

CELTIC CARE™
HEALTH PLAN

PENNSYLVANIA

APPLICATION

Underwritten by Celtic Insurance Company, Chicago, IL

OFFICE USE ONLY

PMDDate:	_____
Info. Rec'd Date:	_____
Eff. Date:	_____
Initials:	_____
Cert #:	_____

Please print in ink

Requested Effective Date: 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. MO. / DAY / YR.	Authorization Code: (If QuikCoveragewas requested)	Please check if this application is for: <input type="checkbox"/> New Applicant <input type="checkbox"/> Add Dependent <input type="checkbox"/> Plan Change <input type="checkbox"/> Reapply
Initial Payment Method: (Complete Section 4): <input type="checkbox"/> Credit card <input type="checkbox"/> Check	Subsequent Payment Schedule <input type="checkbox"/> Monthly Automatic Pay - One month premium required (Complete Section 4) <input type="checkbox"/> Monthly Billing* - One month premium required <input type="checkbox"/> Quarterly Billing* - Three months premium required *(\$8 billing fee per month or quarter)	
Total Payment Submitted: \$ _____ /Monthly + \$15.00 One-time, non refundable Application Fee = \$ _____ Total Payment submitted \$ _____ /Quarterly + \$15.00 One-time, non refundable Application Fee = \$ _____ Total Payment submitted		
Have you and/or any dependent to be covered previously applied for insurance with Celtic Insurance Company? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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: <input type="checkbox"/> Male <input type="checkbox"/> Female		
First	Middle	Last			
Birth Date: / /	Age:	Place of Birth: (Country)	Height: ft. in.	Weight: lbs.	
Social Security Number:			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Home Phone Number: () ()	Phone Number during regular business hours: () ()	Occupation: (Position and Type of Business)			
Best Time To Call: a.m. p.m.	Primary Applicant's Home Address:				
Street		City	State	Zip	Country

GUARDIAN INFORMATION (For Applicants under 18 years of age):

Guardian's Name: (with whom the child resides):	Relationship to Child	Social Security Number:
First Middle Last		

BILLING INFORMATION If different from Applicant's Home Address (Please send bills to):

Name and Billing Address:					
Name	Street	City	State	Zip	
Does the payor want to include other family members on one billing statement? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES," the Family Billing Statement Form needs to be completed, dated, signed and submitted with the application.					
Is/are the Applicant(s) a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "No," has the Applicant(s) to be insured been a permanent legal resident of the U.S. for the last two years? <input type="checkbox"/> Yes* <input type="checkbox"/> No**					
* If applicant answered "Yes" to above question, attach a copy of the permanent resident or Green Card for each applicant. ** If applicant answered "No" to above questions, coverage cannot be granted.					

Earning your trust, every day



SECTION 1: GENERAL INFORMATION (continued)

Have you or any dependent to be insured used any type of tobacco product in the past 12 months? Yes* No

*If "Yes," check all who apply: Applicant Spouse Dependent(s)

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.)

Spouse's Name	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse's Social Security Number:
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First	Middle	Last	
Birth Date: / /	Age:	Height:	Weight:
		ft. in.	lbs.

Spouse's Occupation: (Position and Type of Business)

Name of Dependent Child(ren):	Social Security Number:	Birth Date:	Sex:	HT. (ft. & in.)	WT. (lbs.)

