



Apply Now

- When completing the health history application, try to answer all medical questions with as much detail as possible. Don't worry about leaving anything blank – we will review your application upon receipt and let you know if you missed anything.
- Keep in mind the underwriting process can take up to six weeks. If the underwriter requests medical records, the decision could take longer (up to 60 days). If you need coverage right away, call us or visit our website to sign up for short-term medical insurance (coverage can start as early as midnight tonight).
- Please review the following chart for payment details:

	MEDICA	MCHA	BLUE CROSS	HEALTH PARTNERS
1 st Month's Premium required with application	✓	✓	✓	
Automatic withdrawal required for monthly payment	✓	✓	✓	✓

*Checks must be written from a personal account; however, there are exceptions to this rule. Please contact an InsuranceSmart representative for details. All checks are payable to the insurance carrier NOT InsuranceSmart.

- Sign and date application. Applications must be received by the home office of the insurance company within 15 days of the signature date.
- Return the application to:

InsuranceSmart

9220 Bass Lake Rd, Suite 300

New Hope, MN 55428

Fax 763-577-0358 (HealthPartners applications may be received via fax)

We will send a confirmation notice upon receipt of your application. Do not cancel your existing medical policy until you have verification that your new policy has been approved. Should you be declined coverage, you may qualify for the Minnesota Comprehensive Health Association (MCHA) Plan. Please contact an InsuranceSmart representative for more details.

We look forward to servicing your insurance needs. Please don't hesitate to contact us at 763-550-0638 or 800-645-6920 with any questions or concerns you may have.



9220 Bass Lake Road, Ste 300 – New Hope, MN 55428

763-550-0638 or 800-645-6920 Fax 763-577-0358

www.InsuranceSmartOnline.com ■ MN Lic #IA-20018362

**MINNESOTA
APPLICATION FOR MEDICAL INSURANCE**

PLEASE PRINT IN BLACK INK

AGENT INFORMATION

Agency Name and Time Number RON GRAMS JR INC DBA INSURANCE SMART 000858DJ100001
 Agent Name and Time Number RON GRAMS JR. 000858DJ000001 Phone # 763-550-0638
 Agent Fax Number 763-577-0358 General Agent is located in the state of MINNESOTA

TYPE OF ACTIVITY check appropriate box

- New Applicant**
- Upgrading Coverage**
Existing Policy # _____
- Change to an existing policy. Policy #** _____
- Adding Dependent

Reinstatement of Coverage

Applying for removal of special exception rider

Applying for removal/reduction of special class premium

Other _____

PERSON(S) TO BE INSURED

	Name			Sex	Age	Birthdate Mo/Day/Yr	State of Birth	Height	Weight	Social Security #	Tobacco User
	Last	First	M.I.								Refer to p. 4, #26
1. (Primary)											<input type="checkbox"/> Yes <input type="checkbox"/> No
2. (Spouse)											<input type="checkbox"/> Yes <input type="checkbox"/> No

3. DEPENDENT'S NAME	Name			Relationship	Sex	Age	Full Time Student		Birthdate Mo/ Day /Yr	Height	Weight	Social Security #
	Last	First	M.I.				Yes	No				

4. Resident Address

STREET _____ CITY _____ STATE _____ ZIP _____

5. Does any proposed insured live outside the above household? Yes No

If yes, explain _____
(IN CASE OF A MINOR, CUSTODIAL PARENTS SIGNATURE WILL BE REQUIRED TO ATTEST TO MEDICAL HISTORY)

6. Home Phone Number _____ AREA CODE _____ NUMBER _____ Best time to call _____

7a. Occupation (Primary): _____ Full-Time Part-time Hours worked per week _____

Company Name: _____ Work Phone Number: _____

Duties: _____

Self Employed: Yes No Covered by Worker's Compensation: Yes No

7b. Occupation (Spouse): _____ Full-Time Part-time Hours worked per week _____

Company Name: _____ Work Phone Number: _____

Duties: _____

Self Employed: Yes No Covered by Worker's Compensation: Yes No

POLICY INFORMATION – PLEASE PROVIDE A PROPOSAL/QUOTE

BILLING

8. Quarterly Annual Semi-Annual Bank Draft (Complete attached form) Existing Account # _____
 Send premium notices to: Insured Other (Print name, street number, city, state & zip)

OTHER COVERAGE IN FORCE OR APPLIED FOR

9. 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/ Individual/ COBRA	Type of Coverage	Effective Date	Termination Date

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

The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Medical Authorization on page 6 for a definition of "Emergency Medical Personnel".

