

# RK Asset Management

## Application Instructions for CIGNA

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to RK Asset Management for review along with the completed application. If you do not have access to a fax machine, send the completed application to RK Asset Management along with the required first month's payment.

## HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

## IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to CIGNA** if you are not paying by credit card for the first month.

Mail completed applications and check to:

**RK Asset Management**  
**Attn: New Enrollment**  
**16524 N. Dale Mabry Hwy**

**Tampa, FL 33618**

RK Asset Management will review your application for completeness and accuracy before we submit it to CIGNA for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 866-307-3393 or e-mail us at [info@floridianquote.com](mailto:info@floridianquote.com).

Norvax form #IN-1

# RK Asset Management

## FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**\*\*Please FAX this cover letter with the completed application to:**

**RK Asset Management**

**FAX# 813-265-2038**

Dear RK Asset Management,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Please contact me at this phone number \_\_\_\_\_  
after you have reviewed my application for completeness and accuracy.

I will contact RK Asset Management at 866-307-3393 to verify receipt of my application.

**\*\*I understand that RK Asset Management will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to RK Asset Management. :

**RK Asset Management**

**Attn: New Enrollment**

**16524 N. Dale Mabry Hwy**

**Tampa, FL 33618**

I will send the original, signed application and premium payment, as soon as I have been contacted by RK Asset Management with confirmation that my application has been received by fax and reviewed for completeness.



<b>Dependent's Last Name:</b>		First Name:		M.I.	Social Security Number:	
Date of Birth:	Age:	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height:		Open Access Plan Primary Care Physician ID Number Optional _____
				Ft.	In.	Weight: (Lbs.)
<b>C1.</b> Is any applicant listed on this enrollment form a non-citizen resident of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>C2.</b> If "Yes," has the applicant(s) resided within the U.S. in the last consecutive 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," provide name(s) and explain: _____			

CIGNA Use Only	Effective Date
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**Section D. Current Coverage and Additional Prior Coverage Information**

**D1.** Does any applicant(s) have current health care coverage?  Yes  No

**D2.** Was any applicant(s) insured within the last **62** days?  Yes  No

**D3. If any applicant answered "Yes" to any of the above, please provide the following information:**  
 Name of prior or current Health plan carrier: \_\_\_\_\_ Type of Policy: \_\_\_\_\_  
 Applicants Covered: \_\_\_\_\_  
 Most Recent Coverage Start Date: \_\_\_\_\_ Termination date: \_\_\_\_\_ Date Policy Paid Through: \_\_\_\_\_

**D4.** Has any applicant applying for coverage ever been declined, had a waiver applied or had a premium adjustment for life, disability or health insurance, or had such insurance plan rescinded?  Yes  No If "Yes," provide the following information:  
 Name of Applicant: \_\_\_\_\_ Explanation: \_\_\_\_\_

**D5.** Is any applicant applying for coverage eligible for Medicare?  Yes  No  
 Applicant Name: \_\_\_\_\_

**D6.** Has any applicant applying for coverage ever filed a claim or received benefits for disability insurance or Workers' Compensation?  Yes  No  
 If "Yes," provide details: Name: \_\_\_\_\_ Dates: \_\_\_\_\_ Condition(s): \_\_\_\_\_

**D7.** Each applicant must agree to cancel all other health policies or plans, including HMO or PPO coverage, providing benefits for health services similar to this plan.

**Section E. Health Questionnaire**

All questions must be answered and complete details provided to all "Yes" answers for Sections E and F in Section G.

To the best of your knowledge, has any applicant listed on this application, in the past ten (10) years, been diagnosed or received treatment or sought treatment by a licensed member of the medical profession, had treatment recommended including prescription medication, laboratory tests or X-rays/CT scans/MRIs, received treatment, or been hospitalized for the following conditions or diseases as stated in questions numbers E.1 through F18? This is not an all inclusive list and the categories below do not limit your health information responses.

Any diagnosis and treatment received from a licensed member of the medical profession between the signature date and the effective date of coverage must be reported to CIGNA. This information may be used to determine whether CIGNA offers coverage to any applicant or the premium rate for each applicant CIGNA chooses to cover under this Individual and Family policy.

