agency or the Medical Information Bureau (MIB) having non-medical information, including but not limited to my occupation(s), avocations, driving history, criminal history, prior insurance coverage, to provide such information to MDwise. MDwise can use the information to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement. Unless previously revoked, this authorization is valid for 30 months from the date I signed it.

This authorization is subject to revocation at any time by written notice to MDwise except to the extent that MDwise has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I will not be considered for coverage.

MDwise may release this information about me to the MIB or any member company for the purposes described in the MDwise Notice of Privacy Practices. I have received the MDwise Notice of Privacy Practices.

I certify that I have personally completed this application. I have retained a copy of this authorization.

SIGNED: \_\_\_\_\_

DATE:   -   -    
(MM-DD-YY)

## Review Before Mailing this Application

1. Print clearly and complete the application in blue or black ink.
2. If you make any changes while completing this form (for example, if you cross out something you wrote), be sure to **initial and date** those changes.
3. If any **corrections** are needed or if the form is incomplete, the application may have to be returned to you, or we may try to call you, to obtain the necessary information. In that case, we will record your information on a form that will be attached to your application.
4. Coverage effective dates must be the first of the month. If approved, the earliest effective date will be the first of the month following the date your application is approved subject to monthly enrollment processing timeframes.
5. **Answer all medical history questions.** Failure to do so will delay the processing of your application.
6. If you answered "yes" to any of the health history questions, give complete details in the "**Medical History Details**" section.
7. If you knowingly present false, incomplete, or misleading information in an application for insurance, you may be committing insurance fraud.
8. There is no coverage until approved in writing by MDwise, Inc.
9. Applications received by MDwise more than 15 days after the signed date will not be accepted.
10. P.O. Boxes are not accepted as a Primary Resident Address.
11. If you received a letter from the State indicating coverage eligibility, please include it with this application.
12. Mail this application to:  
MDwise, Inc.  
Attn: HIP New Member Applications  
P.O. Box 44236  
Indianapolis, IN 46244-0236

