South Carolina

# Celtic Health Plan

Underwritten by Celtic Insurance Company, Chicago, IL

PLEASE PRINT IN INK

## SECTION 1 - ENROLLMENT INFORMATION

**Application Date:** (mm/dd/yyyy)

Postmark on application envelope is the Application Date. If no postmarked date, the Application Date is the confirmed receipt date of the application by Celtic.

**I am Applying for:** Select one of the options below

☐ **Open Enrollment.**

☐ **Special Enrollment** (Celtic must be notified within 60 days of the Qualifying Event to be eligible for Special Enrollment. Special Enrollment only applies to those individuals who experience a Qualifying Event.)

- ☐ for a birth, adoption or placement for adoption.
- ☐ as a qualified individual gaining a spouse/dependent or becoming a spouse/dependent through marriage.
- ☐ as a qualified individual or dependent that has lost minimum essential coverage for any reason other than fraud, misrepresentation, or failure to pay premium.
- ☐ as an individual, who was not previously a citizen, national, or lawfully present individual that has gained such status.
- ☐ due to loss of employer sponsored insurance.
- ☐ as a qualified individual gaining access as a result of a permanent move.

**Date of Qualifying Event:** (mm/dd/yyyy)

(Include a copy of paperwork showing date of Qualifying Event. (i.e.- certificate of creditable coverage, marriage certificate, birth certificate, citizenship papers, etc.)

☐ **Reinstatement**

## SECTION 2 - GENERAL INFORMATION

**Who is to be insured?** ☐ Applicant Only ☐ Applicant/Spouse ☐ Applicant/Child(ren) ☐ Family

**Have you and/or any dependent to be covered previously applied for insurance with Celtic Insurance Company?** ☐ Yes ☐ No

### PRIMARY APPLICANT INFORMATION:

**Name:**

FIRST MIDDLE LAST

**Current Residential Address:** (P.O. Box is not acceptable.)

STREET CITY STATE ZIP

| | | | |
|---|---|---|---|
| **Birth Date:** (mm/dd/yyyy) | **Age:** | **Social Security Number:** | ☐ Male ☐ Female |
| **Email Address:** | | **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed | |
| **Home Phone Number:** ( ) | **Best time to call:** a.m. p.m. | **Phone # during regular business hours** ( ) | **Best time to call:** a.m. p.m. |

## SECTION 2 - GENERAL INFORMATION: (CONTINUED)

**Is the Primary Applicant to be insured a U.S. citizen or a permanent legal resident of the U.S.?** ☐ Yes ☐ No
(If "No," coverage cannot be granted.)

**Is the Primary Applicant to be insured currently a resident in the state they are applying for coverage?** ☐ Yes ☐ No

**Has the Primary Applicant to be insured used any type of tobacco product in the last 12 months?** ☐ Yes ☐ No

### GUARDIAN INFORMATION: (For Applicants under 18 years of age.)

**Guardian's Name:** (with whom the child resides)

FIRST MIDDLE LAST

☐ Parent ☐ Legal Guardian ☐ Grandparent ☐ Other _____

### SPOUSE INFORMATION:

**Name:**

FIRST MIDDLE LAST

| **Birth Date:** (mm/dd/yyyy) | **Age:** | **Social Security Number:** | ☐ Male ☐ Female |
|---|---|---|---|

**Is the spouse a U.S. citizen or a permanent legal resident of the U.S.?** ☐ Yes ☐ No (If "No," coverage cannot be granted.)

