



RECEIVED DATE  
OFFICE USE ONLY

All Applications must be submitted to:  
Care Access Health Plan  
Underwriting Department  
P.O. Box 4276  
Hallandale, Florida 33008-4276  
Phone: (305) 614-5010  
Toll Free: (800) 576-6460

**Enrollment Application**

This enrollment application allows family members that are applying for individual membership to apply by completing one enrollment form. Coverage provided by Care Access is described in the Individual Member Contract and Handbook. Each family member (applicant) accepted by Care Access will be covered individually.

**Section I – Important Instructions**

1. You, the Primary Applicant, must accurately **COMPLETE ALL QUESTIONS AND INFORMATION REQUESTED to avoid delay in processing.**
  2. Please **PRINT** clearly in **BLACK or BLUE INK.**
  3. This **APPLICATION MUST BE RECEIVED WITHIN 30 DAYS FROM THE DATE OF SIGNATURE.**
  4. If you need help completing this form, please call your Agent or Care Access.
  5. Any fraudulent statement made will void your membership beginning two (2) years from the date membership becomes effective.
- WARNING: 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.**

**Section II – Important Information**

1. Submit the completed application with your personal check, money order or cashier's check for deposit towards initial first month's premium made for all applicants payable to Care Access Health Plan.
2. The actual effective date will be the first of the month following approval by Care Access Health Plan.
3. **Coverage is not effective until you are notified in writing by Care Access Health Plan.**

**A. TELL US WHO IS APPLYING FOR COVERAGE AND SELECT THE PRODUCT(S)**

I AM APPLYING FOR:  Self  Spouse  Child(ren)/Dependent(s)  
(Check All That Apply)

Attached is my deposit for the 1<sup>st</sup> month's premium in the amount of \$

Check No:

MONTHLY BILLING OPTIONS	MONTHLY BILLING INSTRUCTIONS – Complete this section ONLY if you have checked the Monthly Direct Billing option box to the left.
(Choose one and complete the corresponding form enclosed)	Bill to: Name _____ C/O _____ Address _____ _____ City _____ State _____ Zip Code _____ Tel# _____ Fax# _____
<input type="checkbox"/> Monthly Electronic Funds Transfer (EFT)	
<input type="checkbox"/> Debit Card	
<input type="checkbox"/> Monthly Direct Billing (complete the box to the right)	
<input type="checkbox"/> Credit Card	
<b>Check, Money Order, or Cashier's Check MUST accompany enrollment application(s), and made payable to Care Access Health Plan.</b>	

## B. PERSONAL INFORMATION

Primary Applicant's Last Name		First Name	MI	State or Country of Birth
Home Address			Home Phone Number (    )	
City	State	Zip	County	
Applicant's Occupation	Applicant's Employer		Business Phone Number (    )	
Spouse's Occupation	Spouse's Employer		Business Phone Number (    )	

- Have any applicants had an exclusion imposed, postponed, had a waiver applied or been charged an extra premium for life, disability, or health insurance or had such insurance declined or rescinded? If yes, provide applicants' names, insurance company's name and a brief explanation.  
 Yes    No \_\_\_\_\_  
 \_\_\_\_\_
- Have any applicants had previous coverage with any other Carrier within the last 63 days? If so, please provide name of Carrier, effective and termination date of coverage. \_\_\_\_\_
- Have any applicants had previous coverage with Care Access Health Plan? If yes, provide applicant's names and effective dates of coverage. \_\_\_\_\_

### ADDITIONAL INFORMATION (OPTIONAL)

Applicant's Social Security Number	Driver's License Number (if applicable)
Passport Number/Country Issued (if applicable)	Alien Registration Number (if applicable)
Spouse's Social Security Number	Driver's License Number (if applicable) and state
Passport Number/Country Issued (if applicable)	Alien Registration Number (if applicable) and where issued

## C. APPLICANT INFORMATION AND PRIMARY CARE PHYSICIAN (PCP) SELECTION

<b>Primary Applicant 1</b> <b>ID # _____</b>  <u>Plan Option</u> <input type="checkbox"/> Low <input type="checkbox"/> High  <u>Dental Option</u> <input type="checkbox"/> 801 D <input type="checkbox"/> 802 D	Last Name		First Name		MI	Premium \$ _____	
	Date of Birth	Sex	Height Ft.    In.	Weight lbs	Social Security Number		
	PCP Last Name		First Name		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No (list current doctor's name, address & phone below) Name: _____ Address: _____ Phone: _____		
	PCP Number		PCP Office Location (City)				
<b>Applicant 2</b> <b>ID # _____</b>  <u>Plan Option</u> <input type="checkbox"/> Low <input type="checkbox"/> High  <u>Dental Option</u> <input type="checkbox"/> 801 D <input type="checkbox"/> 802 D	Last Name		First Name		MI	Premium \$ _____	
	Date of Birth	Sex	Height Ft.    In.	Weight lbs	Social Security Number		
	PCP Last Name		First Name		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No (list current doctor's name, address & phone below) Name: _____ Address: _____ Phone: _____		
	PCP Number		PCP Office Location (City)				

