Wisconsin

CELTIC®

Celtic Health Plan

Underwritten by Celtic Insurance Company, Chicago, IL

PLEASE PRINT IN INK

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**

APPLICANT INFORMATION

PRIMARY APPLICANT 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's Name:

FIRST MIDDLE LAST

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

SPOUSE/DOMESTIC PARTNER INFORMATION:

Is the Spouse/Domestic Partner to be insured a U.S. citizen or a permanent legal resident of the U.S.? ☐ Yes ☐ No
(If "No," coverage cannot be granted.)

Has the Spouse/Domestic Partner to be insured used any type of tobacco product in the last 12 months? ☐ Yes ☐ No

APPLICANT INFORMATION (CONTINUED)

DEPENDENT INFORMATION: (Answer questions for each Dependent to be insured.)

Dependent's First Name: **Last Name:**

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

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

Dependent's First Name: **Last Name:**

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

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

Dependent's First Name: **Last Name:**

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

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

Dependent's First Name: **Last Name:**

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

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

Dependent's First Name: **Last Name:**

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

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

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.

INDIVIDUAL UNIFORM APPLICATION FOR INDIVIDUAL MAJOR MEDICAL HEALTH INSURANCE FORM

Ref: Section Ins 3.33, Wis. Adm. Code, and s. 601.41 (10), Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov

This form is designed for an individual's initial application for coverage. Please contact the insurer with questions regarding this form.

Instructions: Please complete the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application, please attach, sign and date each page.

I. INFORMATION

Primary Applicant/Insured Information:

First, Middle and Last Name				
Social Security No.*	Place of Birth	Birth Date	Gender	Height _____ Weight _____
Residential Address				
City	County	State	Zip Code	
Mailing Address, if different from residential address				
City	County	State	Zip Code	
Home Phone	Alternative Phone		Email (Optional)	

*If you have a Social Security Number.

The Primary Applicant is:

[ ] Single [ ] Married [ ] Under the age of 18**

**If primary applicant is under the age of 18, please complete sections – II. C. and V.

Employment Information:
Primary job duties:

Self-Employed: [ ] Yes [ ] No

II. ADDITIONAL APPLICANTS

A. Please complete ONLY if your spouse and/or children under the age of 27 are applying for coverage. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

Spouse Name (First; M.I.; Last)	Gender	Social Security Number*/ Place of Birth	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

Child Name (First; M.I.; Last)	Gender	Social Security Number*	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

B. Does the child(ren) named within this application live with you at the address shown above?

[ ] Yes [ ] No If "No," please list the child(ren)'s name and mailing address(es):

Mailing Address Named Applicant			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child.			

C. If the primary applicant is under the age of 18, provide the name and mailing address of the legal guardian or custodial parent:

Mailing Address Legal Guardian or Custodial Parent			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child			

III. CURRENT AND PREVIOUS COVERAGE

Please provide information about you or your dependent's individual or group health insurance coverage or other health coverage (either prior or current). It will help us determine whether you will have any waiting periods for preexisting conditions for the health insurance you are applying for. By providing this information you are not reducing your health insurance.

Does anyone applying for coverage have current health coverage?
[ ] Yes [ ] No If "Yes," please indicate insurer and applicant _____.

Has any applicant had health insurance coverage within the last 18 months?
[ ] Yes [ ] No If "Yes," please indicate insurer and applicant_____.

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted?
[ ] Yes [ ] No

Is any applicant enrolled in Medicare?
[ ] Yes [ ] No If "Yes," name of applicant _____. For this applicant, please stop here – this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid or other governmental health programs (i.e. BadgerCare, TRICARE, Veterans services)?
[ ] Yes [ ] No If "Yes," name of applicant _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

IV. MEDICAL INFORMATION

NOTICE TO APPLICANT:

The insurance company does not use or collect genetic information for any Underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the insurance company in any manner. For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.

You are required to disclose information regarding any disease or condition for which:

- Any applicant has been diagnosed or treated by any healthcare provider.
- Any applicant has had testing with abnormal results.
- Any applicant is awaiting test results.
- Any applicant has been recommended or scheduled for diagnostic testing, consultation, treatment, follow-up, or surgery.
- Any applicant has taken or has been advised to take any prescription medication.
- Any change in health status for which any applicant has not sought medical care or treatment.

Within the last FIVE (5) YEARS has anyone, including you or any family member requesting coverage, received counseling, care or treatment, medication, medical advice or been told a diagnosis for any of the conditions or illnesses listed below? (Please check all conditions that apply.)

Please mark "Yes" or "No" for each item, for you and any family members requesting coverage. Provide additional information for each question you answer "Yes" to on the Additional Medical Details page that follows the health questions.

Answers to the medical questions should be complete, true and correct to the best of your knowledge. You are required to promptly notify us if there is a change in your or your family's health prior to the effective date of coverage and provide updated information. If at any time during the underwriting process prior to the effective date of coverage, you or your health history changes, please notify us immediately as this may impact your coverage.

