

OHIO

CELTIC

# Open Enrollment Application

UNDERWRITTEN BY CELTIC INSURANCE COMPANY, CHICAGO, IL

Please print in ink

**Requested Effective Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)

NOTE: the 29, 30 and 31 of the month are not eligible as effective dates. Application is valid within 60 days from the signature date.

**Initial Payment Method:**

One month/quarter premium: (Complete Section 3)

- Credit card (including Check/Debit cards)  
 Check

**Subsequent Payment Schedule:**

- Monthly Automatic Pay  
 Monthly Billing\* - One month premium required  
 Quarterly Billing\* - Three months premium required

\*Billing fee applies

**Total Payment Submitted:**

\$ \_\_\_\_\_ /Monthly

\$ \_\_\_\_\_ /Quarterly

**SECTION 1: GENERAL INFORMATION**

If child-only coverage is being requested, the child is the primary applicant and a separate application must be completed for each child.

**Primary Applicant's Name:****Sex:**  Male  Female

FIRST		MIDDLE		LAST	
<b>Birth Date:</b> / /	<b>Age:</b>	<b>Social Security Number:</b>			
<b>Address:</b>			<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Home Phone Number:</b> ( )	<b>Best Time To Call:</b> a.m. p.m.	<b>Phone Number during regular business hours:</b> ( )			
<b>Primary Applicant's Current Residential Address:</b>					

STREET CITY STATE ZIP

**Is the Primary Applicant to be insured a U.S. citizen or a permanent legal resident of the U.S.?**  Yes  No**GUARDIAN INFORMATION:** (For Applicants under 18 years of age)**Guardian's Name:** (with whom the child resides)

FIRST		MIDDLE		LAST	
<input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Grandparent <input type="checkbox"/> Other _____					

**BILLING INFORMATION:** If different from Primary Applicant's Residential Address (Please send bills to)**Name and Billing Address:**

NAME STREET CITY STATE ZIP

**PLAN INFORMATION****Who is to be insured?**  Applicant (only)  Applicant/Spouse  Applicant/Child(ren)  Family**DEPENDENT INFORMATION:** (Complete only for dependents to be covered under this plan.)

<b>Spouse's Name:</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Spouse's Social Security Number:</b>
FIRST MIDDLE LAST		

<b>Phone Number during regular business hours:</b> ( )	<b>Best Time To Call:</b> a.m. p.m.
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<b>Birth Date:</b> / /	<b>Age:</b>
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**Is the spouse a U.S. citizen or a permanent legal resident of the U.S.?**  Yes  No

**SECTION 1: GENERAL INFORMATION (continued)****DEPENDENT INFORMATION:** (Continued)

ACCURATE READINGS REQUIRED

Name of Dependent Child(ren): First & Last Name	Social Security Number:	Birth Date:	Age:	Sex: (M/F)	HT. (ft. & in.)	WT. (lbs.)	*US Citizen or Permanent Legal Resident (yes/no)

**PLAN OPTIONS:** (Choose ONE of the three plans):

- Basic:** \$1,000 deductible, 50/50 coinsurance
- Standard:** \$750 deductible, 70/30 coinsurance
- PPO Plan:** \$750 deductible, 80/20 coinsurance (in-network) / 60/40 coinsurance (out-of-network)

**SECTION 2: ELIGIBILITY VERIFICATION**

Due to recent changes in Ohio state law, the following information must be completed in order to determine your eligibility rights. These questions must be answered truthfully and completely to the best of your knowledge and belief.

**CHOOSE ONE:**

- FEDERALLY ELIGIBLE:** List all health insurance coverage in the past 18 months starting with the most recent coverage. (This information is required for all federally eligible individuals applying for coverage through open enrollment.)

