ADA Hospital Indemnity Plan

Application for Insurance HIWS17

ADA American Dental Association® GREAT-WEST FINANCIAL™

Read all forms | Complete sections 1 thru 10 | Mail or Fax ALL completed forms

Questions? 866.607.5334 | insurance.ada.org | planspecialist@greatwest.com | **Submit to:** P.O. Box 340 | Denver, CO 80201 | Fax: 303.737.4843

1 Member Information

Please print legibly

ADA Number

Full Legal Name

Address

City State ZIP

Office Phone

Home Phone

Fax Number

Cell Phone

Email

Best way to be contacted (if needed): ☐ Phone ☐ Email

☐ Yes! Please sign me up to receive promotional information and announcements from ADA Members Insurance Plans via email.

2 Eligibility Verification

You must be under age 65 to request new or additional Member, Spouse or Domestic Partner, and/or Child coverage. If you are 65 or over and already insured in this Plan, you may enroll your Legal Spouse or Domestic Partner under age 65 and/or eligible dependents under age 21, or under age 27 if a full-time student.

☐ Yes ☐ No Are you an ADA member under age 65?

☐ Yes ☐ No Are you full-time, active military?

☐ Yes ☐ No Are you actively engaged in the full-time duties of your profession? ***Must work at least 20 hours per week.***
If "No", please give details: _____

3 Guaranteed Acceptance Coverage

Basic Hospital Indemnity Coverage is guaranteed for all eligible enrollees. You may select any Hospital Daily Benefit amount between $100 and $1,000 (in $50 increments only). *All family members insured under this Plan will have the same Hospital Daily Benefit. Contact an Insurance Plan Specialist for details at 866.607.5334.*

Extended Care Rider requires underwriting - see sections 6 and 7.

Hospital Daily Benefit Requested:

☐ $1,000 (maximum)
☐ $100 (minimum)
☐ Other: $_____ (minimum $100 benefit with additional $50 increments)

Individuals to Enroll:

☐ **Member** Full Name / / Date of Birth Gender: ☐ Male ☐ Female

☐ **Spouse** or ☐ **Domestic Partner*** Full Name / / Date of Birth Gender: ☐ Male ☐ Female

☐ **Child(ren)** Full Name / / Date of Birth Relationship Gender: ☐ Male ☐ Female

Full Name / / Date of Birth Relationship Gender: ☐ Male ☐ Female

Full Name / / Date of Birth Relationship Gender: ☐ Male ☐ Female

When applying for coverage for a Domestic Partner, you and your partner must also complete an Affidavit of Domestic Partnership. Call 800.568.2001 or visit insurance.ada.org to obtain this form.

Continue to next page for payment information and signature.

Continue to next page

4 Payment Information

Please complete this section **ONLY** if you are applying for coverage for the **FIRST TIME**.

I wish to pay premiums by: **(select one)**:

- ☐ Check (semi-annual)
- ☐ Autopay (semi-annual)
- ☐ Autopay (monthly, 1st of the month)*
- ☐ Autopay (monthly, 10th of the month)*

*A 2% service charge will be added to monthly Autopay withdrawals

Autopay Terms and Conditions: All monthly withdrawals will be made, as elected, on the 1st or 10th of the month in which premium is due. Autopay will terminate (1) when you (or the bank depositor, if other than the Certificate owner) provide Great-West Life & Annuity Insurance Company 30 days' written notice; or (2) at Great-West Life & Annuity Insurance Company's election, upon 30 days' written notice to you and/or the bank depositor; or (3) at the discretion of Great-West Life & Annuity Insurance Company, if your designated bank does not transfer funds. In this case, you will receive a lapse notice detailing how to reinstate your coverage. Should the Autopay program terminate, you will be notified to select another payment preference.

Send no money now; you will be billed later.

If you selected Autopay, please fill out the information below and ATTACH a VOIDED check to your application.