WITHIN THE LAST FIVE (5) YEARS:

1. Infectious and Parasitic Diseases

a. AIDS (acquired immunodeficiency syndrome), ARC (AIDS-related complex), HIV positive [The reporting of HIV test results is limited to FDA-licensed tests, and you need not report results of tests conducted at an anonymous counseling and [ ] Yes [ ] No

testing site or through the use of a home test kit.] .....
b. Lyme's Disease ..... [ ] Yes [ ] No
c. Sexually transmitted disease(s) ..... [ ] Yes [ ] No

2. Blood, Gland, Endocrine, Metabolic and Immune Disorders (other than HIV, ARC, AIDS)

a. Anemia/blood disorder ..... [ ] Yes [ ] No
b. Thyroid disease ..... [ ] Yes [ ] No
c. Diabetes/high or low blood sugar. ..... [ ] Yes [ ] No (If "Yes," record last HGA1C reading and date on the Additional Medical Details page.)
d. Adrenal disorder ..... [ ] Yes [ ] No
e. Enlargement of lymph nodes ..... [ ] Yes [ ] No
f. Endocrine/gland/hormone system ..... [ ] Yes [ ] No

3. Cancer, Cyst and Tumors

a. Cancer. ..... [ ] Yes [ ] No (If "Yes," include the stage, type and location of the tumor on the Additional Medical Details page.)
b. Tumors, cyst, lump, polyp ..... [ ] Yes [ ] No

4. Mental/Nervous/Behavioral Disorders

a. Alcohol/chemical/drug abuse/dependency ..... [ ] Yes [ ] No
b. Has any applicant used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs? ..... [ ] Yes [ ] No
c. Eating disorders such as, but not limited to, anorexia or bulimia ..... [ ] Yes [ ] No
d. Mental/emotional condition/depression ..... [ ] Yes [ ] No
e. Autism ..... [ ] Yes [ ] No
f. Suicide attempt ..... [ ] Yes [ ] No
g. Alcohol, chemical, drug abuse therapy, treatment or counseling within last 5 years ..... [ ] Yes [ ] No (if "Yes," record date of last session in on the Additional Medical Details page)

5. Brain and Nervous System

a. Brain disease or injury/concussion ..... [ ] Yes [ ] No
b. Convulsion/seizures/epilepsy ..... [ ] Yes [ ] No
c. Chronic headaches/migraines ..... [ ] Yes [ ] No
d. Neurological condition/disease/injury ..... [ ] Yes [ ] No
e. Sleep apnea/chronic sleep disorder ..... [ ] Yes [ ] No
f. Stroke ..... [ ] Yes [ ] No
g. Multiple Sclerosis ..... [ ] Yes [ ] No
h. Paralysis ..... [ ] Yes [ ] No

6. Skin Disorders

a. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer ..... [ ] Yes [ ] No

7. Eyes, Ears, Nose

a. Chronic ear/nose condition/disease	[ ] Yes [ ] No
b. Chronic eye condition/disease	[ ] Yes [ ] No
c. Cataracts/glaucoma	[ ] Yes [ ] No

8. Mouth, Throat or Jaw

a. Chronic throat/tonsil/adenoid/disease/disorder	[ ] Yes [ ] No
b. TMJ/jaw joint	[ ] Yes [ ] No

9. Heart or Circulatory System

a. Blood/circulatory disorder	[ ] Yes [ ] No
b. Heart attack/chest pain/murmur/angina	[ ] Yes [ ] No
c. Elevated/High cholesterol (if "Yes," record last reading and the date on the Additional Medical Details page)	[ ] Yes [ ] No
d. Elevated/High or low blood pressure (if "Yes," record last 3 readings and dates in past 12 months on the Additional Medical Details page)	[ ] Yes [ ] No
e. Phlebitis/blood clot	[ ] Yes [ ] No
f. Heart disease/disorder	[ ] Yes [ ] No

10. Respiratory System

a. Asthma	[ ] Yes [ ] No
b. Emphysema/Chronic obstructive pulmonary disease (COPD)	[ ] Yes [ ] No
c. Chronic respiratory/lung condition	[ ] Yes [ ] No
d. Pneumonia/bronchitis	[ ] Yes [ ] No

11. Digestive System

a. Appendicitis/chronic abdominal pain	[ ] Yes [ ] No
b. Blood in stool	[ ] Yes [ ] No
c. Colon/rectum/intestine/bowel/Crohn's disease	[ ] Yes [ ] No
d. Ulcer/esophageal reflux	[ ] Yes [ ] No
e. Gallbladder	[ ] Yes [ ] No
f. Liver condition/hepatitis/pancreas	[ ] Yes [ ] No

12. Urinary System

a. Bladder/urinary tract	[ ] Yes [ ] No
b. Kidney/kidney stones	[ ] Yes [ ] No

13. Male or Female Reproductive Systems

a. Breast (lumps or masses)	[ ] Yes [ ] No
b. Prostate/elevated PSA/prostatitis	[ ] Yes [ ] No
c. Reproductive system disorder/infertility/dysfunction	[ ] Yes [ ] No
d. Abnormal pap smear or mammography	[ ] Yes [ ] No

