My Health Alliance
HEALTH PLANS FOR INDIVIDUALS

HEALTH ALLIANCE INDIVIDUAL SHORT TERM APPLICATION FORM

SECTION D: EVIDENCE OF INSURABILITY

IMPORTANT! Please complete one form for each dependent to be covered by Applicant listed in Section B of APPLICATION/CHANGE FORM.

Please respond to each question on this page. This application will be returned to you for further information if any question is left blank. Please complete the information by checking "YES" or "NO." If the answer is "YES" to any of the following questions, this coverage cannot be issued. The information you provide is confidential — please answer honestly and completely. For assistance, call the Health Alliance Member Service representatives at 1-866-247-3296. Please complete a separate Evidence of Insurability form for each person seeking coverage.

Applicant's Name: _____

Applicant's Social Security Number: _____

Dependent's Name: _____

Personal Information: Age: _____ Height: _____ Weight: _____

1. Have you or anyone named here been declined for insurance due to health reasons within the past 18 months?
   ❑ Yes ❑ No
   If so, why? _____
2. Do you or any person to be covered have hospital, major medical, group health, government or medical insurance coverage that will not terminate prior to the effective date of this coverage?
   ❑ Yes ❑ No
3. Is any female to be covered now pregnant or is any male to be covered an expectant parent?
   ❑ Yes ❑ No
4. Are you or anyone named here over 300 pounds if male or over 250 pounds if female?
   ❑ Yes ❑ No
5. In the past five years, has any person applying for coverage here been advised, consulted, tested, diagnosed, treated, hospitalized, taken medication for or been recommended for treatment for any of the following: heart or circulatory system disorder, including heart attack or stroke; insulin-dependent diabetes; cancer or tumors; disorder of the blood, including hemophilia or leukemia; kidney or liver disorder; mental or nervous conditions or disorders; alcoholism or alcohol abuse; drug abuse, addiction or dependency; organ transplant; emphysema; crohn's disease, ulcerative colitis or hepatitis.
   ❑ Yes ❑ No
6. Has any person applying for coverage here ever been diagnosed or treated by a physician for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC); or has any person applying for coverage here in the past five years tested positive for HIV virus or other immune disorders?
   ❑ Yes ❑ No