CELTICARE PLAN OPTIONS (Choose one of the three plans)

CeltiCare Managed Indemnity Plan:
 80/20 \$_____ deductible (\$250, \$500, \$1,000, \$2,500, \$5,000) 100% \$_____ deductible (\$1,000, \$2,500, \$5,000)

<p>CeltiCare "Any Doc" PPO Plan: <input type="checkbox"/> 80/20 \$_____ deductible (\$250, \$500, \$1,000, \$2,500, \$5,000) <input type="checkbox"/> 100% \$_____ deductible (\$1,000, \$2,500, \$5,000)</p>	<p>Is there a Celtic PPO Hospital Near You? <input type="checkbox"/> YES <input type="checkbox"/> NO* (*If no, do not select the PPO plan)</p>
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<p>CeltiCare Select PPO Plan: <input type="checkbox"/> 80/20 \$_____ deductible (\$250, \$500, \$1,000, \$2,500, \$5,000) <input type="checkbox"/> 100% \$_____ deductible (\$1,000, \$2,500, \$5,000)</p>	<p>Is there a Celtic PPO Hospital AND PHYSICIAN Near You? <input type="checkbox"/> YES <input type="checkbox"/> NO* (*If no, do not select the PPO plan)</p>
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BENEFIT OPTIONS

<p>Would you like the CeltiCare Plus Option? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

OTHER HEALTH COVERAGE

Do you or any dependents to be insured have any major medical health insurance coverage currently in force?
 YES NO

If "YES," please supply the following information:
Name of covered individual: _____
Carrier Name: _____ **Telephone #:** _____
Policy Number or Group Number: _____

Will the insurance coverage applied for be used to replace this existing coverage? YES NO
 (If "Yes," a replacement form may be required in your state. Consult your agent. If "No," coverage cannot be issued.)

IMPORTANT: DO NOTcancel any existing health coverage until written notification of your acceptance by Celtic.

SECTION 2: HEALTH AND OCCUPATION QUESTIONS

HEALTH QUESTIONS

For this insurance to be issued, 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 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.** (Any changes, corrections or alterations must be initialed and dated by the primary applicant)

- YES* NO **1. PREGNANCY**
 Are you, your spouse or any dependent(s) whether to be covered or not, now pregnant?
(If "YES," this coverage cannot be provided.)

- YES* NO **2. GENERAL HEALTH**
 Has anyone to be insured ever been counseled or medically advised that they have or may have had 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 (including breast implants)?

- YES* NO **3. SPECIFIC HEALTH CONDITIONS**
 Have you or any dependent(s) to be insured ever been treated for, had symptoms of, or been medically 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; any disease or disorder of the reproductive system including infertility, complications of pregnancy and sexual dysfunction; 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; alcohol, substance or drug abuse or dependence; emotional, psychological, psychiatric or nervous condition or disorder; or history of sexually transmitted disease(s)?

- YES* NO **4. RECENT MEDICAL TREATMENT**
 Within the past 24 months, have you or any dependent(s) to be insured received, been advised or recommended for tests, hospitalization or surgery 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? Are you or any dependent(s) to be insured scheduled for or awaiting the results of any tests, biopsies, procedures or lab work?

- YES* NO **5. 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)?

6. OCCUPATION/AVOCATION QUESTION*

Do you or any dependents(s) to be insured participate in or work in any of the following:
 Please check the appropriate box(es), P=primary applicant and S=spouse

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Motorized vehicle racing | Professional fire fighting | Liquor sales & service including bars, restaurants & taverns** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hazardous materials | Volunteer fire fighting | Casinos/gambling** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mining | Poultry farming | Entertainment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Roofing | Taxi driving | Police/Security** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Crop dusting | Professional sports or athletics | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Offshore drilling | Construction** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Inter-state trucking | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

** These activities require additional information. Each applicant who answers "yes" must complete Section 3B.

*QuikCoverage cannot be granted over the phone. Please mail in your application for processing.

SECTION 3A: ADDITIONAL HEALTH QUESTION INFORMATION

To be completed if the applicant or any dependent(s) answered "Yes" to any questions in Section 2. If more space is needed attach a separate sheet, each separate sheet must be signed and dated by the primary applicant.

Please give month and year when providing dates. Also, please give specifics when listing conditions, (Ex. Broken left leg.)

