



Broker No. – 7133

GA No. – 6997

Billing Cycle

Monthly

Quarterly

<b>Print In Ink</b>	<b>Non-Group Application Statement for Persons Not Eligible for Medicare</b>			Social Security No.
1. Applicant's last Name	First Name	M.I.	Telephone Number	

2. Home Address

City	County	State	Zip Code
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3. Male <input type="checkbox"/>	Female <input type="checkbox"/>	4. Date of Birth: Month / Day / Year
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5. <input type="checkbox"/> Single	<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Married	Date of Marriage: Month / Day / Year
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6. Spouse's Name (Last, First, Middle)	Sex	7. Date of Birth: Month / Day / Year
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8. Please provide the following information for your current or prior plan						
	Name and Address Of Insurer	Telephone Number of Insurer	Name of Policyholder	Policy I.D. Number	Effective Date of Policy	Termination Date of Prior Policy
Hospital						
Medical						

9. Do you intend to replace an existing accident and health insurance policy or certificate with the GHI Plan you are now applying for:  No  Yes If yes, termination date of your other insurance \_\_\_\_/\_\_\_\_/\_\_\_\_.

If yes, please check the type of plan you intend to replace.

Hospital Insurance

Medical Insurance

Other (Please specify)  \_\_\_\_\_

10. Is there a waiting period for pre-existing conditions under your existing plan?  Yes  No  
If yes, please indicate the effective date of your existing plan. \_\_\_\_\_

11. a. Please complete the information below for each unmarried dependent child under 19 years of age to be covered under the Plan. An unmarried dependent child will be covered until December 31 of the year he/she becomes 19.

Last Name	First Name	Middle Initial	Date of Birth / /
Last Name	First Name	Middle Initial	Date of Birth / /
Last Name	First Name	Middle Initial	Date of Birth / /
Last Name	First Name	Middle Initial	Date of Birth / /

12a. Please complete the information below for each unmarried, dependent child between 19 and 22 years of age who is a full-time student in an accredited educational institution and who is to be covered under the plan. Under plans that cover unmarried dependent students, a dependent student will be covered until December 31 of the year he/she becomes 23 or until he/she otherwise ceases to be on unmarried dependent student.

Last Name	First Name	M.I.	Date of Birth	Name & Address of School	Date of Grad.
1.					
2.					
3.					
4.					
5.					
6.					

12b. Are you eligible for group coverage that is comparable to the coverage you are applying for in this application?

No

Yes. Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b. Have you been refused coverage under an employer health plan due to your age, sex, health status or occupation?

No

Yes. Please explain: \_\_\_\_\_

\_\_\_\_\_

13. Has your health insurance coverage been terminated within the last twelve months due to a nonpayment of premiums?

No  Yes

**PLEASE READ THE BENEFIT DESCRIPTION OF EACH GHI OPEN ENROLLMENT PLAN OPTION IN THE GHI OPEN ENROLLMENT BROCHURE BEFORE MAKING YOUR SELECTION.**

14. If you are a new applicant, or if you wish to add or change hospital coverage or hospital/medical coverage Please check the appropriate box below for the **TYPE OF CONTRACT and TYPE OF COVERAGE requested.** (The **TYPE OF CONTRACT** selected must be in accordance with your marital status, as outlined in the instructions.)

I am applying for: (please check 1 box from each column)

Individual

Value Option (365-Day Hospital Plan and Medical Plan)

Family

See attached sheet for applicable rates

If you are applying for individual coverage and if your spouse is eligible for Medicare, check here.

**PLEASE DO NOT SUBMIT PAYMENT WITH THIS APPLICATION.**

15. If you are presently enrolled under a GHI Direct Payment Hospital plan, please check the appropriate box below.

I wish to retain my present hospital coverage coverage

I wish to change my present coverage from individual to Family.

I wish to change my present coverage from Family to Individual.

if you are presently enrolled under a GHI Direct Payment Hospital/Medical Plan, check the appropriate box below.

I wish to retain my present hospital/medical

I wish to change my present coverage from individual to Family.

I wish to change my present coverage from Family to Individual.

16. When your application is processed, a bill will be sent to you with the Contract(s).

THERE WILL BE AN ELEVEN-MONTH WAITING PERIOD FOR BENEFITS FOR ANY DISEASE, SYMPTON OR CONDITION THAT WAS PRESENT BEFORE THE FIRST DAY OF COVERAGE, AND FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE SIX-MONTH PERIOD PRIOR TO THE ENROLLMENT DATE OF COVERAGE. THIS WAITING PERIOD WILL BE REDUCED TO THE EXTENT THAT YOU ARE ENTITLED TO A CREDIT FOR COVERAGE UNDER A PREVIOUS HEALTH PLAN.

**IF YOUR CONTRACT IS TERMINATED BECAUSE YOU DID NOT PAY PREMIUMS, YOU CANNOT PURCHASE HEALTH INSURANCE FROM GHI FOR TWELVE MONTHS AFTER THE DATE OF TERMINATION.**

I hereby apply for coverage of the type checked above. If this application is for a family contract, names of my spouse, unmarried dependent children under 19 years of age (or who become 19 in this calendar year), and unmarried full-time student dependent children are provided and I make this application on their behalf as well as my own.

**When the application is processed, coverage will be effective only if payment of the subscription charges is received in accordance with the filing notice.**

I represent and understand that:

A. On my enrollment date, my existing contract(s), if any, will be canceled, except that any remaining waiting period for pre-existing conditions under my

existing contract will apply to a new contract for the same type of coverage. If I am currently covered under an individual contract and wish to change to a family contract for the same type of coverage, my enrollment date in the individual contract will be used to calculate my waiting period for pre-existing conditions. The waiting period for newly covered family members will be calculated from their enrollment date in the family contract. If I am currently covered under a family

contract and wish to change to an individual contract for the same coverage because of divorce, legal separation, annulment or death, my enrollment date in the family contract will be used to compute my waiting period for pre-existing conditions.

B. All statements and answers in this application are true to the best of my knowledge and belief. This application will be made part of the contract(s).

C. Any physician, other practitioner, hospital or

skilled nursing facility that has advised, treated, attended or rendered service to me or to any of the members of my family for whom coverage is requested, or who possesses

any information or records with respect hereto, is authorized and directed to furnish to you all such information and records.

**NOTE: BEFORE DATING AND SIGNING THIS APPLICATION, PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS. ALSO, BE SURE YOU HAVE CHECKED THE APPROPRIATE BOX FOR TYPE OF COVERAGE YOU DESIRE.**

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Applicant's Signature (**Do Not Print**)

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Applicant's Spouse's Signature (**Do Not Print**)  
Necessary Only When Applying for Family Coverage.