<b>E1. Brain/Nervous/Behavior/Emotional</b>	<b>YES</b>	<b>NO</b>	<b>E2. Eyes, Ears, Nose, Throat</b>	<b>YES</b>	<b>NO</b>
Loss of consciousness, fainting, dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Eyes/sight: glaucoma, cataracts, crossed eyes, detached retina, corneal transplant, infections, retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
Numbness, tingling, weakness, paralysis, hemiplegia	<input type="checkbox"/>	<input type="checkbox"/>	Ears/hearing: loss of hearing, deafness, infections, Eustachian tube dysfunction, acoustic neuroma	<input type="checkbox"/>	<input type="checkbox"/>
Confusion, memory loss, Alzheimer's disease, dementia	<input type="checkbox"/>	<input type="checkbox"/>	Nose/breathing: deviated septum, polyps, adenoiditis, sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Head injury, stroke	<input type="checkbox"/>	<input type="checkbox"/>	Throat/swallowing: tonsillitis, strep throat, excessive snoring, sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches, chronic severe headaches	<input type="checkbox"/>	<input type="checkbox"/>			
Narcolepsy, sleep apnea or used a sleep monitoring device	<input type="checkbox"/>	<input type="checkbox"/>	<b>E3. Heart/Circulatory</b>	<b>YES</b>	<b>NO</b>
Tremors, seizures/epilepsy, Multiple sclerosis, muscular dystrophy, Parkinson's disease, cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	Anemia, bleeding/clotting disorders, hemophilia, stroke, TIA	<input type="checkbox"/>	<input type="checkbox"/>
Reflex Sympathetic Dystrophy (RSD), Depression, anxiety, attention deficit, chemical imbalance	<input type="checkbox"/>	<input type="checkbox"/>	Varicose/spider veins, raynauds, phlebitis, thrombosis	<input type="checkbox"/>	<input type="checkbox"/>
Bi-polar, obsessive-compulsive, panic disorders, psychosis, schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged lymph nodes or lymphadenitis	<input type="checkbox"/>	<input type="checkbox"/>
Suicide attempt	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain, angina, congestive heart disease/failure, coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders, anorexia/bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack, bypass surgery/angioplasty, valve disease/replacement, pacemaker/defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
ADHD/hyperactivity, autism, developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure, hypertension, high cholesterol/lipids	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or chemical dependence, substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur, irregular heartbeat, palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Psychotherapy, counseling or support group	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm, rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>

