



NORTH CAROLINA APPLICATION

Underwritten by Celtic Life Insurance Company, Chicago, IL

OFFICE USE ONLY

PMD Date: _____

Info. Rec'd Date: _____

Eff. Date: _____

Initials: _____

Please Print in Ink

PAYMENT METHOD: Monthly Automatic Pay Plan
 Monthly Billing Quarterly Billing
(S8 per-bill charge for monthly or quarterly)

TOTAL PREMIUM SUBMITTED:
\$ _____ /Monthly \$ _____ /Quarterly

If paying monthly, submit an initial premium equal to one month of your premium. If you choose to pay quarterly, submit a full quarter's premium. Business/Employer checks are not accepted in every state.

REQUESTED EFFECTIVE DATE:
(NOTE: the 29, 30 and 31 of the month are not eligible as effective dates.)
Application is valid for 60 days from the signature date. / /

AUTHORIZATION CODE:
(If QuikCoverage was requested)

SECTION 1: GENERAL INFORMATION

PRIMARY INSURED INFORMATION

APPLICANT'S NAME: _____ SEX: Male Female

First Middle Last
BIRTH DATE: / / AGE: PLACE OF BIRTH (COUNTRY): HEIGHT: ft. in. WEIGHT: lbs.

APPLICANT'S HOME ADDRESS: _____ SOCIAL SECURITY NUMBER: _____

Street (P.O. Box not acceptable) County
MARITAL STATUS: Single Married Divorced Widowed

City State Zip
HOME PHONE NUMBER: () WORK PHONE NUMBER: () BEST TIME TO CALL: OCCUPATION: (List primary responsibilities)

ARE YOU SELF EMPLOYED? YES NO IF YES, HOURS WORKED PER WEEK _____

PLAN INFORMATION: CHOOSE ONE OF THE FOLLOWING THREE PLANS AND THE DESIRED BENEFIT OPTIONS.

WHO IS TO BE INSURED? Applicant Spouse Child(ren)

CeltiCare Managed Indemnity Plan

50/50 \$ _____ deductible
(S250, S500, S1000)

80/20 \$ _____ deductible
(S250, S500, S1000)

100% \$ _____ deductible
(S1,000, S2,500, S5,000)

CELTICARE PLUS OPTION? YES NO

CeltiCare "Any Doc" PPO Plan

80/20 \$ _____ deductible
(S250, S500, S1000)

100% \$ _____ deductible
(S1,000, S2,500, S5,000)

CELTICARE PLUS OPTION? YES NO

IS THERE A CELTIC PPO HOSPITAL NEAR YOU? YES NO*
(*If no, do not select the PPO plan)

CeltiCare Select PPO Plan

80/20 \$ _____ deductible
(S250, S500, S1000)

100% \$ _____ deductible
(S1,000, S2,500, S5,000)

CELTICARE PLUS OPTION? YES NO

IS THERE A CELTIC PPO HOSPITAL AND PHYSICIAN NEAR YOU? YES NO*
(*If no, do not select the PPO plan)

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

SPOUSE'S NAME: _____ SPOUSE'S SOCIAL SECURITY NUMBER: _____

First Middle Last
BIRTH DATE: / / AGE: HEIGHT: ft. in. WEIGHT: lbs. SPOUSE'S OCCUPATION: _____

NAME OF CHILD:	SOCIAL SECURITY NUMBER:	SEX:	BIRTH DATE:

SECTION 1: GENERAL INFORMATION (continued)

IS/ARE THE APPLICANT(S) A U.S. CITIZEN?

 YES NOHAS THE APPLICANT(S) TO BE INSURED BEEN A PERMANENT LEGAL RESIDENT OF THE U.S. FOR THE LAST TWO YEARS? YES NO*

*IF APPLICANT ANSWERED "NO" TO ABOVE QUESTIONS, COVERAGE CANNOT BE GRANTED.