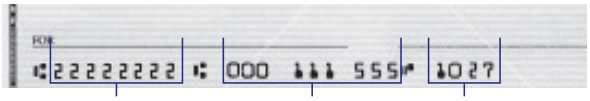
Bank Name

Routing No.

Account No.

Account Holder's name (if other than yourself)

Check one: ☐ Checking ☐ Savings



Routing Number Account Number Check Number

To ensure accurate account information, please ATTACH a voided check or deposit slip to your application.

5 Signature

With regard to the Guaranteed Acceptance Coverage, I understand that the Company will not pay for any condition for which I or any of my eligible dependents received medical treatment, care, medication, or advice within 12 months prior to the effective date of New Coverage or any Increase Coverage, until such Coverage has been in force for 12 consecutive months without medical treatment, care, medication, or advice being rendered or recommended for such condition or until such Coverage has been in force for 24 consecutive months, whichever occurs first. The Guaranteed Acceptance Coverage will become effective as of the date your completed Application is received at the Company's Executive Offices, subject to payment of your premium when billed. You will be sent a Certificate and a notice of the interim premium due from the date Coverage begins until the next renewal date. When you have paid this premium, you will receive your Certificate. If the Member or an eligible Dependent is confined in a hospital on the effective date, then the coverage will not start until the date the Member or Dependent is discharged from the hospital.

Signature of Member Date of Signature / /

STOP

GUARANTEED ACCEPTANCE COVERAGE ONLY

Stop here if you are ONLY requesting Hospital Indemnity Coverage.

GO

OPTIONAL COVERAGE:

If you are applying for the Extended Care Rider, you MUST COMPLETE sections 6-10.

6 Optional Coverage: Extended Care Rider Requested

You may apply for an optional Extended Care Rider that pays the following Benefits:

Home Health Care:	$100 per day up to a maximum benefit of $20,000
Skilled Nursing Facility:	$250 per day up to a maximum benefit of $50,000*
Nursing Home:	$250 per day up to a maximum benefit of $50,000*

**An elimination period is applied starting at age 70*

You may apply for (a) Member coverage only, (b) Member and Spouse or Domestic Partner coverage, or (c) Spouse or Domestic Partner coverage only (Member must have Guaranteed Acceptance Coverage).

Yes, I am applying for the Extended Care Rider for:

- ☐ **Myself only; or**
- ☐ **Myself and my Spouse or Domestic Partner**

Each applicant must be under age 65 to apply for new or increased Optional coverage and is subject to medical underwriting.

Continue to next page

7 Medical Questionnaire for Extended Care Rider

Complete this section by answering ALL questions if applying for the Optional Extended Care Rider.

Please answer all questions for each applicant.