<b>E4. Respiratory/Lungs</b>	<b>YES NO</b>	<b>E5. Skin</b>	<b>YES NO</b>
Allergies, sinusitis, bronchitis, asthma	<input type="checkbox"/> <input type="checkbox"/>	Acne, birthmarks, dermatitis, eczema, psoriasis	<input type="checkbox"/> <input type="checkbox"/>
Pneumonia, shortness of breath, chronic cough, collapsed lung, sleep apnea	<input type="checkbox"/> <input type="checkbox"/>	Fungal infections, warts, moles	<input type="checkbox"/> <input type="checkbox"/>
Emphysema, COPD, cystic fibrosis	<input type="checkbox"/> <input type="checkbox"/>	Pre-cancerous lesions, skin cancers or melanoma	<input type="checkbox"/> <input type="checkbox"/>
Tuberculosis, fungal infections, difficulty breathing, or spitting/coughing up blood?	<input type="checkbox"/> <input type="checkbox"/>	Herpes	<input type="checkbox"/> <input type="checkbox"/>
		2 <sup>nd</sup> or 3 <sup>rd</sup> degree burns, scars/keloid	<input type="checkbox"/> <input type="checkbox"/>
		Cosmetic or reconstructive surgery	<input type="checkbox"/> <input type="checkbox"/>
<b>E6. Digestive</b>	<b>YES NO</b>	<b>E7. Musculoskeletal</b>	<b>YES NO</b>
Infections of the mouth/throat/tonsils, problems with jaw, chewing or swallowing	<input type="checkbox"/> <input type="checkbox"/>	Injuries of bones, joints, muscles, ligaments, tendons, disc disease/disorder	<input type="checkbox"/> <input type="checkbox"/>
Ulcers, hernia, gastric/acid reflux, GERD	<input type="checkbox"/> <input type="checkbox"/>	Strain/sprain, fracture, bone spur	<input type="checkbox"/> <input type="checkbox"/>
Colitis, Crohn's disease, Irritable Bowel Syndrome (IBS), chronic diarrhea	<input type="checkbox"/> <input type="checkbox"/>	Arthritis	<input type="checkbox"/> <input type="checkbox"/>
Intestinal problems, colon polyps, rectal bleeding or hemorrhoids	<input type="checkbox"/> <input type="checkbox"/>	Fibromyalgia, gout, osteoporosis, polio	<input type="checkbox"/> <input type="checkbox"/>
Diseases of the pancreas, liver, or gallbladder	<input type="checkbox"/> <input type="checkbox"/>	Herniated disc, chronic neck pain, chronic back pain	<input type="checkbox"/> <input type="checkbox"/>
Hepatitis A/B/C/other, jaundice, cirrhosis	<input type="checkbox"/> <input type="checkbox"/>	Joint replacement, internal/external fixations, permanent hardware	<input type="checkbox"/> <input type="checkbox"/>
Unexplained weight loss or gain, eating disorder or gastric bypass/banding?	<input type="checkbox"/> <input type="checkbox"/>	Amputation, prosthesis	<input type="checkbox"/> <input type="checkbox"/>
<b>E8. Urinary</b>	<b>YES NO</b>	<b>E9. Endocrine/Metabolic/Glandular/Hormonal</b>	<b>YES NO</b>
Bladder infections, kidney infections, cystitis, kidney stones	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>
Blood in urine, painful/difficult urination, frequency	<input type="checkbox"/> <input type="checkbox"/>	Thyroid disorders, adrenal/pituitary disorders	<input type="checkbox"/> <input type="checkbox"/>
Stress incontinence, bed wetting, neurogenic bladder	<input type="checkbox"/> <input type="checkbox"/>	Lupus, scleroderma, chronic fatigue syndrome, Epstein-Barr, mononucleosis	<input type="checkbox"/> <input type="checkbox"/>
Polycystic kidney disease, renal failure, renal dialysis	<input type="checkbox"/> <input type="checkbox"/>		
<b>E10. Male Reproduction</b>	<b>YES NO</b>	<b>E11. Cancer/Tumors</b>	<b>YES NO</b>
Fertility/infertility, low sperm count	<input type="checkbox"/> <input type="checkbox"/>	Cysts, tumors, or abnormal growths	<input type="checkbox"/> <input type="checkbox"/>
Sexual dysfunction, erectile dysfunction	<input type="checkbox"/> <input type="checkbox"/>	Hodgkin's disease, leukemia, lymphoma, other cancer, or malignancy	<input type="checkbox"/> <input type="checkbox"/>
Enlarged prostate, benign prostatic hypertrophy (BPH), prostatitis, undescended testes	<input type="checkbox"/> <input type="checkbox"/>	Received Chemotherapy within the last 10 years	<input type="checkbox"/> <input type="checkbox"/>
Genital / anal herpes, sexually transmitted diseases	<input type="checkbox"/> <input type="checkbox"/>		
<b>E12. Birth Defects/Congenital Abnormalities</b>	<b>YES NO</b>		
Birthmarks, cleft palate/lip, club foot, webbed fingers/toes	<input type="checkbox"/> <input type="checkbox"/>		
Mental retardation, Down's syndrome, Cerebral Palsy	<input type="checkbox"/> <input type="checkbox"/>		
Heart/lung/kidney malformation, skull/facial, other physical deformities	<input type="checkbox"/> <input type="checkbox"/>		
<b>E13. Female Reproduction</b>	<b>YES NO</b>		<b>YES NO</b>
<b>a)</b> Pelvic pain, abnormal menstrual bleeding, absence of menstruation, abnormal Pap smear	<input type="checkbox"/> <input type="checkbox"/>	<b>b)</b> Has any applicant undergone infertility/fertility testing or received assisted reproductive therapy? If "Yes," provide complete detail in Section G.	<input type="checkbox"/> <input type="checkbox"/>
Endometriosis, ovarian cysts, uterine fibroids, miscarriage	<input type="checkbox"/> <input type="checkbox"/>		<b>c)</b> Has it been more than 40 days since her/their last menstrual period? If "Yes," provide name: _____ Reason/Explain: _____
Breast cyst/lump/fibroids, breast implants	<input type="checkbox"/> <input type="checkbox"/>		
Genital warts/herpes, sexually transmitted diseases	<input type="checkbox"/> <input type="checkbox"/>		

