

Tele-App Part 1 Enrollment for Medical Insurance for Individuals and Families



Agent Information

Agency Name _____ Agency Number _____
 Agent Name _____ Agent Number _____
 Agent Fax Number _____ Agent Phone Number _____
 Agent E-mail Address _____

Person(s) To Be Insured

Name (Primary)	Last	First	M.I.	Sex	Date of Birth	Social Security Number
1.						
(Spouse)						
2.						
3. Dependent Children						
Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number

4. Resident Address (Street, City, State and ZIP code. No P.O. Boxes)
 Street _____ City _____ State _____ ZIP _____
 5. Home Phone Number _____ 6. E-Mail Address: _____

7. Are any of the proposed insureds covered by, or has application been made for, any type of medical insurance?
 Yes (complete section below) No

Proposed Insured's Name	Company Name	Company Phone Number	Group (G)/ Individual (I)	Type of Coverage	Effective Date	Term Date

8. Were all proposed insureds covered under the prior plan listed above? Yes No (If no, list those not covered)
 9. Will this proposed coverage replace or change any existing health insurance? Yes No
 10. Are any of the proposed insureds covered by Medicaid? Yes No
 11. Will any proposed insured become eligible for any other form of medical insurance in the next six months? . . . Yes No

Billing

Check-O-Matic (Complete form on the next page) Quarterly Semi-Annual Annual
 Send premium notices to: Insured or Alternate Payor

Name _____
 Address _____
 City _____ State _____ ZIP _____

I (we) hereby authorize Fortis Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account.

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

X _____ X _____
 Signature of Payor Date Signed

REMEMBER TO FAX PAGES 1 & 2 ONLY!

Authorization for Check-O-Matic Billing

Choose the following option that applies:

To begin Check-O-Matic withdrawals:

Select a desired withdrawal day: (1-28): _____

Bank Name _____

Address _____

City _____ State _____

To add this policy to an existing Check-O-Matic:

Existing COM Number _____

Associated Policy Number _____

Jane Doe 2139 S. 33 St. AnyTown, USA 12345	*(Transit Number) 1234
	Date _____
Pay to the order of _____	\$ _____
	_____ Dollars
BANK NAME _____	
Memo _____	
*(Routing Number) _____	*(Account Number) _____ (Check Number) _____

*Routing & Transit Numbers _____ *Account Number _____

Don't send in a voided check – just complete the routing and account information for Check-O-Matic!

Authorization To Obtain Medical Records and Attestation

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Fortis Insurance Company (or any consumer-reporting agency authorized by Fortis Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded personal health history, Part 1 and any amendments shall be the basis for the contract. I also agree that:

(1) I must call Fortis Insurance Company and complete the telephone portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto. **(2)** I understand that if at any time through the enrollment process any of the previous information provided becomes inaccurate or is updated, I have an obligation to contact Fortis Insurance Company and advise of such change. **(3)** Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Fortis Insurance Company. **(4)** Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Fortis Insurance Company, will be in force only when issued by Fortis Insurance Company and accepted by me. **(5)** I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. **(6)** If any of these conditions are not met, Fortis Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

Signature of Primary Proposed Insured _____

(Circle one)
A.M. / P.M.

Signature of Spouse or Other Insured (if proposed to be insured) _____

Date Signed _____

Time Signed _____

City & State _____

Requested Policy Effective Date _____

Conditional Receipt Given? Yes No

Health Advocates Alliance Membership Application

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the right to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure, form 26588.

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association. If participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association-sponsored programs or benefits.

Member Name (Please print) _____

Member Signature _____

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