		Member	Spouse/ Domestic Partner
1.	Have you been diagnosed with or received treatment, care, advice, or medication for any of the following conditions, procedures, or diseases:		
a.	Partial or total loss of hearing in one or both ears, middle ear tumor or acoustic nerve tumor?	☐ Yes ☐ No	☐ Yes ☐ No
b.	Partial or total loss of speech or motor neuron disease?	☐ Yes ☐ No	☐ Yes ☐ No
c.	Partial or total loss of sight, including but not limited to blindness, glaucoma, vision worse than 20/100 corrected?	☐ Yes ☐ No	☐ Yes ☐ No
d.	Alzheimer's disease or other types of dementia?	☐ Yes ☐ No	☐ Yes ☐ No
e.	Cancer in any form, other than basal carcinoma?	☐ Yes ☐ No	☐ Yes ☐ No
f.	Heart disease or disorder, including but not limited to angina, cardiomyopathy, heart attack, congestive heart failure, heart valve surgery, coronary artery disease, or congenital heart disease?	☐ Yes ☐ No	☐ Yes ☐ No
g.	Circulatory system disease or disorder, including but not limited to stroke, TIA, arterial blockage, cerebral vascular insufficiency, hemophilia, peripheral vascular blood vessel disease?	☐ Yes ☐ No	☐ Yes ☐ No
h.	Respiratory system disease or disorder, including but not limited to asthma, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, pulmonary fibrosis?	☐ Yes ☐ No	☐ Yes ☐ No
i.	Chronic kidney disease or disorder, polycystic kidney disease, or kidney failure?	☐ Yes ☐ No	☐ Yes ☐ No
j.	Central Nervous system disease or disorder to include but not limited to Huntington's chorea, multiple sclerosis (MS), Parkinson's disease, or paralysis?	☐ Yes ☐ No	☐ Yes ☐ No
k.	Neuromuscular disease or disorder to include but not limited to ALS, muscular dystrophy, myasthenia gravis?	☐ Yes ☐ No	☐ Yes ☐ No
l.	Endocrine disease or disorder, including but not limited to diabetes, pituitary tumor, Addison's, or Cushing's?	☐ Yes ☐ No	☐ Yes ☐ No
m.	Autoimmune disease or disorder, including but not limited to lupus, psoriasis, scleroderma, ankylosing spondylitis?	☐ Yes ☐ No	☐ Yes ☐ No
n.	Liver disease or disorder, including but not limited to Hepatitis (other than type A), or cirrhosis?	☐ Yes ☐ No	☐ Yes ☐ No
o.	Any organ or tissue transplant (or awaiting one subject to availability of a donor)?	☐ Yes ☐ No	☐ Yes ☐ No
2.	Have you ever tested positive for HIV or its antibodies or been diagnosed with or treated for AIDS, AIDS related disease by a licensed member of the medical profession?	☐ Yes ☐ No	☐ Yes ☐ No
3.	Have you been hospitalized three or more times in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No
4.	Are you currently confined to a hospital or nursing home, or has hospitalization been recommended by a physician?	☐ Yes ☐ No	☐ Yes ☐ No
5.	Do you use a Walker, Motorized Scooter, Stair Lift, Wheelchair or Quad Cane; Hospital Bed; Oxygen, Respirator or Kidney Dialysis; or need assistance or supervision by another person in performing any of the following: Moving in/out of bed or chair, bathing, dressing, eating, toileting, bowel/bladder control, or walking?	☐ Yes ☐ No	☐ Yes ☐ No
6.	What is your current height and weight?	Height:_____ Weight: _____ lbs	Height:_____ Weight: _____ lbs
7.	Have you ever been diagnosed with or received treatment, care, advice, or medication for any serious illness not mentioned above?	☐ Yes ☐ No	☐ Yes ☐ No

Remarks Section

If you answered "Yes" to any of the above medical questions, please explain in detail below. If space is not adequate, attach another sheet.

Question #_____ Applicant Name _____ Dates _____

Reason Consulted/Diagnosis _____

Physician's Name/Address/Phone Number _____

Current Status _____

Continue to next page

7 Medical Questionnaire for Extended Care Rider (continued)

Question #_____ Applicant Name _____ Dates _____

Reason Consulted/Diagnosis _____

_____

Physician's Name/Address/Phone Number _____

_____

Current Status _____

_____

Question #_____ Applicant Name _____ Dates _____

Reason Consulted/Diagnosis _____

_____

Physician's Name/Address/Phone Number _____

_____

Current Status _____

_____

8 Fraud Warnings

Arkansas, District of Columbia, Louisiana and Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **California:** For your protection, California law requires the following to appear on this form: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **Maine, Tennessee and Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Massachusetts, Oregon and Pennsylvania:** Any person who knowingly and with the 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 may be a crime and may subject such person to criminal and civil penalties. **Oklahoma:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **All Other States:** 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.

Continue to next page

9 Notice to Applicants

Please read the following information carefully before you sign this.

This standard disclosure is required of all insurance providers. Be assured that Great-West Life & Annuity Insurance Company's (the Company) business practices meet the highest industry standards.