E13. Female Reproduction (continued)	YES NO		YES NO
<p><b>d)</b> Has any female applicant been diagnosed or received treatment by a licensed medical professional for a current pregnancy, positive home pregnancy test, or in the process of adoption or becoming a surrogate?  If "Yes," provide name: _____</p>	<p><input type="checkbox"/> <input type="checkbox"/></p>	<p><b>e)</b> Has any female applicant had an abnormal Pap smear? If yes, has there been a subsequent normal Pap smear result? Date of last abnormal result: _____ Date of last normal result: _____</p> <p><b>f)</b> Has any female applicant had an abnormal mammogram? If "Yes," has there been a subsequent normal mammogram result? Date of last abnormal result: _____ Date of last normal result: _____ Provide complete detail in Section G</p>	<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
<b>Section F. Health Related Questions</b>			<b>YES NO</b>
All questions must be answered and complete details provided to all "Yes" answers for Sections F in Section G.			
<b>F1.</b> Is any male applicant expecting a child or in the process of adoption or surrogacy with anyone, whether or not listed on this application?			<input type="checkbox"/> <input type="checkbox"/>
<b>F2.</b> Has any applicant been treated or diagnosed by a licensed member of the medical profession for alcohol, chemical or substance abuse, or been advised to reduce alcohol intake within the past 10 years? Name: _____			<input type="checkbox"/> <input type="checkbox"/>
<b>F3.</b> Has any applicant ever used illegal, controlled drugs (prescription medications) or substances, such as marijuana, cocaine, methamphetamine, illegal or IV drugs within the past 10 years except when prescribed by a licensed medical professional? Name: _____ Type of drug/substance: _____ Date discontinued: _____			<input type="checkbox"/> <input type="checkbox"/>
<b>F4.</b> Has any applicant consumed any alcoholic beverage in the last 6 months? (Amount: A drink is a 12 oz. of beer, 6 oz. of wine or 1 oz. of liquor) Name: _____ Type: _____ Amount: _____ per day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> Name: _____ Type: _____ Amount: _____ per day <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>
<b>F5.</b> Has any applicant had their driver's license suspended or restricted within the past 10 years? If "Yes," check name and reason: Name: _____ <input type="checkbox"/> Medical Condition <input type="checkbox"/> DUI/DWI <input type="checkbox"/> Prescribed Medication Name: _____ <input type="checkbox"/> Medical Condition <input type="checkbox"/> DUI/DWI <input type="checkbox"/> Prescribed Medication			<input type="checkbox"/> <input type="checkbox"/>
<b>F6.</b> Has any applicant been arrested or convicted of a DUI or DWI (drunken driving violation) within the past 10 years? If "Yes," provide Name: _____ State: _____ Date(s): _____ Name: _____ State: _____ Date(s): _____			<input type="checkbox"/> <input type="checkbox"/>
<b>F7.</b> Has any applicant tested positive for exposure to the Human Immunodeficiency Virus (HIV) Infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection or another sickness or condition derived from such infection?			<input type="checkbox"/> <input type="checkbox"/>
<b>F8.</b> Has any applicant taken prescription medications or been advised to take prescription medication in the past 2 years for diagnosis or treatment by a licensed member of the medical profession? If "Yes," complete Section H.			<input type="checkbox"/> <input type="checkbox"/>
<b>F9.</b> In the last 10 years, has any applicant had an abnormal physical exam, laboratory result, X-ray, EKG, MRI, CT scan or been advised to undergo further testing or surgery for diagnosis or treatment by a licensed member of the medical profession?			<input type="checkbox"/> <input type="checkbox"/>
<b>F10.</b> In the past 10 years, has any applicant seen, received treatment or been diagnosed or consulted any licensed member of the medical profession for any condition not listed on this application?			<input type="checkbox"/> <input type="checkbox"/>
<b>F11.</b> Has any applicant been a patient in a hospital, outpatient clinic, surgical center, treatment center or other medical facility in the last 10 years?			<input type="checkbox"/> <input type="checkbox"/>
<b>F12.</b> Has any applicant consulted a licensed member of the medical profession for treatment or diagnosis for any condition or symptom(s) in the last <b>12 months</b> for which a diagnosis has not been established?			<input type="checkbox"/> <input type="checkbox"/>
<b>F13.</b> Has any applicant been advised by a licensed member of the medical profession to see a periodontist or oral surgeon for treatment and diagnosis in the last <b>12 months (excluding normal checkups)?</b>			<input type="checkbox"/> <input type="checkbox"/>
<b>F14.</b> Has any applicant used tobacco products, including chewing tobacco, cigarettes, cigars, pipes in the past 2 years? If yes, complete to following: a.) Name(s): _____ b.) <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing Tobacco c.) Quantity per day: _____ d.) How many years? _____ e.) Has the person(s) quit? <input type="checkbox"/> Yes <input type="checkbox"/> No f.) If "yes," when _____			<input type="checkbox"/> <input type="checkbox"/>
<b>F15.</b> Has any applicant ever received health services or pre-screening lab testing from a health fair or other vendor?			<input type="checkbox"/> <input type="checkbox"/>

<b>Section F. Health Related Questions (continued)</b>	<b>YES</b>	<b>NO</b>
<b>F16.</b> Has any applicant ever received treatment or diagnosis or been recommended to have follow up or future diagnostic testing by a licensed member of the medical profession?	<input type="checkbox"/>	<input type="checkbox"/>
<b>F17.</b> Is any applicant a candidate for, or a recipient of, an organ, bone marrow, or stem cell transplant?	<input type="checkbox"/>	<input type="checkbox"/>
<b>F18.</b> Is any applicant currently on the donor waiting list and/or registered to donate an organ or bone marrow (excluding DMV card)?	<input type="checkbox"/>	<input type="checkbox"/>

**Section G. Detailed Health Information**

If you answered "YES" to any of the questions in Sections E and F, you must provide complete details below.