**Has the spouse to be insured used any type of tobacco product in the last 12 months?** ☐ Yes ☐ No

### DEPENDENT INFORMATION: (Complete only for dependents to be covered under this plan.)

| **Name of Dependent Child(ren):** First & Last Name | **Social Security Number:** | **Birth Date:** (mm/dd/yyyy) | **Age:** | **Sex:** (M/F) | **US Citizen or Permanent Legal Resident*** (Yes/No) | **Tobacco User** (Yes/No) |
|---|---|---|---|---|---|---|
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*If No, coverage cannot be granted

## SECTION 3 - PRODUCT

**Celtic Health Plan PPO** - $6,000 Individual Deductible, 80/20% of the next $1,750
$12,000 Family Deductible, 80/20% of the next $3,500

## SECTION 4 - PAYMENT INFORMATION

### TOTAL PAYMENT SUBMITTED:

$ _____ /Monthly
Please submit a check in the amount of one month's premium with your application. You will receive a monthly paper bill thereafter.

## SECTION 5 - AGREEMENT & SIGNATURE

1. **TRUE AND COMPLETE:** My answers to the questions on this application and any additional information I have provided are true and complete and accurately recorded. I understand that under no circumstances is anyone including a producer or company representative allowed to permit me to answer any question inaccurately or untruthfully and I represent that such did not occur. A producer or company representative is not authorized to alter any terms of the Health Plan. I understand that I must make checks payable to Celtic Insurance Company.
2. **OPEN ENROLLMENT EFFECTIVE DATE:** Coverage Effective Dates for initial open enrollment period for a qualified individual—
   (a) An Application Date on or before December 15, 2015 will have a coverage Effective Date of January 1, 2016;
   (b) Between the first and fifteenth day of any subsequent month during the initial open enrollment period will have a coverage Effective Date of the first day of the following month;
   (c) Between the sixteenth and last day of the month for any month between December 2015 and January 31, 2016, will have a coverage Effective Date of the first day of the second following month.
3. **SPECIAL ENROLLMENT EFFECTIVE DATE:** Coverage Effective Dates for special enrollment for a qualified individual except as specified in paragraphs (a) and (b). A qualified individual or enrollee must notify Celtic within 60 days of Qualifying Event.— Application Dates between the first and the fifteenth day of any month will have a coverage Effective Date of the first day of the following month and Application Dates between the sixteenth and the last day of any month will have a coverage Effective Date of the first day of the second following month.
   (a) In the case of birth, adoption or placement for adoption, the coverage Effective Date is on the date of birth, adoption, or placement for adoption;
   (b) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, the coverage Effective Date is on the first day of the following month.
4. **LOSS OF MINIMUM ESSENTIAL COVERAGE:** I understand that Loss of minimum essential coverage does not include termination or loss due to (1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or (2) Situations allowing for a rescission as specified in 45 CFR 147.128.
5. **APPLICATION INFORMATION:** Prior to the effective date of coverage, I understand that I am responsible for communicating any changes to the information I provided on this application. Application changes will be considered in the final coverage approval decision. I will call the Enrollment Department at (877) 865-5478 to inform them of any changes to my information.
6. **HEALTH CARE CERTIFICATION:** I understand that a Health Care Certification Program is a part of the Health Plan. This program requires me to have all hospital confinements, outpatient surgeries, and major diagnostic tests Certified. I understand that failure to do so will result in a reduction of my health plan benefits or no benefits paid at all. The Health Care Certification Program number is 1-800-477-7870.
7. **PREFERRED PROVIDER ORGANIZATION:** I understand I have applied for a PPO as part of my Health Plan, then I agree to participate and comply with all requirements of the PPO plan. I understand that I will maximize my benefits when treatment is received from a participating hospital and physician and that it is my responsibility to ensure that a PPO hospital and physician is near me. I understand this applies not only to myself, but to any dependent to be insured under this health plan.
8. **APPLICATION:** I understand that I am applying as an individual for the Health Plan and am responsible for ensuring that all premium payments are met. I understand that Celtic will individually underwrite my application and that if my application is accepted by Celtic, a Policy will be issued to me. I understand that the plan applied for is not an employer sponsored group health plan, that it will in no way be related to any employer/employee relationship, and it is not offered pursuant to and does not comply with state or federal small employer laws. If premium will be paid from a business/employer account, I hereby certify that no person to be insured under this plan will receive favorable tax treatment under sections 162, 125 or 106 of the United States Revenue Code, unless such favorable tax treatment would not make the plan subject to any state or federal small employer laws.