OTHER HEALTH COVERAGEWERE YOU OR YOUR DEPENDENTS COVERED UNDER ANY OTHER HEALTH INSURANCE PLAN IN THE LAST 18 MONTHS? YES NO

IF YES, PLEASE SUPPLY THE FOLLOWING INFORMATION: Please include a copy of your present carrier's identification card.*

NAME OF COVERED INDIVIDUAL: _____

CARRIER NAME: _____

TELEPHONE #: _____

CARRIER ADDRESS: _____

CITY, STATE, ZIP: _____

TYPE OF COVERAGE: EMPLOYER-BASED INDIVIDUAL Other _____

EFFECTIVE DATE: _____

TERMINATION DATE: _____

POLICY NUMBER OR GROUP NUMBER: _____

DEDUCTIBLE AMOUNT SATISFIED: _____

IF APPLICANT(S) IS CURRENTLY COVERED BY ANOTHER HEALTH PLAN, WILL THE POLICY BE TERMINATED UPON APPROVAL FROM COMPANY? YES NOHAVE YOU AND/OR ANY DEPENDENT TO BE COVERED PREVIOUSLY APPLIED FOR INSURANCE WITH CELTIC LIFE INSURANCE? YES NO

*Above information is needed for every person covered under prior coverage and applying for coverage with Celtic. If multiple policies, please list information on a separate sheet. For deductible credit, copies of Explanation of Benefits (EOBs) are required as proof.

SECTION 2: HEALTH QUESTIONS

For this insurance to be in force, the following health questions must be answered fully and truthfully to the best of your knowledge and belief and all of the health information (including routine physical exams) must be provided, and Celtic Life Insurance Company must approve this application. No one may change this requirement in any way. If any information on any form is misstated or omitted, coverage may later be rescinded. Rescission voids coverage from the effective date, and any premiums already paid will be refunded, minus any claims already paid. No payments will be made for any claims submitted, whether or not the treatment was related to the condition that was omitted or misstated. **PLEASE DO NOT MARK OVER OR STRIKE OUT ANY SIGNATURE, DATE OR HEALTH QUESTION INFORMATION.**

 YES* NO **1. PREGNANCY AND GENERAL HEALTH**

Are you, your spouse or any dependent(s) now pregnant or an expectant parent or were there any complications during a previous pregnancy? Has anyone to be insured ever been counseled or advised that they have or may have any disease, disorder, impairment, deformity, familial or congenital abnormality, injury or any chronic or untreatable condition whether active or in remission? Does anyone to be insured have a prosthetic device or implant?

 YES* NO **2. SPECIFIC HEALTH CONDITIONS**

Have you or any dependent(s) to be insured ever been treated for, had symptoms of, or been advised or counseled that they have or may have had a heart condition, (including a heart murmur), stroke, high blood pressure or other circulatory disorder; blood disorder**; diabetes; cancer, tumor or cyst; liver, kidney, genital or urinary tract disorder; seizures or other nervous system disorder; back, spine, joint or other musculoskeletal system disorder; arthritis; skin disorder; digestive system disorder; asthma, allergies or other respiratory disorder; eye or ear disorders; emotional, psychological, psychiatric or nervous condition or disorder; or history of sexually transmitted disease(s)?

 YES* NO **3. RECENT MEDICAL TREATMENT**

Have you or any dependent(s) to be covered been hospitalized or had medical or surgical consultation, advice or treatment for any condition(s) (including medication, psychological or marital counseling or therapy), or been advised of any abnormal test results or laboratory findings during the past 24 months? Are you or any dependent(s) to be covered scheduled for or awaiting the results of any tests, biopsies, procedures or lab work?

 YES* NO **4. IMMUNE SYSTEM DISORDER**

Have you or any dependent(s) to be insured ever been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS or other immune system disorders***, or ever tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?

 YES* NO **5. SPECIAL OCCUPATIONS**

Are you or any dependent(s) to be insured engaged in or employed by any of the following industries or occupations: Sports or athletics; aviation; entertainment; liquor sales and service (including bars and taverns), chemical dependency counseling, poultry farming, commercial fishing, diving, salvage, extermination, sanitation/waste disposal, police/security, fire fighting, excavation/demolition, mining, drilling, construction, roofing, commercial window washing, moving and storage, timber or logging, tree trimming, trucking, taxi driving, paramedical or ambulance service.