Applicant:	Insurance Carrier, Company, Provider:	*Type of Coverage:	Effective Date:	Termination Date:	Reason for Termination:

**For all coverage listed above, please attach acceptable \*\*proof of coverage.**

\* Type of coverage: Employment Based Group Health Plan, including HMO, COBRA, State Continuation, Individual, Governmental, CHAMPUS, Peace Corp., Medicare or Medicaid, etc.

\*\* Acceptable proof of coverage includes carrier-issued Creditable Coverage Certifications, Explanation of Benefits (EOBs), Billing Statements, Employer letters regarding coverage, any documentation which provides enough information to confirm type, dates of coverage, etc.

**Were you or your dependents covered under any other Health Insurance plan in the last 18 months?**  Yes\*  No

**\*If "Yes," what type of coverage was your or your dependents last plan?**

- Employer Based Group  Individual  COBRA  Other

**If you currently have a major medical plan in force or had coverage in the last 18 months complete the following:**

Name of covered individual(s): \_\_\_\_\_

Carrier Name: \_\_\_\_\_

**IMPORTANT:** DO NOT cancel any existing health coverage until written notification of your acceptance by Celtic.

- NON-FEDERALLY ELIGIBLE**

**Is anyone applying for coverage currently confined to a health care facility because of a chronic illness, permanent injury or other infirmity?**  Yes  No

**For both Federally Eligible and Non-Federally Eligible individuals, please answer the following questions.**

If the answer is YES to ANY of the following questions please give name of applicant and details:	Name of Applicant:	Date of Eligibility:	Date Eligibility Ends:
Is anyone applying for coverage <b>eligible</b> Medicare A or B?			
Is anyone applying for coverage <b>eligible</b> for coverage under an employer sponsored or employee based group health plan, governmental plan or church plan?			
Is anyone applying for coverage <b>eligible</b> for COBRA or State Continuation?			
Is anyone applying for coverage <b>eligible</b> Medicaid?			

**SECTION 3: PREMIUM PAYMENT METHOD AND AUTHORIZATION AGREEMENT**

**INITIAL PAYMENT: CREDIT CARD OR CHECK, PRODUCER PAYMENTS ARE NOT ACCEPTED**

1. For Initial Payment Only: I authorize Celtic Insurance Company to bill my account for the initial payment and I agree to pay the initial payment billed in accordance to my payment selection on this application by checking the following credit card box:

VISA® (including Check/Debit cards\*)  Mastercard® (including Check/Debit cards\*)  Discover®

\* Debit cards must have a Visa or Mastercard logo on the front of the Debit Card.

Card No.:  Expiration Date (MO/YR):

Cardholder's Name: \_\_\_\_\_

2. Or, attach your check below for total payment submitted.

**MONTHLY AUTOMATIC PAY PLAN**

**Note:** If your withdrawal is not honored by your bank, you will be removed from the Monthly Automatic Pay Plan and sent a paper bill.

Payor Name or Depositor if different: (Please print)

FIRST MIDDLE LAST

Relationship to Applicant:  Self  Parent  Legal Guardian  Other \_\_\_\_\_

Signature of Primary Payor: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Financial Institution: \_\_\_\_\_

Specify type of account:  Checking or  Savings **Checking/Savings Account Number:** \_\_\_\_\_

**ABA 9 Digit Routing Number:** (See below or please call your Financial Institution for assistance)

Celtic Insurance Company is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month, until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Health Plan is not issued.

I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by Celtic Insurance Company, and I agree that the bank named shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Celtic Insurance Company in writing.