Ques. No.: _____	Proposed Insured's Name: _____	Degree of Recovery (<i>Complete, partial...</i>)/Date of Recovery: _____
Diagnosis: _____		_____
Onset Date: _____	Date Last Treated: _____	Details of Treatment: _____
Length of Treatment: _____		_____
Medication(s), including over the counter (<i>if recommended by a physician</i>): _____		_____
_____		_____
Type and Date of Testing/Surgery: _____		Doctor's name, Address and Phone Number: _____
_____		_____

Ques. No.: _____	Proposed Insured's Name: _____	Degree of Recovery (<i>Complete, partial...</i>)/Date of Recovery: _____
Diagnosis: _____		_____
Onset Date: _____	Date Last Treated: _____	Details of Treatment: _____
Length of Treatment: _____		_____
Medication(s), including over the counter (<i>if recommended by a physician</i>): _____		_____
_____		_____
Type and Date of Testing/Surgery: _____		Doctor's name, Address and Phone Number: _____
_____		_____

Ques. No.: _____	Proposed Insured's Name: _____	Degree of Recovery (<i>Complete, partial...</i>)/Date of Recovery: _____
Diagnosis: _____		_____
Onset Date: _____	Date Last Treated: _____	Details of Treatment: _____
Length of Treatment: _____		_____
Medication(s), including over the counter (<i>if recommended by a physician</i>): _____		_____
_____		_____
Type and Date of Testing/Surgery: _____		Doctor's name, Address and Phone Number: _____
_____		_____

SECTION 3B: ADDITIONAL OCCUPATION/AVOCATION INFORMATION

To be completed, only if the applicant or spouse checked a box in Section 2 under Question 6.

Proposed Insured's Name: _____	Name & type of business or company: _____
Job Title: _____	Hours worked: _____
Duties: _____	
Is liquor served at your place of employment? <input type="checkbox"/> YES <input type="checkbox"/> NO	On-site gambling facilities? <input type="checkbox"/> YES <input type="checkbox"/> NO
Construction: % of work performed inside? _____	% of work performed outside? _____
Max. number of floors/stories that you work? _____	Tools used? _____
Liquor Sales/Service: % of revenue generated from liquor sales? _____	% for food sales? _____
Do you own, manage, or tend bar or place of business where liquor is sold? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Entertainment: What type of places do you perform (theater, bars, etc) _____	
Police/Security: Do you carry a gun? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION 4: PREMIUM PAYMENT METHOD AND AUTHORIZATION AGREEMENT

Initial Payment (Credit Card or Check): PRODUCER PAYMENTS ARE NOT ACCEPTED.

1. For Initial Payment Only: VISA Mastercard I authorize Celtic Insurance Company to bill my VISA/Mastercard account for the initial payment.

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

Cardholder's Name: _____

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

MONTHLY AUTOMATIC PAY PLAN

Payor Name or Depositor if different (Please print):	Relationship to Applicant
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First Middle Last

Signature of Primary Payor:	Date: / /
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Name of Financial Institution:	Address: CITY STATE ZIP
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Specify type of account: <input type="checkbox"/> Checking or <input type="checkbox"/> Savings	Checking/Savings Account Number:
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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 Certificate 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.

Joe Smith 123 Main Street Anytown, IL 12345	ATTACH YOUR INITIAL CHECK OR MONEY ORDER FOR PREMIUM PAYMENT	1117
	Date _____	
	Pay to the order of _____ \$ <input style="width:50px" type="text"/>	
	_____ Dollars	
Routing Number For _____		
<input style="border: 1px solid black; border-radius: 50%; padding: 2px 5px;" type="text" value="123456789"/> 1234567891011 1117		

MONTHLY AUTOMATIC PAY PLAN APPLICANTS ONLY <h1>Voided Check</h1> (Deposit Slips are not acceptable)

