

Your Rights Your Options



**CONVERSION
P R O G R A M**



Earning Your Trust, Every Day

CONVERSION COVERAGE GUARANTEED

Celtic Conversion Coverage guarantees your right to medical coverage regardless of your health or past medical history.

Even though coverage through your group health plan, policy or COBRA is about to expire, you will be relieved to know that you have been provided the option to obtain major medical insurance. Even after your health plan or COBRA benefits expire, you will have the right to choose a plan that's right for you.

Select the coverage that best meets your needs.

In addition to Celtic Conversion Coverage, Celtic also offers a Short-Term Health plan to persons who only need medical insurance for a limited period of time and who can meet Celtic's underwriting requirements. To determine which plan may best fit your needs ask yourself the following questions.

Celtic Conversion Coverage

- Do you need health insurance for a long period of time?
- Do you need health insurance for a serious or ongoing medical condition?
- Do you need immediate coverage for any pre-existing health conditions?
- If you answered "yes" to **any** of the above, then Conversion Coverage is probably the best plan for you.

Celtic Short-Term Health Plan*

- Do you need health insurance for only a short time? (*ie. A few months*)
- Are you in good health and free of any serious or ongoing medical conditions?
- Are you able to accept limited coverage for pre-existing conditions?
- If you answered "yes" to **all** of the above, then Short-Term coverage may be the best plan for you.

For additional information regarding Short-Term, call **(800) 365-2365**.

IF YOU HAVE SELECTED CELTIC CONVERSION COVERAGE

You are eligible if:

You were covered for three consecutive months under your group plan* and you have met the maximum period of eligibility under COBRA (providing COBRA is available). You may apply if you are in any of the following categories:

1. You and/or your dependents are no longer eligible under your group plan or any other medical plan.
2. The covered group plan participant has died, and you are a dependent spouse or child.
3. You have moved out of the service area of your participating HMO.
4. You are a covered dependent that has reached the maximum age under the group plan.

* Note: In the states of AZ, NM, and OK you may be eligible regardless of how long you were covered under your group plan. However, to be eligible you must still meet the other requirements listed above.

You are not eligible if:

1. Your group health plan was discontinued.
2. Your employer's group plan ended and there is a succeeding medical expense plan.
3. You or your employer failed to pay the required premium and/or fees.
4. You are age 65 or older.
5. You are covered or eligible for Medicare or other medical expense benefits offered by any group plan, individual policy, prepayment plan, government program or any other plan which, according to our rules, results in excessive coverage or over-insurance.
6. You fail to apply for Conversion within 31 days after your group coverage or COBRA coverage terminates. (Note: Some states allow a longer period of time to convert. Please contact Celtic at **(800) 365-2365** for more information.)

Celtic Conversion Coverage & Benefits

Celtic offers a variety of Conversion health plans to meet your needs. Specific benefits may vary from state to state.

Further information concerning rates and benefits can only be provided to you upon our receipt of this completed form within the 31 day period referred to above.

Details concerning Celtic Short-Term health coverage can be obtained by calling Celtic directly at **(800) 365-2365**.

HEALTH PLAN COMPARISON AT-A-GLANCE

	CONVERSION COVERAGE	SHORT-TERM HEALTH PLAN
Benefits	Choice of plan maximums, subject to certain dollar limits	Choice of deductibles, plan maximums generally higher than conversion
Pre-Existing Conditions	Fully covered and subject to policy limitations	Not covered in most states
Length of Coverage Period	Continues in force as long as premiums are paid	1 to 6 months only
Underwriting Requirements	None. Coverage is guaranteed regardless of present health or past medical history	Must be in excellent health and able to answer "no" to all health questions on the application
Cost	Higher than Short-Term and possibly more than COBRA Continuation	Relatively inexpensive
To Apply	Complete the information requested in the brochure and send it to us.	For additional information regarding Short-Term, call (800) 365-2365 .

* Not available in all states. For further information contact Celtic or refer to the brochure.

NOTIFICATION OF YOUR RIGHT TO CONVERT

Celtic Insurance Company • 233 S. Wacker Drive, Suite 700 • Chicago, IL 60606

FOR OFFICE USE ONLY

GENERAL INFORMATION *(To be completed by Applicant)*

Please fill out the following information completely or this form will be returned to you. **PLEASE PRINT**

My participation in my present medical expense plan is provided by: *(Name of Employer)* _____

My Employer's plan terminated effective: _____ My CONTINUATION/COBRA PLAN terminated effective: _____

THIS IS NOT AN APPLICATION FOR COVERAGE!