To be completed if the applicant or any dependent(s) answered "YES" to question 5.

*QuikCoverage cannot be granted over the phone. Please mail in your application and we will be happy to process it.

**Blood disorder includes all conditions of the blood presently recognized as disorders, both primary disorders of the blood (e.g. anemia, polycythemia, leukopenia, leukocytosis, clotting disorders, platelet disorders, immune disorders whether congenital or acquired, or disorders of gammaglobulin) and disorders that reflect other disease processes (e.g. infections, malignancies, sources of blood loss, biliary tract disease).

***Immune system disorder includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation and the immune-deficiency disorders, both congenital and acquired. Also included in disorders of immunity are lupus erythematosus, Grave's disease, rheumatoid arthritis, primary biliary cirrhosis and others.

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

OCCUPATION TITLE: _____

ARE YOU OR YOUR DEPENDENTS COVERED BY WORKER'S COMPENSATION? YES NO

PRIMARY RESPONSIBILITIES: _____

SECTION 3: ADDITIONAL HEALTH QUESTION INFORMATION

To be completed if the applicant or any dependent(s) answered "YES" to any question in Section 2.

NAME OF PERSON	CONDITION	DATE OF CONDITION	DETAILS OF TREATMENT (INCLUDING MEDICATION IF ANY)	DEGREE OF RECOVERY	DATE OF RECOVERY
Example: Incorrect John Doe	Broken arm	1993	N/A	full	several months later
Example: Correct John Doe	Broken right arm	6/93	Set and Cast	complete	8/93

CONDITION	NAME OF TREATING PHYSICIAN:
	First Last

PHYSICIAN'S ADDRESS:
Street City State Zip

CONDITION	NAME OF TREATING PHYSICIAN:
	First Last

PHYSICIAN'S ADDRESS:
Street City State Zip

CONDITION	NAME OF TREATING PHYSICIAN:
	First Last

PHYSICIAN'S ADDRESS:
Street City State Zip

SECTION 4: AGREEMENT AND SIGNATURE

- 1. TRUE AND COMPLETE:** To the best of my knowledge and belief my answers to the questions on this application and any additional information I have provided are true and complete. I understand that it is my responsibility to provide truthful and accurate information. 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 Policy.
- 2. PRE-EXISTING CONDITIONS:** I understand that if I fully disclose any condition for which an insured person received a diagnosis, consultation, treatment or medical advice during the 12 months prior to the effective date, and approved by Celtic in accordance with its underwriting guidelines, benefits will be paid for any expenses incurred for that condition unless excluded in a rider.
- 3. EFFECTIVE DATE:** If QuikCoverage has been applied for and approved, I understand that coverage is effective at the moment approval was given over the phone, provided that, (1) the answers on this completed and signed application agree with those answers given to QuikQuote, (2) the application envelope is postmarked by the next working day (**metered mail is not an acceptable postmark**), and (3) all materials are received within 10 working days. Otherwise, I understand that if the insurance is approved and an effective date has been requested, coverage will become effective the later of 1) 12:01 a.m. on the requested effective date; or 2) 12:01 a.m. on the day following the postmarked date on the application envelope addressed to Celtic Life. Application is valid for 60 days from the signature date. If no effective date is requested, I understand that insurance, if approved, will become effective the date the application and all required medical and other information is received by Celtic Life.
- 4. HEALTH CARE CERTIFICATION:** I understand that a Health Care Certification Program is a part of the CeltiCare Health Plan. This program requires that all hospital confinements, hospital outpatient surgeries and major diagnostic tests be Certified. I authorize release of medical information pertaining to myself and all eligible dependents, to Celtic Life Insurance Company, and its affiliates, or their representatives for compliance with the Health Care Certification Program requirements. I agree to participate and comply with the Health Care Certification Program and understand that failure to do so will result in a reduction of my plan benefits or no benefits paid at all.
- 5. PREFERRED PROVIDER ORGANIZATION:** I understand that if I have elected the Preferred Provider Organization option as a part of my CeltiCare Health Plan, then I agree to participate and comply with all requirements of the Preferred Provider Organization. I understand that a failure to do so will result in a reduction of my plan benefits.
- 6. 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, including information concerning advice, diagnosis, treatment or care of physical, psychiatric, mental or emotional conditions, drug, substance, or alcohol abuse, illness, and copies of all hospital or medical records, or non-medical information, to give to Celtic Life Insurance Company, its reinsurers, or its legal representatives, and its affiliates, any and all such information. Such information will be used by Celtic Life Insurance Company to determine eligibility for insurance and make claim determinations. 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. Anyone who knowingly misrepresents or falsifies such requested information may upon conviction be subject to a fine or imprisonment. I acknowledge having received and read the Notice of Information Practice and the Medical Information Bureau Consumer Notice.
- 7. OTHER COVERAGE:** I understand that in order to be eligible for this coverage, neither I, nor any dependents applied for can be covered under any other major medical plan. I hereby attest that no one applying for coverage under the CeltiCare Health Plan will be covered under any other coverage.
- 8. APPLICATION:** I understand that I am applying for the CeltiCare Health Plan. I recognize that Celtic will individually underwrite my application. I agree that if my application is accepted by Celtic, a Policy will be issued to me as an individual, and will in no way be linked to any employer/employee relationship. I understand that I am applying for medical insurance coverage in a plan that is not intended by its issuer, Celtic Life Insurance Company, to be a small employer health plan. Application is hereby made for the CeltiCare Health Plan.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