## SECTION 5 - AGREEMENT & SIGNATURE: (CONTINUED)

**9. AUTHORIZATION TO RELEASE INFORMATION:** I authorize any physician, medical or health care practitioner, hospital, clinic, other medically related facility, insurance company, third party administrator, employer or consumer reporting agency having information regarding me and all dependents applying for coverage, including information concerning advice, diagnosis, treatment or care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness or injury, and copies of all hospital records, medical records, pharmaceutical records or non-medical information, to give to Celtic Insurance Company, its reinsurers, or its legal representatives, and its affiliates, any and all such information. However, such information does not include psychotherapy notes (as defined by 45 C.F.R. §164.501). This information will be used by Celtic to determine eligibility for insurance and make benefit determinations. I understand that there is a possibility of redisclosure of any information pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand failure to sign this authorization may result in the denial of my application for coverage or eligibility for benefits.

I understand that I can revoke this authorization by submitting a signed request to Celtic Insurance Company, as described in Celtic's HIPAA Notice of Privacy Practices for Protected Health Information (PHI), at any time by giving written notice to Celtic and my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. I know that I may request to receive a copy of this authorization. This authorization shall remain valid for two years from the date shown below. A photocopy of this authorization shall be considered as valid as the original.

**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, which is a crime as determined by a court of law and subjects such person to criminal and civil penalties.**

Signature of PRIMARY APPLICANT: _____

Signature of SPOUSE: _____

Signature of Dependent Child (age 18 years of age or older): _____

Signature of Dependent Child (age 18 years of age or older): _____

Signature of Dependent Child (age 18 years of age or older): _____

Date: (mm/dd/yyyy) _____

**Mail this application to:**

**Celtic Insurance Co.**
**P.O. Box 26110**
**Little Rock, AR 72221**

**www.celtic-net.com**

## PLEASE KEEP THE FOLLOWING SECTIONS FOR YOUR RECORDS

### NOTICE OF INFORMATION PRACTICES:

In order to properly administer your insurance coverage, we must collect personal information. You are our most important source of information, but we may also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see (and copy if you wish) items of personal information about you which appear in our files. You also have the right to seek correction, amendment, or deletion of information you believe to be inaccurate.

If you have questions or desire additional information about the items disclosed above, please write to us at Celtic Insurance Company, 77 West Wacker Drive, 12th Floor, Chicago, IL 60601.

Requests for medical information will only be disclosed to your attending physician.

### CONDITIONAL RECEIPT FOR HEALTH PLAN:

Coverage will become effective on the "Effective Date" (as defined below) if all of the following conditions are met: (1) On the Date of Application, the applicant and all proposed insureds must be a risk acceptable to Celtic. (2) If Celtic cannot determine the acceptability of the applicant(s) as defined in (1) above, due to the nonreceipt (within 60 days of the date of application) of medical or other material information that Celtic has requested from the applicant or other sources; then this condition has not been fulfilled and no coverage will be provided under the terms of this Conditional Receipt. (3) The initial premium, equal to one month of the first yearly premium has been paid, and the check, credit card or bank draft is honored on the first presentation for payment.

<u>"Effective Date" as used herein means:</u>
For Open Enrollment: Coverage Effective Dates for initial open enrollment period for a qualified individual— (a) An Application Date on or before December 15, 2015 will have a coverage Effective Date of January 1, 2016; (b) Between the first and fifteenth day of any subsequent month during the initial open enrollment period will have a coverage Effective Date of the first day of the following month; (c) Between the sixteenth and last day of the month for any month between December 2015 and January 31, 2016, will have a coverage Effective Date of the first day of the second following month.