I hereby request Celtic Insurance Company to provide me with information regarding Conversion Coverage. The Conversion Coverage, if applied for, and if issued, will be effective on the day following the date that participation in the group medical plan terminates.

Are any dependents to be covered?: Yes No If "Yes", please fill in below:

NAME	RELATIONSHIP	BIRTH DATE	AGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were these dependents covered under the prior group plan?: Yes No If "No", please explain: _____

Are you, or any other person for whom coverage is being applied, currently employed, or expect to be employed in the near future?:

Yes No If "Yes", please explain: _____

If "Yes", was medical insurance offered?: Yes No

Was the medical insurance declined?: Yes No

Will a medical insurance plan be offered at a later date?: Yes No If "Yes," please indicate date coverage will be effective: _____

Are you, or any other person for whom coverage is being applied, eligible for or covered by an other medical expense insurance policy *(either individual or group)*, medical service subscriber contract or prepayment plan, or any other plan or program (insured or uninsured) offered privately or through a government program?: Yes No **If "Yes", please include a copy of your policy.**

To be eligible for conversion Coverage, mail this completed form within 31 days of termination of coverage to:

Celtic Insurance Company • P.O. Box 06469 • Chicago, IL 60606 • (800) 365-2365

Name: *(person whose benefits are terminating)* _____

Date of Birth: _____ Age: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone Number: (____) _____

How were you covered under the employer's group plan? Employee Spouse Dependent

Reason for termination of group plan coverage: _____

EMPLOYER'S OR ADMINISTRATOR'S STATEMENT *(To be completed by former employer or administrator)*

Name of Employer or Administrator: _____ Parent Company Name: _____

Employer Headquarters Address: _____

City: _____ State: _____ Zip: _____ Phone Number: (____) _____

Date applicant first became covered under: THE GROUP PLAN: _____ CONTINUATION/COBRA PLAN: _____

Date applicant coverage terminated under: THE GROUP PLAN: _____ CONTINUATION/COBRA PLAN: _____

Reason for termination: _____

If applicant is a former employee, last day actively at work: _____

Is the applicant covered under any other extension of benefits provision?: Yes No If "Yes", please explain: _____

Are benefits limited by a pre-existing condition for this applicant?: Yes No If "Yes", please explain: _____

Is the applicant eligible for, or covered by, any other medical expense benefit plan?: Yes No If "Yes", name & details of benefit plan: _____

Person completing Employer Statement: _____ Title: _____ Phone Number: (____) _____

I hereby certify that the above information is correct to the best of my knowledge. I have enclosed a copy of the employee's enrollment card.

Employer's or Administrator's signature: _____ Date: _____

Please print in ink

Group Number

(For Administrative Use Only)

THREE EASY STEPS TO OBTAIN A CONVERSION APPLICATION

To obtain an application and to receive more information about Celtic Conversion Coverage, take the following steps:

1. Complete the "General Information" section in this brochure.
2. Have your administrator or former employer fill out the "Administrator's or Employer's Statement" section of this brochure.
3. Send the completed forms to:

Celtic Conversion Coverage

P.O. Box 06469

Chicago, IL 60606

or fax us at (312) 441-0822

Remember that your employer or your group health plan is providing you with the option to obtain Celtic Conversion Coverage. It is now up to you to exercise your Conversion option by completing this form and returning it to Celtic within 31 days after the date your health coverage ends. *(Some states allow a longer period in which to exercise your option. Please contact Celtic directly for more information.)*

If you have any questions or require additional information, please call a Celtic Conversion Client Services Representative at **(800) 365-2365**.



Solid, Strong, Committed . . .

these are the characteristics that have shaped Celtic Insurance Company. And they are representative of the way in which we conduct business. Celtic is a company known for financial stability. We have always protected our customers with a conservative investment strategy and reliable products. We also believe our quality products should be backed by superior service. So you can count on our well trained personnel to administer your policy efficiently and without delay.

CELTIC

Insured by Celtic Insurance Company, a Celtic Group Company
2004 Celtic Insurance Company