SIGNATURE: APPLICANT _____ SPOUSE: _____

DATED AND SIGNED AT: _____ on ____ / ____ / ____
City State Date

SECTION 5: PRODUCER INFORMATION

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.

WRITING PRODUCERS NAME:

Are you licensed in the state where the application was completed?

YES NO

Are you currently appointed with Celtic in the state where the application was completed?

YES NO*

*If NO, please submit appointment materials with this application. Some states require pre-appointment, check your Take 3 Agent Appointment Brochure for the pre-appointment state listings.

Tax ID Number (Optional):

Social Security Number (Required):

COMMISSIONS PAID TO:

ADDRESS:

City

State

Zip

TELEPHONE NUMBER:

()

FAX NUMBER:

()

Does the payor want to include other family members on one billing statement?

YES NO

If YES, the family billing statement form needs to be completed, dated, signed and submitted with the application.

Business/Employer checks are not accepted in every state. Please check with your District Sales Manager for further information.

Please check this box if you would like the Policy to be sent directly to insured. If this box is not checked, the Policy will be sent to your attention at the above address.

PRODUCER'S STATEMENT: I certify that I have truly and accurately recorded all the information given to me by the applicant, and I certify that I know of no other medical information of those persons applying for coverage other than that contained on this application. I have witnessed the signing of this application by the applicant. I understand that commissions cannot be paid unless I am appointed with Celtic.

PRODUCER'S SIGNATURE: _____ DATE: ____ / ____ / ____

**Mail this application and the initial premium check to:
Celtic Life Insurance Co., ATTN: New Business
P.O. Box 061110 Wacker Drive Post Office, Chicago, IL 60606**

Producer checks are not accepted.

I5-582-00049-NC

6/99

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CELTIC

Insured by Celtic Life Insurance Company

A Celtic Group Company

PREMIUM PAYMENT METHOD

Please note the following requirements for each payment method:

1. If selecting the Monthly Billing Method, attach a check below for the initial premium equal to one month of your premium.
2. If selecting the Quarterly Billing Method, attach a check below for a full quarter's premium.
3. If selecting the Monthly Automatic Pay Plan Method: (1) Attach a check below for the initial premium equal to one month of your premium; (2) attach a voided check or savings account deposit slip below (must be from a personal account*); and (3) complete the Primary Payor Information section below.