13. Have any of the proposed insureds ever been declined, postponed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance or had such coverage rescinded? Yes No
 If yes, give details

HAZARDOUS ACTIVITIES & DRIVING

14. Have any of the proposed insureds ever participated in organized racing including but not limited to, automobile, motorcycle or powerboat racing or any of the following activities: skydiving, ultralight flying, scuba diving, hang gliding, rock or mountain climbing? Yes No

If yes, indicate who and which activity	When/How Often	Do you plan continued participation? <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

15. Have any of the proposed insureds been convicted of driving while intoxicated in the past 5 years or convicted of 2 or more moving violations in the past 2 years? Yes No
 If yes, indicate who and type of violation. _____ Date/s _____

HEALTH STATEMENT

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH YES ANSWER ON PAGE 5 "ADDITIONAL MEDICAL DETAILS".

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

16. HAD ANY DIAGNOSIS OF, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYSICIAN CONCERNING:

Yes No

The applicant does not have to disclose an HIV (AIDS Virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Refer to the Medical Authorization on page 6 for a definition of "Emergency Medical Personnel".

- a) The lungs or respiratory system including but not limited to hayfever or other allergies, sinus infections, asthma, bronchitis, tuberculosis, pneumonia or emphysema?
- b) The heart or circulatory system including but not limited to high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis or elevated cholesterol? (provide last blood pressure reading and cholesterol level if known)
- c) The digestive system including but not limited to ulcer, gastritis, heartburn, intestinal disorder, colitis, gallbladder, hemorrhoids, hernia, disorder of the pancreas, spleen, or liver including but not limited to, hepatitis, jaundice or cirrhosis?
- d) The nervous system including but not limited to epilepsy, seizures, unconsciousness, convulsions, vertigo, headaches, paralysis, multiple sclerosis, cerebral palsy, Parkinson's disease, stroke or mini-stroke, TIA or brain attack?
- e) Mental disease or nervous disorder including but not limited to any emotional disorder, anxiety, depression, attention deficit disorder, eating disorder, or psychiatric treatment or counseling?
- f) Congenital disorder, birth defects or developmental disorders including but not limited to Down Syndrome, mental retardation, autism, cleft palate, club foot, or congenital heart defects?
- g) The genitourinary system including but not limited to any kidney disorder, kidney stones, cystitis, prostatitis, bladder infections, or sexually transmitted disease?.....
- h) Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder?.....
- i) The muscular, skeletal or connective tissue disorder including but not limited to arthritis, lupus (SLE), temporomandibular joint disease (TMJ), any back or spine disorder or treatment of any muscular or neuromuscular disorder or any manipulation therapy?
- j) Blood or lymph disorders including but not limited to anemia or lymphadenopathy?.....
- k) Cancer? Provide location, type of cancer and treatment received
- l) Tumor, cyst or growth of any kind; any breast or skin disorders? Provide location, state if treated or removed and date
- m) Any disorder of the eyes, ears, (including ear infections or ear tubes), nose or throat. Tonsils or adenoids, any speech or hearing impairment?.....
- n) 1. Any disorder of the reproductive organs, including but not limited to disorders of the penis, testes, vagina, ovaries and cervix, uterus, diagnosed or treated for infertility or irregular menstruation?
- 2. To the best of your knowledge, are you, your spouse or any dependent now pregnant?
- 3. Is any person not named on this application form now pregnant by any person to be insured?

IF EITHER N-2 OR N-3 IS ANSWERED YES, MEDICAL COVERAGE CANNOT BE ISSUED.

QUESTIONS 4-6 FOR FEMALE APPLICANTS:

- 4. Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage?
- 5. DATE OF LAST PAP SMEAR _____ RESULTS _____
- 6. Have you been instructed to have a repeat pap smear or any follow-up treatment or tests as a result of your last pap smear?

- 17. Been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession?
- 18. Been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession?
- 19. Diagnosed or treated for an immune deficiency disorder, lymphadenopathy (swollen lymph nodes), loss of appetite, significant weight loss, chronic fatigue, fever, oral thrush, skin rashes or unexplained infections?
- 20. Had surgery or has diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed?
- 21. Does any person have any fixation/prosthetic devices present including but not limited to plates, screws, pins, implants (including breast implants), shunts, pacemakers or valve replacements?.....
- 22. Had an electrocardiogram, chest x-ray, or blood test or any other diagnostic testing of any kind or been hospital confined in the past 10 years? If yes, give name of physician or hospital and results.
- 23. Been a member of Alcoholics Anonymous or had any treatment, including but not limited to, counseling for alcoholism or alcohol abuse or been advised by a physician to discontinue or decrease alcohol consumption?
- 24. Used, within the past 5 years, cocaine, hallucinogenic, or other illegal drugs or received treatment for drug abuse or chemical dependency?
- 25. To the best of your knowledge, does any person to be insured have any mental or physical impairment, disease or deformity not indicated above?