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**ATTACH YOUR INITIAL CHECK OR MONEY  
ORDER FOR PREMIUM PAYMENT**

Joe Smith  
123 Main Street  
Anytown, IL 12345

Date \_\_\_\_\_

Pay to the order of \_\_\_\_\_ \$

\_\_\_\_\_ Dollars

**Routing Number**

For \_\_\_\_\_

123456789 1234567891011 1117

**DO NOT STAPLE CHECKS TO FORM.**

## SECTION 4: AGREEMENT AND 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 a producer or company representative allowed to permit me to answer any question inaccurately or untruthfully and I represent that such did not occur. The producer is not authorized to alter any terms of the Health Plan. I understand that I may not pay cash or make checks payable to the agent or broker, or leave the payee blank.
- 2. OTHER COVERAGE:** I understand that in order to be eligible for this coverage, neither I, nor any dependents to be insured can be covered under any other major medical plan. I hereby attest that no one applying for coverage under the Health Plan will be covered under any other coverage.
- 3. PREFERRED PROVIDER ORGANIZATION:** I understand if I have selected the PPO plan option 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.
- 4. 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 eligible dependents, 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, 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.
- 5.** In completing this form I understand that I have met the initial criteria to be eligible for the Open Enrollment policy in the State of Ohio. I understand that further information may be required to confirm my eligibility, or that of my dependents, and that the insurance company may deny coverage if I refuse to cooperate, to the best of my ability, with any attempt to confirm eligibility. If I am denied coverage any premium payments which I have submitted will be returned to me in full. I also understand that my initial eligibility application included the names of all individuals for whom I am applying for coverage. I further understand that failure to include an individual on the initial eligibility application may result in the denial of coverage for that individual.

**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 and subjects such person to criminal and civil penalties.**

Signature of PRIMARY APPLICANT: \_\_\_\_\_

Signature of SPOUSE: \_\_\_\_\_

Date: \_\_\_\_\_

## SECTION 5: PRODUCER INFORMATION

**You must be currently licensed and appointed with Celtic in the state where the application was completed.**

**NOTE: If you have written business with Celtic *in this state* during this calendar year, just complete your name, Social Security number and sign below. There is no need to submit a copy of your license with every case.**

<b>Writing Producer's Name:</b>	<b>Producer Number:</b>	
<b>Address:</b>		
<small>CITY</small>	<small>STATE</small>	<small>ZIP</small>
<b>Telephone Number:</b> (Including Area Code)	<b>Fax Number:</b> (Including Area Code)	
<b>Email:</b>		

**Mail this application to:**

**Celtic Insurance Co.  
P.O. Box 26110  
Little Rock, AR 72221  
[www.celtic-net.com](http://www.celtic-net.com)**

## PLEASE KEEP THE FOLLOWING SECTIONS FOR YOUR RECORDS

### NOTICE OF INFORMATION PRACTICES

In order to properly underwrite and administer your insurance coverage, we must collect personal information concerning your insurability. 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, including the nature and scope of information contained in investigative consumer reports. 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, Underwriting Department, 233 South Wacker Drive, Suite 700, Chicago, IL 60606.

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

### CONDITIONAL RECEIPT FOR HEALTHPLAN

#### ALWAYS COLLECT THE INITIAL PREMIUM AND GIVE THE APPLICANT THIS CONDITIONAL RECEIPT.

No insurance will become effective prior to the approval of your application by Celtic. No producer or broker is authorized to alter or waive any of the following provisions of the receipt:

Applicant's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Amount Received: \_\_\_\_\_

Date: \_\_\_\_\_

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/quarter of the first yearly premium has been paid, and the check, credit card or bank draft is honored on the first presentation for payment.

"Effective Date" as used herein means 12:01 a.m. on the later of: (A) the Requested Effective Date; (B) the day following the post-marked date on the application envelope addressed to Celtic; the day following the fax date to Celtic; or the date after the electronic submission of the application to Celtic.

If no postmarked date, the effective date is the day 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, 233 South Wacker Drive, Suite 700, Chicago, IL 60606.

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, 233 S. Wacker Dr., Suite 700, Chicago, IL 60606. 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 33839, Indianapolis, IN 46203-0839. 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 33839, Indianapolis, IN 46203-0839.

*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, 233 S. Wacker Dr., Suite 700, Chicago, IL 60606. 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, 233 South Wacker Drive, Suite 700, Chicago, IL 60606. Celtic will not retaliate against you for filing a complaint.