<u>For Special Enrollment:</u>
Coverage Effective Dates for special enrollment for a qualified individual except as specified in paragraphs (a) and (b). A qualified individual or enrollee must notify Celtic within 60 days of Qualifying Event.— Application Dates between the first and the fifteenth day of any month will have a coverage Effective Date of the first day of the following month and Application Dates between the sixteenth and the last day of any month will have a coverage Effective Date of the first day of the second following month. (a) In the case of birth, adoption or placement for adoption, the coverage Effective Date is on the date of birth, adoption, or placement for adoption; (b) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, the coverage Effective Date is on the first day of the following month.

If no postmarked date, the effective date will be no earlier than 30 calendar days after the confirmed receipt date of the application. **Note: Metered mail is not an acceptable postmark.**

## HIPAA Notice OF Privacy Practices For Protected Health Information ("PHI")
## For CELTIC Insurance Company ("Celtic")

Effective November 1, 2003

**This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review It Carefully.**

Celtic is committed to protecting the confidentiality and security of information it collects about you and does not share information about you with any other companies for their use in marketing products to you. **If the practices described in this Notice are acceptable to you, there is nothing you need to do.** If after reading this notice you still have questions, feel free to send them to

Attn: HIPAA Privacy Officer, 77 West Wacker Drive, 12th Floor, Chicago, IL 60601.

You have received this notice because of your proposed or actual health insurance coverage with Celtic Insurance Company. Celtic is required by federal law to maintain the privacy of your Protected Health Information ("PHI"), and to provide you with this notice of its legal duties and privacy practices regarding your PHI. Celtic is required to abide by the terms of this notice as currently in effect, and reserves the right to change the terms of this notice and to make new notice provisions effective for all PHI that it maintains. Notice of any such changes will be provided to you.

1. **Protected Health Information ("PHI"):**
   This notice describes how Celtic may use and disclose your PHI if needed, to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, which is individually identifiable information that relates to your past, present or future health or condition and related health care services. Examples of PHI used by Celtic include, but are not limited to, your application for coverage and claims submitted by you or health care providers on your behalf.

2. **Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations:**
   Your PHI may be used and disclosed by Celtic for purposes of payment or health care operations. Celtic may use or share your PHI with providers for payment purposes. Celtic may share your PHI with third party "business associates" that perform various functions for the Company. Celtic maintains written agreements with its business associates contractually binding them to protect the privacy of your PHI. Celtic may use or disclose, as needed, your PHI to support the Company's business activities related to providing health insurance benefits. These activities may include, but are not limited to, quality assessment, underwriting, premium rating, actuarial analysis, reinsurance, medical review, legal services, auditing, fraud and abuse detection, regulatory compliance, business planning and development, and general management and administration.

3. **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object:**
   Celtic may use or disclose your PHI in certain circumstances without your consent or authorization. These situations may include, but are not limited to, the following:

   Required by Law: Celtic may use or disclose your PHI to the extent state or federal law requires use or disclosure. Any use or disclosure will be compliant with applicable law, and will be limited to the requirements of such law. Celtic will notify you of the uses or disclosures if the law requires such notification.

   Public Health: Celtic may disclose your PHI to a public health authority for public health activities and purposes if applicable law permits the authority to collect or receive the information. Celtic also may disclose your PHI, when directed by a public health authority, to a foreign government agency that is collaborating with such authority.

   Health Oversight: Celtic may disclose PHI to a health oversight agency for activities authorized by state or federal law, such as audits and investigations.

   Abuse or Neglect: Celtic may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. Furthermore, Celtic may disclose your PHI to the governmental entity authorized to receive such information, in accordance with state or federal law, if the Company reasonably believes that you have been a victim of abuse, neglect or domestic violence.

   Legal Proceedings: Celtic may disclose PHI in the course of judicial or administrative proceedings, in response to a court order or administrative tribunal, to the extent such disclosure is expressly authorized, and in response to a subpoena, discovery request, or other lawful purpose.

   Military Activity and National Security: Celtic may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military. Celtic also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities.

**4. Other Permitted or Required Uses and Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to Object:**

Celtic may use or disclose your PHI in certain circumstances with your consent, authorization or if you have no objection. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of your PHI, then Celtic may determine, using professional judgment, whether such use or disclosure is in your best interest. If such circumstances arise, only the PHI that is necessary and relevant to the provision of your health insurance benefits will be disclosed.