PRIMARY PAYOR INFORMATION

SIGNATURE OF PRIMARY PAYOR (OR DEPOSITOR IF DIFFERENT):			DATE:
			/ /
NAME OF BANK:		CHECKING/SAVINGS ACCOUNT NUMBER:	
		SPECIFY TYPE OF ACCOUNT: <input type="checkbox"/> CHECKING or <input type="checkbox"/> SAVINGS	
City	State	Zip	
PAYOR NAME (PLEASE PRINT):		RELATIONSHIP TO APPLICANT:	
First	Middle	Last	

Celtic Life 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 Certificate is not issued.

I further authorize the bank named below to pay and charge to my account those payments that are drawn on my account by Celtic Life Insurance Company, and I agree that the bank named below 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 Life Insurance Company in writing.

***We cannot draft from a business/employer account.**

ALL APPLICANTS ATTACH YOUR CHECK HERE

Initial Premium/Quarterly Premium Check

Business/Employer Checks are not accepted in every state.
Please call your District Sales Manager for more information.

MONTHLY AUTOMATIC PAY PLAN APPLICANTS ONLY

Voided Check or Savings Account Slip

CONDITIONAL RECEIPT FOR CELTICARE HEALTH PLAN

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 Life. 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: _____

Requested Effective Date: _____

- (A) If QuikCoverage has been granted over the phone (please indicate **Authorization Code:** _____), coverage is effective at the moment that approval was given over the phone, provided that all the following conditions are met:
- (1) The answers on the completed and signed CeltiCare Health Plan Application Form agree with those answers that were given to QuikQuote.
 - (2) The application, the initial premium, and the Monthly Automatic Pay Plan Agreement are mailed to Celtic, and postmarked no later than the next business day after the QuikCoverage call took place.
Note: Metered mail is not an acceptable postmark.
 - (3) The application, the initial premium, and the Monthly Automatic Pay Plan Agreement are received by Celtic within ten (10) working days of the time approval was granted by QuikCoverage.
- (B) If the conditions in (A) were not met, or if QuikCoverage was not granted or applied for, 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 Life, under its rules, standards, and procedures for the exact coverage and premium applied for without any modification.
 - (2) The initial premium is equal to one month/quarter of the first yearly premium (as calculated in accordance with the Producer Guide) has been paid on or prior to the Effective Date, and the check is honored on the first presentation for payment.
 - (3) Celtic Life determines that the applicant(s) is acceptable as defined in (B) (1) above. If Celtic cannot determine the acceptability of the applicant(s) as defined in (B) (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.

"Effective Date" as used herein means 12:01 a.m. on the later of: (A) the Requested Effective Date; (B) the day following the postmarked date on the application envelope addressed to Celtic Life; or if no effective date is requested (C) the date all medical and other information is received by Celtic Life.

IMPORTANT NOTE TO INSUREDS

1. If you need medical treatment or are admitted to the hospital before you receive your Policy and Health Care Certification ID card, you must still call the Certification Program to receive certification at **1-800-477-7870**.
2. Applicants must make out initial premium checks. No agent checks will be accepted. All premiums must be made payable to Celtic Life. Do not pay cash or make checks payable to the agent or broker or leave the payee blank.
3. Available premium payment methods are: Monthly Automatic Pay Plan, Monthly or Quarterly billing. No other premium payment will be accepted. If you choose monthly or quarterly billing statements you will be charged an \$8 per-bill fee.

NOTICE OF INFORMATION PRACTICES

In order to properly underwrite and administer your insurance coverage, we must collect certain necessary and helpful 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 Life Insurance Company, Underwriting Department, 200 South Wacker Drive, Suite 900, Chicago, IL 60606.

Medical information requests will only be disclosed to your attending physician.

CONSUMER NOTICE

While the information you provide to us regarding your insurability is treated as confidential, we, Celtic Life Insurance Company or our reinsurers, may make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file.

Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information, however, will be disclosed only to your attending physician.) If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction according to the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112. Telephone is (617) 426-3660.

We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefit may be submitted.