HEALTH STATEMENT (continued)

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH YES ANSWER ON PAGE 5 "ADDITIONAL MEDICAL DETAILS".

Yes No

26. Have you or your spouse (if to be insured) smoked cigarettes or used tobacco in any form or nicotine substitute within the past year?..... Primary Proposed Ins.
Spouse
- 26a. Have you or your spouse EVER smoked cigarettes or used tobacco products? If yes, indicate who, amount per day and year quit. _____
27. Is any proposed insured currently taking or taken within the past 3 months, any medication or receiving medical treatment of any kind? Provide details of treatment including name and dosage of all medications.

REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM OR RIDER

28. Has there been any medical treatment for, or have you consulted with a physician concerning the condition(s) which has been ridered or rated since the covered person's effective date? Yes No If yes, provide details _____

REGULAR PHYSICIAN

29. Regular physician or medical practitioner for each proposed insured: (If none, provide last doctor seen, date, reason & results)

Primary Proposed Insured's Physician _____

Address _____

Date Last Seen _____ Reason & Results _____

Spouse's Physician _____

Address _____

Date Last Seen _____ Reason & Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason & Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason & Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason & Results _____

Child's Name _____ Physician _____

Address _____

Date Last Seen _____ Reason & Results _____

ADDITIONAL MEDICAL DETAILS

(Attach a separate sheet if additional space is needed. Date and sign any additional sheet.)

		Provide dates, type of treatment, and results.	Name of Doctor or Hospital and Complete Address and Phone Number.
Person	Question No.		
Condition:			
Person	Question No.		
Condition:			
Person	Question No.		
Condition:			
Person	Question No.		
Condition:			
Person	Question No.		
Condition:			
Person	Question No.		
Condition:			
Person	Question No.		
Condition:			
Person	Question No.		
Condition:			
Person	Question No.		
Condition:			

I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. The application form and any amendments shall be the basis for the contract. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date of the application; B) The requested Effective Date. A change in the health of the proposed insured(s) after the completion of the application form and before the delivery of the contract may affect my eligibility for insurance with the company. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.

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

This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.

I agree that a photographic copy of this authorization shall be valid for two years from the date signed.

I acknowledge receiving the Fair Credit Reporting Act Pre-Notification, the notification regarding the Medical Information Bureau, the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.

We, the undersigned Proposed Insured(s) and agent acknowledge that the Proposed Insured(s) has read the completed application. We understand and acknowledge that any fraudulent statement or material misrepresentation on the application and/or any amendments which is determined to be willfully false or intentionally misleading may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

A.M.

P.M.

Signature of Primary Proposed Insured

DATE SIGNED TIME SIGNED CITY & STATE

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

Signature(s) of Other Dependents 18 or Over
(If proposed to be insured)

Guardian's Signature

Requested Effective Date _____

Premium Amount Sent \$ _____
20.00

One Time Processing Fee Sent \$ _____

Conditional Receipt Taken? Yes No

ATTENTION: (Agent)

I have reviewed this application to ensure that all required items have been completed.

To the best of my knowledge there is , is not a replacement of Medical Insurance involved in this transaction.

Are you aware of any mental or physical impairment, disease or deformity of any proposed insured which is not disclosed on this application? Yes No

If yes, please explain _____

Ron Grams Jr.

Licensed Resident Agent's Signature

RON GRAMS JR. 000858DJ000001

Print Agent Name & Agent Number or Business Number

Initial here if you witnessed the signing of this form by the Proposed Insured(s).

FAIR CREDIT REPORTING ACT AND PRIVACY ACT PRE-NOTIFICATION

Thank you for considering Time Insurance Company as your insurance carrier. Your application will be processed as quickly as possible. Public Law 91-508 and state privacy acts require that we advise you that an investigative consumer report may be made in connection with this application which will provide applicable information concerning character and general reputation. The information for this report may be obtained through telephone or personal interviews with you, your friends, neighbors and associates. You may request an interview in connection with the preparation of the report. Upon written request, you are entitled to receive a copy of the report.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

Information collected by us and used to issue an insurance policy or certificate may be disclosed to third parties without your specific authorization.

You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin 53203.