*EOBs Sent to Primary Insured:* Unless you object and instruct otherwise, all explanations of benefits ("EOBs"), including for all covered family members and eligible dependents, will be sent to the primary insured person.

**5. Uses and Disclosures of PHI Based Upon Your Written Authorization:**

Celtic may engage in other uses and disclosures of your PHI upon receiving your written authorization. You may revoke an authorization, in writing, at any time, except to the extent that an action has been taken in reasonable reliance on the use or disclosure indicated in the authorization.

**6. Your Rights:**

The following is a description of your rights with respect to your PHI and a brief description of how you may exercise those rights.

*Inspect and Copy Your PHI:* You may obtain and inspect a copy of your PHI that is in a designated record set for as long as Celtic maintains it. However, federal law prohibits Celtic from allowing an inspection or copy of psychotherapy notes; privileged information compiled in reasonable anticipation of or use in a legal proceeding; or PHI that is subject to a law which prohibits its access. If you wish to receive a copy of your PHI, your request must be made using Celtic's "Medical Records Request" form. You may request this form by submitting a written request to Attn: HIPAA Records Request Department, Celtic Insurance Company, 77 West Wacker Drive, 12th Floor, Chicago, IL 60601. Note that there is a fee of $25 per provider that must be received by Celtic from you before records will be released. Since your health care providers are the original source of this information, and they may or may not charge a fee for copies, you may wish to request this information from your provider(s) before requesting it from Celtic.

*Place a Restriction on Your PHI:* You may request that Celtic not use or disclose your PHI. Your request should be in writing, it must state the specific restriction requested, and it must state to whom the restriction applies. Your request should be sent to: Attn: Policyowner Service Department, Celtic Insurance Company, P.O. Box 26110, Little Rock, AR 72221. Celtic is not required to agree to a request for such a restriction, but will deny such a request only for a reasonable reason and will provide a written explanation of the reason for the denial. If Celtic agrees to the restriction, it may still disclose your PHI as permitted by law, or if your restricted PHI is needed for emergency medical treatment.

*Alternative Means of Receiving Confidential Communications:* You have the right to request that Celtic send and/or receive confidential communications by alternative means or to an alternative location. Celtic will accommodate your reasonable requests. Your request should be sent to: Attn: Policyowner Service Department, Celtic Insurance Company, P.O. Box 26110, Little Rock, AR 72221.

*Amend Your PHI:* You may request an amendment to your PHI in a designated record set for as long as Celtic maintains this information. Your request must be in writing, provide a reason to support the requested amendment, and sent to Attn: HIPAA Records Request Department, Celtic Insurance Company, 77 West Wacker Drive, 12th Floor, Chicago, IL 60601. In certain circumstances, Celtic may deny your request for an amendment. If Celtic denies your request for an amendment, you have the right to submit a statement of disagreement and Celtic may prepare a rebuttal to your statement. Celtic will provide you with a copy of any rebuttal. Since your health care providers are the original source of this information, you may consider making a request to amend your PHI directly to the individual providers.

*Receive an Accounting of Certain Disclosures:* You have the right to request an accounting of disclosures Celtic has made of your PHI. However, this right does not include any disclosures Celtic has made for purposes of treatment, payment or healthcare operations as described in this notice, nor does it include disclosures made for notification purposes. Please note that at the current time Celtic does not disclose PHI for any reason other than treatment, payment or healthcare operations.

*Complaints:* You have the right to voice a complaint to the U.S. Secretary of Health and Human Services if you believe your privacy rights have been violated. You also may file a complaint with Celtic by sending it to Attn: HIPAA Privacy Officer, 77 West Wacker Drive, 12th Floor, Chicago, IL 60601. Celtic will not retaliate against you for filing a complaint.


**Insured by Celtic Insurance Company**

Celtic Group Company