<b>Applicant 3</b> <b>ID # _____</b>  <u>Plan Option</u> <input type="checkbox"/> Low <input type="checkbox"/> High  <u>Dental Option</u> <input type="checkbox"/> 801 D <input type="checkbox"/> 802 D	Last Name		First Name		MI	Premium \$
	Date of Birth	Sex	Height Ft.      In.	Weight lbs	Social Security Number	
	PCP Last Name		First Name		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No (list current doctor's name, address & phone below)	
	PCP Number		PCP Office Location (City)		Name: _____ Address: _____ Phone: _____	
<b>Applicant 4</b> <b>ID # _____</b>  <u>Plan Option</u> <input type="checkbox"/> Low <input type="checkbox"/> High  <u>Dental Option</u> <input type="checkbox"/> 801 D <input type="checkbox"/> 802 D	Last Name		First Name		MI	Premium \$
	Date of Birth	Sex	Height Ft.      In.	Weight lbs	Social Security Number	
	PCP Last Name		First Name		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No (list current doctor's name, address & phone below)	
	PCP Number		PCP Office Location (City)		Name: _____ Address: _____ Phone: _____	
<b>Applicant 5</b> <b>ID # _____</b>  <u>Plan Option</u> <input type="checkbox"/> Low <input type="checkbox"/> High  <u>Dental Option</u> <input type="checkbox"/> 801 D <input type="checkbox"/> 802 D	Last Name		First Name		MI	Premium \$
	Date of Birth	Sex	Height Ft.      In.	Weight lbs	Social Security Number	
	PCP Last Name		First Name		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No (list current doctor's name, address & phone below)	
	PCP Number		PCP Office Location (City)		Name: _____ Address: _____ Phone: _____	

**Dependent child(ren) age 19 to 24, must live in the household and be dependent for support from Primary Applicant, or be a full-time or part-time student. Supporting documentation must be attached to this application for approval. IF ADDITIONAL SPACE IS NEEDED, PLEASE COMPLETE ANOTHER ENROLLMENT APPLICATION(S).**

D. STATEMENT OF HEALTH		
Please make sure that all of the information contained herein is complete, true and accurate. If accepted for membership, any misstatements or omissions in this questionnaire may result in rescission of membership and the voiding of the Individual Member Contract and Handbook to the original effective date. Answer the following questions for yourself and each applicant applying for membership. All questions in this section must be answered and column checked "Yes" or "No".		
	<b>Yes</b>	<b>No</b>
1. Are you or any applicant(s) experiencing any symptoms for which you have not yet seen a doctor or has any testing and/or treatment been recommended by a physician that has not yet been done?		
2. In the past ten (10) years have you or any applicant had any testing, diagnosis, consultation, counseling, treatment, emergency care, inpatient or outpatient hospitalization, and/or medications for any of the following diseases or disorders:		

**Check the "Yes" column by the specific condition, disease or disorder listed below. If a condition, disease or disorder is not listed please use Section M (below).**