Information Practices and Notice Regarding Medical Information Bureau
Information regarding your insurability will be treated as confidential. Great-West Life & Annuity Insurance Company, or its reinsurers may however make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact them directly and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com or by calling (866) 692-6901.

Great-West Life & Annuity Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted and to any other persons as allowed by law. A medical examination by an examiner, approved by the Company, may be requested for any applicant. The fee for the examination will be paid by the Company. Applications accepted for insurance will receive insurance certificates stating the terms and provisions of the group policy.

Acceptance of your application is subject to the underwriting requirements of Great-West Life & Annuity Insurance Company. Depending on your medical history, coverage may be declined or a rider(s) issued excluding coverage for certain condition(s).

The effective date of coverage will be the date your application is approved by the Company. Premiums will be due from that effective date to the next renewal date, either April 1 or October 1. If your application for insurance is not accepted, you will be informed promptly.

Benefits provided under Group Policy No. 1117GH-HI issued to the American Dental Association; insured by Great-West Life & Annuity Insurance Company. Benefits are provided through a group policy filed in the State of Illinois, and coverage is available to all eligible ADA members residing in any U.S. state or territory. This policy is filed in accordance with and governed by Illinois law. Each Plan participant will receive a Certificate of Insurance explaining the terms and conditions of the policy.

By my signature below, I hereby declare that my answers and statements to the questions contained herein are full, complete, true and a condition of obtaining this insurance. I understand and agree that providing false, incomplete, or misleading information as a part of this application, or in filing a claim may constitute fraud or intentional misrepresentation which may result in the denial of claims, the rescission of coverage and potential criminal penalties. I have the right to access my personal medical and financial information in my files and to request that any inaccurate information be corrected. I hereby apply for insurance under Group Policy No. 1117GH-HI issued by Great-West Life & Annuity Insurance Company to the American Dental Association subject to all terms, conditions, and provisions of said policy.

I authorize Great-West Life & Annuity Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. and/or obtain an investigative consumer report on me.

ADA No.

Print Name of Member — Date of Birth

Signature of Member — Date of Signature

Print Name of Legal Spouse or Domestic Partner — Date of Birth

Signature of Legal Spouse or Domestic Partner — Date of Signature

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10 HIPAA Authorization for Release of Medical Information

Please fill out and mail this HIPAA Compliant Authorization form along with your application. We cannot begin to process your application until we receive the signed HIPAA form.

ADA No.

Print Name of Insured/Patient

Date of Birth / /

I authorize MIB, Inc. any health plan, physician, healthcare professional, hospital, clinic, laboratory, holders of prescription information on me, including but not limited to, pharmacies, pharmacy benefits managers, and insurers, medical facility, or other healthcare professional that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, insurance coverage information and any other protected health information concerning me to Great-West Life & Annuity Insurance Company (the Company). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic, medical facility, or other healthcare provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Great-West Life & Annuity Insurance Company may administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have or have applied for with Great-West Life & Annuity Insurance Company.

This authorization shall remain in force for 12 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of "My Providers" have already relied on this Authorization to disclose information about me or to the extent that Great-West Life & Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be re-disclosed by Great-West Life & Annuity Insurance Company except as authorized by me or as required by law.

I understand that "My Providers" may not refuse to provide treatment or payment for healthcare services if I refuse to sign this authorization, or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Great-West Life & Annuity Insurance Company may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Insured/Patient or Personal Representative

Date of Signature / /

Description of Personal Representative's Authority or Relationship to Patient

Continue to next page

FOR SPOUSE or DOMESTIC PARTNER (if applying for Optional Coverage)

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ADA No.

Print Name of Insured/Patient

Date of Birth / /

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This protected health information is to be disclosed under this Authorization so that Great-West Life & Annuity Insurance Company may administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have or have applied for with Great-West Life & Annuity Insurance Company.

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Signature of Insured/Patient or Personal Representative

Date of Signature / /

Description of Personal Representative's Authority or Relationship to Patient