SECTION 5: 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 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 Certificate. I understand that I may not pay cash or make checks payable to the agent or broker, or leave the payee blank.
2. **PRE-EXISTING CONDITIONS:** I understand that eligible expenses for pre-existing conditions may be limited.
3. **AIDS/IMMUNE SYSTEM DISORDER LIMITATION:** I understand that the CeltiCare Health Plan includes an AIDS/HIV Limitation provision.
4. **EFFECTIVE DATE:** Except as provided in the Conditional Receipt, I understand that insurance, if approved, will become effective the day after the confirmed receipt date the application and all required medical and other information is received by Celtic and the initial premium is paid in full. Application is valid within 60 days from the signature date.
5. **HEALTH CARE CERTIFICATION:** I understand that a Health Care Certification Program is a part of the CeltiCare Health Plan. This program requires me to have all hospital confinements Certified. I understand that failure to do so will result in a reduction of my plan benefits or no benefits paid at all. The Health Care Certification Program number is 1-800-477-7870.
6. **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 CeltiCare Health Plan will be covered under any other coverage.
7. **APPLICATION:** I understand that I am applying for membership in the Celtic 18 Plus Health Plan Trust and am responsible for ensuring that all premium payments are met. I understand that Celtic will individually underwrite my application and that if my application is accepted by Celtic, a Certificate will be issued to me. I understand that the plan applied for is not an employer-sponsored group health plan, that it will in no way be related to any employer/employee relationship, and it is not offered pursuant to and does not comply with state or federal small employer laws. If premium will be paid from a business/employer account, I hereby certify that no person to be insured under this plan will receive favorable tax treatment under sections 162, 125 or 106 of the United States Revenue Code, unless such favorable tax treatment would not make the plan subject to any state or federal small employer laws.
8. **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 Insurance Company, its reinsurers, or its legal representatives, and its affiliates, any and all such information. Such information will be used by Celtic Insurance Company to determine eligibility for insurance and make claim determinations. 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.

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: PRIMARY APPLICANT: _____ SPOUSE: _____
(Parent or Guardian if under 18 years of age)

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

SECTION 6: 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 Producer's Name:	Social Security Number or Agent Number
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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 with Celtic to verify pre-appointment states.

Commissions paid to:

Address:

City **State** **Zip**

Telephone Number: ()	Fax Number: ()
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CERTIFICATE INFORMATION

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

PRODUCER'S STATEMENT: I certify that the answers given to the questions in this application were provided by the primary applicant and the applicant was instructed that all information must be accurate and complete. I understand that commissions cannot be paid unless I am appointed with Celtic.

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

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

CONDITIONAL RECEIPT FOR CELTICARE HEALTH PLAN

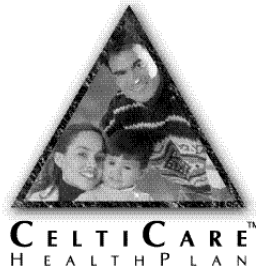
ALWAYS COLLECT THE INITIAL PREMIUM AND GIVE THE APPLICANT THIS CONDITIONAL RECEIPT .

No insurance will become effective prior to the approval of your application by Celtic. 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:** _____

- (A) If QuikCoverage has been granted over the phone (please indicate Authorization Code: _____), coverage is effective at the moment 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 completed application and the initial premium are mailed to Celtic, and postmarked no later than the next business day and received within 10 working days after QuikCoverage was granted.
- (B) If the conditions in (A) are not met, or if QuikCoverage was not 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, for the exact coverage and premium applied for without any modification. (2) 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. (3) The initial premium, equal to one month/quarter of the first yearly premium, has been paid on or prior to the Effective Date, and the check or credit card 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, if no effective date is requested; (C) no postmarked date, the effective date is the day after the confirmed receipt date of the application and all required medical and other information is received by Celtic. Note: Metered mail is not an acceptable postmark.



CELTIC

Insured by Celtic Insurance Company

Celtic Group Company

G5-583-00094-PA

6/01

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, 200 South Wacker Drive, Suite 900, Chicago, IL 60606.

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