	Yes	No
A. ≤Alcohol or Drug Abuse ≤Chemical Dependency ≤Anorexia or Eating Disorder ≤Mental or Psychiatric Disorder		
B. Cardiovascular Disorders such as: ≤Heart Disease ≤Chest Pain ≤Heart Attack ≤Stroke ≤Anemia ≤High Blood Pressure (if yes, most recent B/P_____ / _____) ≤Congestive Heart Failure (CHF) ≤Any other Circulatory or Hematological Disorders		
C. Stomach, Liver and/or Colon Disorders such as: ≤Peptic Ulcers ≤Colitis ≤Diverticulitis ≤Cirrhosis .....≤Hepatitis ≤Other Liver Disorder ≤Rectal Disorders ≤Hernias ≤Pancreatic Disease ≤Gallbladder Disease		
D. Eye, Ear, Nose and/or Throat Disorders such as: ≤Cataracts ≤Glaucoma ≤Tinnitus ≤Nasal Polyps ≤Recurrent Sinusitis ≤Tonsillitis		
E. Genitourinary and/or Kidney Disorders such as: ≤Prostatic Cancer or Enlargement ≤Endometriosis ≤Pelvic Inflammatory Disease (PID) ≤Fibroids ≤Abnormal Uterine Bleeding ≤Cervical Dysplasia ≤Abnormal PAP Smear		
F. Respiratory or Lung Disorders such as: ≤Tuberculosis ≤Chronic Obstructive Pulmonary Disease (COPD) ≤Asthma ≤Bronchitis ≤Emphysema ≤Pneumonia ≤Sleep Apnea ≤Coughing Up Blood		
G. Bone, Back, Spine or Joint Disorders such as: ≤Temporomandibular Joint Disease (TMJ) ≤Arthritis ≤Gout ≤Joint Replacements ≤Herniated Disc ≤Sciatica ≤Any Other Connective Tissue Disease or Musculoskeletal Disorders		
H. Head, Brain or Nervous System Disorders such as: ≤Migraine Headaches ≤Frequent Fainting ≤Convulsions ≤Seizures ≤Epilepsy ≤Multiple Sclerosis ≤Paralysis ≤Stroke ≤Cerebral Aneurysm ≤Alzheimer's ≤Parkinson's Disease		
I. Endocrine (Glandular) or Metabolic Disorders such as: ≤Diabetes ≤Thyroid ≤Pituitary ≤Adrenal ≤Hyperlipidemia ≤High Cholesterol ≤Hemochromatosis ≤Obesity		
J. Malignant Disorders such as: ≤Cancer ≤Lymphoma and Leukemia ≤Melanoma or Skin Cancer		
K. Skin Disorders or any other Dermatologic Condition		
L. ≤Deformities ≤Congenital/Birth Defects ≤Mental Retardation ≤Developmental Delay ≤Cleft Lip/Palate		
M. Other medical condition, disease or disorder not listed above: _____ _____		
3. Have you or any applicant listed ever had or been treated for: ≤Herpes ≤Human Papilloma Virus (HPV) ≤Syphilis ≤Chlamydia ≤Any Other Sexually Transmitted Disease (STD)		
4. Are you or any applicant listed, currently taking or have taken any prescribed medication within the past two years? If "Yes", list the prescriptions in <b>Section G, Prescription Medication Information.</b>		
5. Have you or any applicant ever had an abnormal mammogram (including males)?		
6. Has any female applicant performed a home pregnancy test which has reacted positive or been diagnosed as pregnant?		
7. Have you or any applicant been covered by Care Access or any of its subsidiaries/affiliates within the past three (3) years? If yes, please provide member number: _____		
8. Are you or any applicant expecting the birth of a child or the addition of any other dependent for whom you (or any applicant) may have a duty to provide medical care?		
9. Have you or any applicant ever tested positive for: ≤Human Immunodeficiency Virus (HIV) ≤Been diagnosed as having AIDS Related Complex (ARC) ≤Acquired Immunodeficiency Syndrome (AIDS) ≤Any medical condition derived from such infection?		

**E. HEALTH HISTORY INFORMATION**

If you answered "Yes" for yourself and/or any applicant to any question in Section D, Statement of Health, please provide complete details for each applicant below or attach additional sheets, if necessary. Please provide information regarding the last doctor visit and/or physical examination of ALL APPLICANTS that wish to be enrolled.

APPLICANT'S NAME	QUESTION #	CONDITION, INJURY, SYMPTOM OF ILL HEALTH	ONSET DATE (MO/YR)	DATE OF LAST TREATMENT (MO/YR)	DEGREE OF RECOVERY	NAME AND ADDRESS OF HOSPITAL AND ATTENDING PROVIDER

**F. PHYSICIAN INFORMATION**

Give names and addresses of all physicians seen within the last two (2) years.

APPLICANT'S NAME	PROVIDER NAME / ADDRESS / PHONE	DATE OF SERVICE	REASON FOR CONSULTATION

**G. PRESCRIPTION MEDICATION INFORMATION**

List all medications taken within the last two years.

APPLICANT'S NAME	MEDICATION / DOSAGE FREQUENCY (i.e. Lopressor / 100 mg daily)	ILLNESS FOR WHICH THE MEDICATION IS PRESCRIBED	DATE PRESCRIBED (MO/DAY/YR)	DATE DISCONTINUED (MO/DAY/YR)	NAME AND PHONE NUMBER OF DOCTOR OR HOSPITAL

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicant. The primary applicant or legal guardian must sign all additional sheets.

**H. CONDITIONS OF ENROLLMENT**

**GENERAL CONDITIONS**

*Initial*

Care Access reserves the right to reject any application. We may selectively accept you and/or any applying dependent(s). You and/or any applicant will not become a member unless this Application meets our underwriting guidelines and a Notice of Acceptance is issued to you and/or any applicant. Even though you sent Care Access a check for the first month's premium, the Notice of Acceptance is the only binding method of acceptance. If rejected, the first month's premium check will be returned to you.

An agent cannot grant approval, change terms or waive requirements for membership. We may require that you have laboratory tests, an exam and provide medical records (if requested).