14. Pregnancy, Birth or Congenital Abnormalities

a. Birth defect/congenital deformities	[ ] Yes [ ] No

b. Pregnancy complications	[ ] Yes [ ] No
c. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date _____.)	[ ] Yes [ ] No

15. Muscular or Skeletal System

a. Back/neck/spine disorder	[ ] Yes [ ] No
b. Bone/orthopedic disorder	[ ] Yes [ ] No
c. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia	[ ] Yes [ ] No
d. Osteoarthritis/osteoporosis/osteopenia	[ ] Yes [ ] No
e. Rheumatoid arthritis	[ ] Yes [ ] No
f. Knee/shoulder/hip/joint surgery/disorder	[ ] Yes [ ] No
g. Hernia	[ ] Yes [ ] No

16. Miscellaneous

a. Cosmetic surgery/implants	[ ] Yes [ ] No
b. Use of prosthetic devices/limbs	[ ] Yes [ ] No
c. Had chronic fatigue	[ ] Yes [ ] No
d. Is any person to be insured now disabled, on disability, or unable to perform normal work or age-related activities	[ ] Yes [ ] No
e. Any fluctuations in weight (+/- 20lbs) in the past 12 months	[ ] Yes [ ] No
f. Implantable devices/stents/shunts/pace maker	[ ] Yes [ ] No
g. Allergies	[ ] Yes [ ] No
h. Transplants	[ ] Yes [ ] No

17. Other Injury, Illness, Treatment or Condition

a. Within the last 5 years, has any applicant had any other injury, illness, treatment, or condition not already listed; been hospitalized or scheduled to be hospitalized; had surgery or had surgery scheduled; had a test or a test scheduled; been recommended to have a test or surgery that was not performed for any reason not already mentioned; been prescribed medication for a condition or injury not already mentioned? (We are NOT seeking the results of HIV Antibody test.)	[ ] Yes [ ] No

18. Tobacco Use

a. Has any applicant used tobacco products in any form within the last 12 months?	[ ] Yes [ ] No
If "Yes", provide the name of applicant(s), amount of tobacco used and frequency:	

19. Other Activities

a. Has any applicant been involved in or participated in organized motorized racing or other extreme activities?	[ ] Yes [ ] No
If "Yes", provide the name of applicant(s), activity and frequency of the activity:	

ONLY complete this section if you need assistance with completing the medical information portion of this Application. Please note that this may require additional time to process your application.

Please contact me at this phone number during business hours:

I am unavailable during business hours, please contact me at this number during evenings or weekends:

Additional Medical Details Page

For any "Yes" responses in the medical information questions, please provide complete details below. Not providing complete details will delay the application process. Within the last five years has anyone been prescribed medications that were recommended or received from a licensed health care professional? Use an additional sheet(s) of paper if necessary.

All additional pages must be signed and dated by the primary applicant.

Question # or additional information								
Applicant Name								
Specific Diagnosis & Type of Treatment								
Duration of Condition	**Began mm/yy**		**Began mm/yy**		**Began mm/yy**		**Began mm/yy**	
	End mm/yy		**End mm/yy**		**End mm/yy**		**End mm/yy**	
Name/ Dosage/ Frequency of medication & Dates of Medication Use	**Name of Rx**		**Name of Rx**		**Name of Rx**		**Name of Rx**	
	Dose		**Dose**		**Dose**		**Dose**	
	Began mm/yy	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**
Was surgery performed								
Description of surgery/ Procedures/ Tests/Result & Dates								
Current Status/ O-Ongoing/ R-Resolved								
Readings for Blood Pressure, Cholesterol & Diabetes	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**
Physician/ Hospital Name, City, State								

V. TERMS AND CONDITIONS

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified the person(s) who assisted me. I agree that the answers are, to the best of my knowledge and ability, complete and true.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company on the certificate or policy.

I understand that any intentional misrepresentation relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a family member made an intentional misrepresentation in the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application that is intended to mislead an insurer or conceal significant information about the applicant.

I understand that I may request a copy of this Application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original.

Signature (or e-signature) of Primary Applicant (If Primary Applicant is under the age of 18, Signature of legal guardian or custodial parent)	**Date Signed**
Signature (or e-signature) of Spouse	**Date Signed**

Signature (or e-signature) of each listed child who has attained the age of 18

Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**Date Signed**

Complete this section if someone assisted you in the completion of this Application

The following person assisted me in completing the Application:
Please explain the assistant's relationship to you and your family:

Individual Uniform Application Form

OCI 26-503 (c. 06/2010)

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

CELTIC INSURANCE COMPANY
77 West Wacker Drive, 12th Floor, Chicago, IL 60601

Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with coverage to be issued by CELTIC INSURANCE COMPANY. Your new policy provides 10 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under your new policy.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

2. The new policy may be issued at a higher age than your present coverage. If so, the cost may be higher.

3. If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be sure to truthfully and completely answer all questions on the application. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____ _____

(Applicant) (Date)

_____

(Print) Applicant's Name