Check here if you are attaching additional pages.

<b>Question #</b> _____	<b>Applicant's Name:</b> _____		
Condition, Illness, Diagnosis	From Month/Yr _____ To Month/Yr _____		
Describe Treatment, Testing, Prognosis – Provide Details	Name / Address and Phone of Health Care Provider/Facility: _____		
Ongoing symptoms/treatment or follow-up treatment needed? <input type="checkbox"/> Yes, list details: _____ <input type="checkbox"/> No, all treatment complete	_____ _____		
<b>Question #</b> _____	<b>Applicant's Name:</b> _____		
Condition, Illness, Diagnosis	From Month/Yr _____ To Month/Yr _____		
Describe Treatment, Testing, Prognosis – Provide Details	Name / Address and Phone of Health Care Provider/Facility: _____		
Ongoing symptoms/treatment or follow-up treatment needed? <input type="checkbox"/> Yes, list details: _____ <input type="checkbox"/> No, all treatment complete	_____ _____		
<b>Question #</b> _____	<b>Applicant's Name:</b> _____		
Condition, Illness, Diagnosis	From Month/Yr _____ To Month/Yr _____		
Describe Treatment, Testing, Prognosis – Provide Details	Name / Address and Phone of Health Care Provider/Facility: _____		
Ongoing symptoms/treatment or follow-up treatment needed? <input type="checkbox"/> Yes, list details: _____ <input type="checkbox"/> No, all treatment complete	_____ _____		

**Section H.**

List all prescription medication and/or samples received from your health care provider taken by you and your dependents within the past 2 years.

Check here if you are attaching additional pages.

Applicant Name	Question Number	Name of Medication, Dosage, Frequency	Date Prescribed Mo/Day/Yr	Date Discontinued Mo/Day/Yr	Reason/Condition/ Diagnosis	Prescribing Physician/ Health Care Provider

**Section I.**

If any applicant answered "YES" to Section E3 for Elevated Cholesterol, Triglycerides, and/or High Blood Pressure/Hypertension, please complete the details required in the table below.

Check here if you are attaching additional pages.

Applicant Name	Date of Result	Cholesterol	Triglycerides	HDL	LDL	DATE	Blood Pressure Reading
Reading within last 12 months							

**Section J.**

Has any applicant experienced a weight change greater than 20 pounds in the past 12 months? If you answered "YES", please complete details in the following section.

Check here if you are attaching additional pages.

Applicant's Name	Weight Change Within Last 12 Months	Cause For Weight Change
	<input type="checkbox"/> Gained _____ Lbs. <input type="checkbox"/> Lost _____ Lbs.	<input type="checkbox"/> Diet <input type="checkbox"/> Medication <input type="checkbox"/> Pregnancy <input type="checkbox"/> Unknown
	<input type="checkbox"/> Gained _____ Lbs. <input type="checkbox"/> Lost _____ Lbs.	<input type="checkbox"/> Diet <input type="checkbox"/> Medication <input type="checkbox"/> Pregnancy <input type="checkbox"/> Unknown

**Section K.**

List last visit to doctor or person providing care (including checkup) – Complete for ALL family members listed on this application.

Check here if you are attaching additional pages.

Applicant's Name	Date of Visit/Service	Reason for Visit	Results		Please provide complete detail for Health care provider below.
			Normal ✓	Abnormal – explain findings:	
					Name: _____ Phone: _____ Address: _____ City: _____ State: _____ ZIP Code: _____
					Name: _____ Phone: _____ Address: _____ City: _____ State: _____ ZIP Code: _____

**Section L. Important Information**

1. CIGNA will enroll all eligible family members unless otherwise instructed.

I, the applicant, instruct that CIGNA not enroll any eligible applicants unless ALL family members are approved for coverage.

