Enrollment Form for Individual Coverage
Illinois

To complete the enrollment process, please be thorough and fill out all sections.

Requested Effective Date of Coverage / Date of Change _____/_____/______

Policy Number (if known)

Reason for Application
□ New Plan □ Life Event / Date ___/____/_____ □ Status Change ____/____/____ □ Dependent Add / Delete
□ Change Name / Address □ Annual Open Enrollment □ Other ______________________________________

A. Primary Applicant's Information

Last Name	First Name	MI	Social Security Number

Address	Apt#	City	County	State	Zip Code	Home/Cell Phone

Date of Birth	Gender	Email Address	Work Phone
/ /	□ M □ F		

Marital Status □ Single □ Married [□ Divorced □ Widowed]

Do you use tobacco?[1] □ Yes □ No

[Primary Care Physician Existing Patient? □ Yes □ No Address ____
Physician First & Last Name ___________________________________ ____]

B. Family Information

List all enrolling (Attach sheet if necessary)

Relationship	Last Name	First Name	MI	Gender	Date of Birth
				□ M □ F	/ /

Spouse [/Domestic Partner]	Social Security Number	Do you use tobacco?[1] □ Yes □ No

[Primary Care Physician Existing Patient? □ Yes □ No Address ____
Physician First & Last Name ___________________________________ ____]

Relationship	Last Name	First Name	MI	Gender	Date of Birth
				□ M □ F	/ /

Dependent	Social Security Number	Do you use tobacco?[1] □ Yes □ No

[Primary Care Physician Existing Patient? □ Yes □ No Address ____
Physician First & Last Name ___________________________________ ____]

Relationship	Last Name	First Name	MI	Gender	Date of Birth
				□ M □ F	/ /

Dependent	Social Security Number	Do you use tobacco?[1] □ Yes □ No

[Primary Care Physician Existing Patient? □ Yes □ No Address ____
Physician First & Last Name ___________________________________ ____]

(1) Tobacco means all tobacco products, including, but not limited to, cigarettes, cigars, and chewing tobacco. You should only check the "yes" box above if tobacco was used four or more times per week on average (excluding religious or ceremonial use) within the past 6 months by someone of legal age to purchase tobacco in the state of residence.

Medical coverage provided by Harken Health Insurance Company

B. Family Information (continued)

Relationship	Last Name	First Name	MI	Gender	Date of Birth
Dependent	Social Security Number	Do you use tobacco?[1] □ Yes □ No		□ M □ F	/ /

[Primary Care Physician Existing Patient? □ Yes □ No Address ______________________________
Physician First & Last Name ______________________________ ______________________________]

Relationship	Last Name	First Name	MI	Gender	Date of Birth
Dependent	Social Security Number	Do you use tobacco?[1] □ Yes □ No		□ M □ F	/ /

[Primary Care Physician Existing Patient? □ Yes □ No Address ______________________________
Physician First & Last Name ______________________________ ______________________________]

C. Product Selection

Please select the medical plan being purchased. Attach your health insurance quote.

□Care Platinum I □Care Platinum II □Care Gold I □Care Gold II □Care Silver I □Care Silver II □Care Bronze

[D. Prior Medical Insurance Information

Within the last 12 months, have you, your spouse, or your dependents had any other medical coverage?
□ No □ Yes (if yes, please complete this section.)

Prior medical carrier name	Effective date	End date
______________________________	____/____/____	____/____/____]

[E.] Medicare Status

On the day this coverage begins, will you, your spouse or any of your dependents be covered under Medicare?	
□ Yes Please List the names	Applicant's Name:
	Spouse Name:
	Dependent Name:
	Dependent Name:
□ No (move to next section)	Dependent Name:

[F. Census Information (optional)

NOTE: Responding to this question is optional and is not required. Data collected in this section will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being. This information will not be used in the eligibility process.

1. Race, check all that apply: □ White □ Black, African-American □ American Indian/Alaska Native □ Asian □ Native Hawaiian/Pacific Islander □ Other Race, please specify________________________

2. Are you of Hispanic or Latino origin? □ Yes □ No]

[G.] Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS
As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

I authorize Harken Health Insurance Company and its affiliates (collectively, " Harken Health Insurance Company") to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records. I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services. I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to Harken Health Insurance Company and Affiliates. I understand that the purpose of the disclosure and use of my information is to allow Harken Health Insurance Company to facilitate the appropriate management of treatment, services, payment and benefits. I further understand that the information disclosed will not be used for purposes of eligibility, enrollment, underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. I understand I may revoke this authorization at any time by notifying my Harken Health Insurance Company representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, Harken Health Insurance Company also requires that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. This authorization, unless revoked earlier, expires 30 months after the date it is signed.

I understand that I am completing a health application and that each response must be complete and accurate. I (we) request the indicated medical coverage. I (we) have not given the agent or any other persons any required information not included on the application. I (we) understand that Harken Health Insurance Company is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.

Please note that if you leave out information or make a misrepresentation on this form we may be allowed by law to take one or more of the following actions: terminate or non-renew your coverage or change your premium retroactively to the date your policy became effective.

I have been informed about: 1) the number, mix and distribution of network providers; 2) the existence of limitations and disclosures pertaining to my choice of certain healthcare providers; and 3) that Harken Health Insurance Company and its Affiliates have contracted with certain healthcare providers and facilities to provide these services on a negotiated basis. I understand that provider reimbursements will not include any incentives or disincentives for providers that order or provide less than appropriate care to their patients or for denying, reducing, limiting or delaying such care.

Please maintain a copy of this authorization for your records.

Date	Applicant Signature for all applying	Spouse Signature (if applying for coverage)

[H.] Broker Statement

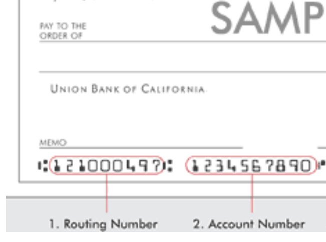
Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Information Practices [and a Conditional Receipt or Conditions Prior to Coverage].

Signature of Licensed Broker	Print Full Name Ryan Kennelly
Broker Number | 8 | 4 | 7 | 8 | 9 | 1 | 1 | | | |	Broker Email Address ryan@ilhealthagents.com

[I.] Electronic Funds Transfer (EFT) Authorization – Only if paying EFT

I (we) hereby authorize Harken Health to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account. I agree this authorization will remain in effect until you actually receive written notification of its termination from me.



Type of Account: □ Checking □ Savings

Nine-digit Routing No.
|___|___|___|___|___|___|___|___|___|

Account No.
|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Financial Institution's Name ____________________________

Address____________________________________

City, State, Zip____________________________________

Draft on_______________ _________________________
(Day) (Date Signed)

X____
Authorized Account Signature

Email Address________________________________

[J. Initial Payment Credit Authorization

I authorize Harken Health to bill my American Express/MasterCard/Visa account for the initial Payment.

Type of Card: □ MasterCard □ Visa □ American Express

Card Number:
|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Exp. Date:
|___|___| |___|___|___|___|
Month Year

Billing ZIP Code
|___|___|___|___|___|

NOTE: Some care issuers/financial institutions charge cash advance fees on insurance payments.

X____]
Signature of Authorized User

[When completed or for additional information
Contact us at Harken Health Insurance Company

Online www.harkenhealth.com or
Call Direct Sales [(844) 566-3390]

Harken Health Insurance Company Address:

[2700 Midwest Drive
Onalaska, WI 54650]]