Each applicant or legal guardian understands that it is his/her responsibility to provide Care Access with any changes in the health status of the applicant and/or his/her dependent(s) prior to the effective date of coverage.

**Any intentional or unintentional non-disclosure or misstatement of fact in application materials is cause for disenrollment and rescission of the Plan Contract and Care Access may recoup any amounts paid for Covered Services obtained as a result of such non-disclosure or misstatement of fact.** In the event of disenrollment or rescission of the Individual Member, Care Access shall have no liability for the provision of coverage under the Individual Member Contract and Handbook.

**PAYMENT OF PREMIUM**

*Initial*

**Please note that this coverage is Individual or Individual group coverage and not a commercial group policy. You and/or any applicant are responsible for the first month's premium deposit as well as any future payments if accepted for coverage, and any non-payment will be subject to termination.**

**OMISSIONS CLAUSE**

*Initial*

I represent that all statements and answers made in this document, by whomsoever written including on any attached papers, are complete, true and correct. I agree that this shall be the basis of my acceptance for membership. I realize that any misrepresentation or omission, for any reason, regarding the presence or history of pre-existing conditions may result in rescission of my coverage.

**DECLINATION CLAUSE**

*Initial*

If Care Access Health Plan denies your request for membership, you will be notified in writing. Care Access will not provide reasons for the denial.

**I. APPLICANT'S CERTIFICATION**

**MINOR AS A PRIMARY APPLICANT**

*Initial*

If the Primary Applicant under this Application is under 18 years of age, the Applicant's parent or legal guardian must sign as such. In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information in this Application and for payment of premium. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this Application.

**ACKNOWLEDGEMENT AND AGREEMENT**

*Initial*

I understand and agree that by enrolling or accepting services under a health plan with Care Access, I and any enrolled dependents are obligated to understand and abide by all terms, conditions and provisions of the Individual Member Contract and Handbook. I have read and understand the terms on all pages on this Application including the conditions of enrollment. I understand if this application is accepted it will become part of the Individual Member Contract and Handbook. My signature below indicates my acceptance of these terms and that the information entered in this application is complete, true and correct.

**PRE-EXISTING CLAUSE**

*Initial*

I understand that there are pre-existing condition exclusions and waiting periods, and that my coverage and that of any of the applicants identified on the enrollment application shall be subject to those exclusions and waiting periods for any pre-existing conditions as defined by the Individual Member Contract and Handbook. I also understand that there is a 24 month waiting period on all pre-existing conditions, including medications.

**AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION**

*Initial*

I, on my behalf and on behalf of any applying family member under the age of 18, do hereby authorize Care Access and its authorized employees, its agents, independent contractors and Participating Providers to release to, or obtain from, any person, provider, organization or government agency, any information and records, including patient records of applicants and information on any condition, which Care Access requires or is obligated to provide pursuant to legal process, federal, state or local law, or otherwise requires to administer the health plan. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to Care Access, or its reinsurers, any such information. A photocopy of this Authorization is considered as valid as the original. You are entitled to make and return a photocopy of this authorization. This authorization shall remain in effect indefinitely unless properly terminated by written notice.

**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.**

**I have read and understand the terms included in this Application. My signature below indicates my acceptance of these terms and that the information I have entered on this Application is complete, true and correct. Care Access reserves the right to rescind coverage due to any material misrepresentation on this Application. Material misrepresentation is determined at the sole discretion of Care Access.**

X \_\_\_\_\_ Date Signed      X \_\_\_\_\_ Date Signed  
 PRIMARY APPLICANT'S SIGNATURE      PARENT or LEGAL GUARDIAN (if sole Applicant is under 18 years old)

X \_\_\_\_\_ Date Signed  
 SPOUSE'S SIGNATURE

**Check, Money Order, or Cashier's Check MUST accompany enrollment application(s), and made payable to Care Access Health Plan.**

**J. STATEMENT OF ACCOUNTABILITY**

To be completed when application is not completed by the applicant.

I, \_\_\_\_\_, have personally read and completed this Individual Enrollment Application for the applicant named below because:

Applicant does not read English       Applicant does not speak English       Applicant does not write English

Other (explain) \_\_\_\_\_

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by:

\_\_\_\_\_

X \_\_\_\_\_ Today's Date (Required)  
 Signature of Translator (Required)

**K. AGENT'S CERTIFICATION**

Are you aware of any information not disclosed in this Application which may have a bearing on this risk?

Yes, explain and attach explanation       No

**L. AGENT INFORMATION – (To be completed by Agent)**

Agent's Name (Printed): _____	Social Security Number/TIN: _____
Agent's License Number: _____	Address: _____
City: _____	State: _____ Zip Code: _____
Phone: _____	Agent's Email Address: _____