2.  I prefer to receive written correspondence regarding this application via email.

3. Applicants applying for coverage may be declined or receive a premium adjustment based on information CIGNA receives during the underwriting and enrollment process. Written communication containing confidential details will be sent to you if any applicant is declined coverage or if a premium adjustment is applied. If all applicants are declined coverage, the premium will be refunded.

4. Please do not cancel other current health insurance coverage until written notification is received from CIGNA indicating that your application has been approved and you and your dependents are in receipt of your ID cards.

5. CIGNA may decline coverage for any of the applicants identified in this application based on answers to questions about current or past health status. CIGNA also may set premium rates higher than standard quoted rates based on answers to such questions. If you do not want an applicant or dependent enrolled at an increased premium, you must instruct CIGNA accordingly:

I, the applicant, instruct CIGNA to enroll the remaining applicants if an applicant is denied.

I wish to have applicants automatically enrolled at the final rate, even if the rate is higher than the quoted rate; OR

I wish to review rates that are higher than standard before deciding whether to accept coverage.

**Section M. Payment Method**

*NOTE: Easy Pay and Credit Card are the only payment methods allowed for online or faxed applications.  
The accounts will be charged upon approval of your Application.*

**Easy Pay – (Electronic Fund Transfer – EFT)**

Yes, I am requesting Easy Pay option for my initial payment and for ongoing monthly payments (no paper or electronic monthly billing statement will be issued).

Account Number: \_\_\_\_\_  Checking  Saving

Routing Number:

Name of Bank: \_\_\_\_\_ Name(s) on Account: \_\_\_\_\_

I authorize the Company (the CIGNA HealthCare) to make monthly withdrawals, in the amount of my monthly premium, from my bank account as identified on this form and authorize the banking facility (Bank) to charge such withdrawals to my account. This authority will remain in effect until the Company receives written notice from me that the authority is terminated. Such termination will be effective with respect to the next premium due following 21 days after the written notice is received by the Company. I understand that if for any reason, a withdrawal is not honored by the Bank (including, but not limited to, insufficient funds or my direction to the Bank not to honor the withdrawal) my health care contract premium will be unpaid, and failure to pay my health care contract premium may result in termination for my health care contract, that I may be charged an administration fee in addition to my healthcare premium, and that this authorization will remain in place until cancelled and that any due or past due premiums may be withdrawn under this authorization. I understand and agree that termination of this authorization does not relieve me of responsibility for charges incurred under my health care contract. I agree to indemnify and hold harmless the Company and its affiliates and employees for any claims arising out of transfers or deductions from my account in accordance with this authorization.

*Any premium adjustment made during underwriting process will automatically be charged to your account. Please be advised that the premium adjustment may reflect an increase of up to 150% of the standard rate.*

**Credit Card (Available for initial payment only)**

VISA  MASTERCARD

Cardholder's Name – exactly as it appears on the card:

Account Number:

-     -     -

Card Expiration Date:

Account Holder's ZIP Code \_\_\_\_\_ - \_\_\_\_\_

*Any premium adjustment made during underwriting process will automatically be charged to your account.  
Please be advised that the premium adjustment may reflect an increase of up to 150% of the standard rate*

**For Paper Application: Please check here:**  Paper check is attached or  Credit card information provided.

**Ongoing Payment Options if selecting Paper Check or Credit Card for initial payment (please select one option only)**

- Yes, I am submitting a Personal check (or have selected the Credit Card option) for my initial payment and I am requesting the Personal check payment for ongoing quarterly payments (monthly billing option is not available for this ongoing payment method).
- Yes, I am submitting a Personal check for my initial payment (or have selected the Credit Card option) and I am requesting Easy Pay for ongoing monthly payments. (No paper or electronic monthly or quarterly billing statements will be issued.) *Please complete Easy Pay Section.*
- Yes, I am submitting a Personal check (or have selected the Credit Card option) for my initial payment and I am requesting monthly electronic bills (eBills) and will initiate a payment online for ongoing monthly payments.

**For Online electronic submitted Application:****Ongoing Payment Options if Credit Card Option was selected for initial payment (please select one option only).**

- Yes, I agree to recurring automatic Easy Pay option for my ongoing monthly payments. (No paper or electronic monthly billing statement will be issued.)
- Yes, I am requesting to receive monthly electronic bills (eBills) and will initiate a payment online for ongoing monthly payments.

**Section N. Statement of Accountability – To be completed when applicant can not complete the application.**

I, \_\_\_\_\_, personally read and completed this Enrollment Application Form for the Applicant named below because:

- Applicant does not read English    Applicant does not speak English    Applicant does not write English  
 Other (explain): \_\_\_\_\_

I personally translated the contents of this application and, to the best of my knowledge, obtained and listed all the personal and medical information disclosed by:

I also personally translated and fully explained the Conditions and Agreement Section:

\_\_\_\_\_  
 Signature of Translator *required*  
 (Excludes Parent Signature if Child Only Application)

\_\_\_\_\_  
 Today's Date *required*

**Section O. Agent Section**

Writing Agent Name: <b>Floridian Quote</b>		Florida License Number: <b>172890</b>
Street Address: <b>16524 N. Dale Mabry Hwy</b>	City: <b>Tampa</b>	State: <b>FL</b> ZIP Code: <b>33618</b>
Email Address: <b>info@floridianquote.com</b>		
Phone Number: <b>866-307-3393</b>		
Are you aware of any information about your client not disclosed on this application?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Did you see the proposed applicant at the time this application was completed? If "No", please explain: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No
I verify that the application was completed by the applicant unless otherwise noted in the Statement of Accountability		
Signature of Writing Agent:		
Please enter the name of the Agency/Agent that checks are to be made payable to if different from Writing Agent.		Producer Code:
Street Address:	City:	State: ZIP Code:
Email Address:		
Phone Number:		
CIGNA Sale Representative Last Name:		First Name:

**Section P. Conditions and Agreement/Authorization**

1. I understand that 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.
2. I authorize that payment be made under Part B of Medicare to CIGNA for medical and other services furnished by CIGNA for which it pays or has paid, if applicable.
3. I agree that in the event health services provided or covered are the primary responsibility of Medicare, workers' compensation coverage, automobile medical payment coverage, or other payments source CIGNA may be authorized by applicable law to pursue, to fully inform CIGNA and execute such documents and provide such assistance as may be necessary to enable CIGNA to recover the value of services provided, arranged or covered.
4. I understand that I or my authorized representative is entitled to receive a copy of this authorization form.
5. I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.

I acknowledge and agree that coverage shall become effective only after (a) this signed Application has been accepted upon review of the health history I have provided and any medical information reviewed by CIGNA, and (b) a contract has been issued by CIGNA.

I understand that any illness or conditions that may occur or be discovered between the date of my application and the effective date of coverage must be reported to CIGNA. In such event, I further understand that my application may again be reviewed by CIGNA to determine final approval.

I AGREE ON BEHALF OF MYSELF AND AS AUTHORIZED AGENT OR REPRESENTATIVE OF MY ELIGIBLE DEPENDENTS TO THE PROVISIONS CONTAINED ON THIS FORM, INCLUDING THE PROVISIONS REGARDING THE COLLECTION, USE, AND DISCLOSURE OF MEDICAL AND PROTECTED HEALTH INFORMATION. EXPENSES, IF ANY, ASSOCIATED WITH OBTAINING MEDICAL RECORDS ARE THE APPLICANTS FINANCIAL RESPONSIBILITY.

PLEASE NOTE: If you are applying for a medically underwritten plan, there is a waiting period for pre-existing conditions. Services for pre-existing conditions are not covered until 12 months after the contract effective date. A pre-existing condition is one for which medical advice, diagnosis, care, or treatment was recommended or received within 12 months before an individual's enrollment effective date under the contract.

<p><b>All applicants 18 years and older must sign and date application, acknowledging their understanding of and agreement to the conditions listed above. The above statements are true and complete to the best of my knowledge and belief. I understand and agree that for my child, and/or me and my eligible dependents, these statements shall be the basis for determination of acceptance for coverage under my applicable CIGNA benefit plan. I acknowledge and agree that any fraudulent misrepresentation or omission regarding the presence of pre-existing conditions, diseases, or other medical condition of any applicant will render this contract null and void from its date of issue in accordance with applicable law. If my coverage is revoked I will receive written notice that will explain the decision and my right to appeal. I also understand that I will be required to pay for any services that were covered while a member and that CIGNA will refund all amounts paid by me except amounts owed to CIGNA.</b></p>			
Applicant Signature:	Today's Date: (MM/DD/YYYY)	Applicant Spouse's Signature:	Today's Date: (MM/DD/YYYY)
Applicant's Dependent Age 18 or Older:	Today's Date: (MM/DD/YYYY)	Applicant's Dependent Age 18 or Older:	Today's Date: (MM/DD/YYYY)

**Section Q. Authorization to Release Information to CIGNA for Pre-Enrollment Processing**

**TO APPLICANT FOR HEALTH INSURANCE COVERAGE:** CIGNA needs to review your health information to finish processing your application. Thus, it is very important that you immediately sign, date and return this Authorization to give us permission to review your records. If you do not sign and return this Authorization, we may deny your application for coverage because it is incomplete.

**I voluntarily authorize disclosure (either through paper documents, electronic communication, or orally):**

**OF WHAT:** Information about my health maintained in underwriting, eligibility or other files of a health insurer or health maintenance organization, or in medical or patient files of a health care provider, or elsewhere, including, but not limited to: reasons I was rejected for health insurance coverage; medication history; diagnosis, testing and test results, prognosis, and treatment of any physical condition, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes, communicable diseases or disorders or sexually transmitted diseases; genetic information and test results; domestic abuse information; drug, alcohol, or other substance abuse information, including information about treatment or therapy; information related to mental conditions, including diagnoses, treatment plans and medications prescribed (excluding only notes by a mental health professional analyzing or documenting conversations during private therapy sessions and maintained separately from the medical record).

**FROM WHOM:** Any health insurer, health maintenance organization, or other health insurance issuer; any licensed physician, medical practitioner, clinic or other medical or medically related facility; or any other person or organization possessing the information described above.

**TO WHOM:** CIGNA, companies affiliated with CIGNA or other persons or entities authorized by CIGNA to receive the records described above.

**FOR WHAT PURPOSE:** To allow CIGNA to determine if I am eligible for insurance coverage under CIGNA.

**EXPIRES WHEN:** Twenty-four (24) months after the date I sign this Authorization.

**I further agree to or acknowledge the following:**

- I authorize use of a copy of this form (including an electronic copy) for the disclosures requested above.
- I understand that I have the right to revoke this Authorization at any time by sending a written statement to CIGNA at the address listed in the contact section of the application or by providing written notice to the doctor, insurance company or others who disclosed the information. However, the revocation will not be effective if the information already has been disclosed to CIGNA and CIGNA has relied on the information.
- Any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct the persons and organizations identified above to release and disclose all my information without restriction.
- A health care provider or health plan providing me coverage cannot refuse to provide me services based on my failure to sign an Authorization. **However, I understand that because CIGNA cannot obtain information necessary to process my application without this Authorization, CIGNA can deny my application if I do not sign this Authorization, or if I alter or revoke the Authorization.**
- CIGNA is subject to the "HIPAA" federal Privacy Rules. Therefore, information disclosed by providers or health plans pursuant to this Authorization will continue to be protected by the HIPAA Privacy Rules and will not be subject to further disclosure except as allowed by those rules.

I understand that I or my Personal Representative has the right to receive a copy of this Authorization.

**All applicants 18 years and older must sign and date authorization.**

Applicant Signature:	Today's Date: (MM/DD/YYYY)	Applicant Spouse's Signature:	Today's Date: (MM/DD/YYYY)
Applicant's Dependent Age 18 or Older::	Today's Date: (MM/DD/YYYY)	Dependent Applicant Age 18 or Older:	Today's Date: (MM/DD/YYYY)

**Section R . Instructions**

- The applicant is responsible for ensuring that the application is complete and truthful.
- Print clearly using black or blue ink.
- The application must be received by the CIGNA HealthCare underwriting team within 30 days from the signature date.
- Any fraudulent misrepresentation or omission regarding the presence of pre-existing conditions, diseases, or other medical condition of any applicant will render this contract null and void from its date of issue in accordance with applicable law.
- Coverage will become effective only if this application enrollment form is approved and appropriate premium is enclosed.
- Coverage is not guaranteed until you receive written notification from CIGNA HealthCare. Do not cancel your current coverage until you have received notification from CIGNA HealthCare.
- Individuals listed on this application who are currently pregnant, or in the process of adoption or surrogacy, or a non-citizen applicant that has not resided in the U.S. for the past 6 consecutive months are ineligible for coverage. Any other individuals on this application may still be considered for coverage.
- Effective dates are assigned to the 1<sup>st</sup> or 15<sup>th</sup> of the month. Underwriting will assign the next available effective date if not selected by the applicant.

**Section S. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance**

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance you have and replace it with the policy delivered herewith issued by CIGNA HealthCare. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to CIGNA HealthCare within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

**Section T. Contact Information**

Please return the application enrollment form to the broker or submit to the address listed below:

CIGNA HealthCare Individual and Family Plans  
P.O. Box 30362  
Tampa, FL 33630-3362  
FAX # 877.484.5927

[www.CIGNAforYou.com](http://www.CIGNAforYou.com)

If you have any questions about completing this application, please call CIGNA at 1.866.GET.CIGNA (1-866-438-2446) 8:00 AM - 8:00 PM ET



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