

STEPS TO APPLY

ConnectiCare, Inc. & Affiliates

Steps to Apply – ONLINE:

For added convenience, you can apply for ConnectiCare SOLO online. Your ConnectiCare Agent will send you an e-mail invitation that provides detailed information about the online enrollment process. Or, you can go directly to connecticare.com to apply or get a quote yourself. Remember to select your agent from the list provided. Plus, you will be able to check online for an updated status of your application once it's submitted.

Online application has these advantages:

- It expedites the process because the Individual Application Packet (Parts 1-3) goes directly to our underwriting department.
- It helps to prevent you from leaving out necessary information.
- No postage is required.
- No mail delays or lost mail.
- It helps the environment by using less paper.

Steps to Apply – PAPER:

APPLICANTS MUST:

- 1) Complete, sign and date the Individual Application/Change Form – PART 1 – no more than 60 days prior to the requested effective date. Be sure to:
 - a. Check the box for the medical plan being selected.
 - b. Check the boxes for the pharmacy co-pay and pharmacy annual maximum that are being selected (does not apply to HDHP plans).
 - c. Select a Primary Care Physician (PCP) for each family member applying for coverage and write the PCP name and Provider ID number in the appropriate boxes. For a complete list of participating providers and their ID numbers, go to “Find a Doctor” at www.connecticare.com or see our print directory. To request a copy, contact Member Services at 1-800-251-7722.
- 2) Accurately and completely answer all questions on the Individual Health Statement – PART 2 – for each family member applying for coverage.

If the applicant knowingly provides false information and/or omits information on the application or health statement and such information submitted or omitted materially affects the risk assumed by ConnectiCare, ConnectiCare will seek to have the policy rescinded.

- 3) Complete, sign and date the Underwriting Authorization Form – PART 3.
- 4) For dependents under age 18, the application must have a parent/guardian's signature and date – and the parent/guardian's full name must be printed on the application. Dependents age 18 and over must sign and date the application themselves.

Note: Persons under age 19 may not apply for coverage as a subscriber.

- 5) All completed forms must be signed, dated and received at ConnectiCare by the last day of the month for an effective date on the 1st of the next month. (i.e. A complete application received by January 31st would be eligible for a February 1st effective date. A complete application received on February 1st would be eligible for a March 1st effective date. *Please note that if the application is approved in these scenarios, at least two months of premium will be due right away.*)

Steps to Apply – ONLINE or PAPER:

- 6) You do not have to submit your first premium payment with your application. However, once you are approved, all premiums from the effective date of coverage are due by the first of the month following the date of the approval letter, or the effective date of the policy, if later. This could mean that you could owe us more than one month of premium and owe the premium quickly. All premiums not received by the first of the month for the month of coverage are considered past due. This applies to all premium payment methods – check, Electric Funds Transfer (EFT) and credit card.

6a) When paying your premium via EFT, there are two options to choose from:

- You can sign up for EFT along with your initial application. All you have to do is complete the EFT form and attach a voided check or statement savings deposit slip with your application. Complete, sign and date the Electronic Funds Transfer Form — FORM 4. **Be sure to include a check marked “Void”.**
- You can wait to sign up for EFT until after you are accepted by and enrolled in ConnectiCare SOLO. All you need to do is sign the front of the first invoice voucher and return it with your premium payment. For future payment drafts, we will use the checking account number that appears on the check you submit for the initial premium payment. You do not need to submit a separate form when enrolling in EFT this way.

6b) To pay your premium by credit card:

Log on to the secure member section of our website at www.connecticare.com. Click the following links:

- Members
- Managing Your Account
- Get Information About Your Plan
- Billing Invoice & Credit Card Payment

You will need to sign on to the website with a username and password to activate payment by credit card. If you are new to the website, you will need to register first to gain access.

To continue paying your premium by credit card on an ongoing basis, you will need to log on to the site and activate payment each month.

6c) To pay your premium by check:

Mail payments to:
ConnectiCare, Inc.
P.O. Box 30726
Hartford, CT 06150

7) If applicable, complete the Domestic Partner Verification Form or other satisfactory certification as we determine.

8) **OPTIONAL:** Broker Authorization Form – must be completed and received for ConnectiCare to release to the broker ANY information that includes any personal health information. All applicants and dependents age 18 and over must sign this form if they wish to have the broker receive their personal health information.

9.) Effective dates for coverage are the first of the month following the date we receive your complete application.

Acceptance into the plan is based on our review of the Individual Health Statement(s) and the applicant meeting the eligibility requirements and underwriting criteria. As part of our medical underwriting, ConnectiCare may need access to your medical records and other medical information. It is your responsibility to provide us access to that medical information and to pay for any costs your physician’s office may charge to copy and send us those records. If we do not have complete medical information, your application will be incomplete, and will be withdrawn if you do not arrange to have the medical records provided to us within 45 days of the request. For additional copies of ConnectiCare SOLO forms, contact your Agent or call Member Services at 1-800-251-7722.

The following information is being provided in accordance with the recent Connecticut State mandate (SB 46, PA 09-46), which requires Medical Loss Ratio (MLR) disclosure by all insurance companies.

Medical Loss Ratio for calendar year 2009: ConnectiCare, Inc. (CCI) 88.9%

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and is calculated in accordance with Connecticut law.

Medical Loss Ratio for calendar year 2009: ConnectiCare Insurance Company, Inc. (CICI) 96.0%

The medical loss ratio is defined as the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut and is calculated in accordance with Connecticut law.

P.O. Box 4058, Farmington, CT 06034-4058 ■ www.connecticare.com ■ 1-800-251-7722

| | | | | | | | | | |
|--|-----|-------------|--|--|--------------------------|------------------------|------------------------------------|---|--|
| APPLICANT INFORMATION: Complete all sections, sign at bottom and read information on reverse side. | | | | | | | | | |
| Check one: <input type="checkbox"/> New Application <input type="checkbox"/> Add Dependent <input type="checkbox"/> Change Ind. Plan Choice (select new choice below) <input type="checkbox"/> Other (Name change, address change, etc.) Indicate change _____ | | | | | | | Eff. Date (mm/dd/yy) / / | | |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married (Civil Union) <input type="checkbox"/> Legally Separated <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partnership (include "Statement of Domestic Partnership") | | | | | | Email Address _____ | | | |
| First Name | | Middle Name | | | Last Name | | | | |
| Street Address | | | | | | | Home Telephone Number | | |
| City | | State | | | ZIP Code | | Work Telephone Number | | |
| P.O. Box/Billing Address (if different from street address) | | City | | | State | | ZIP Code | | |
| ConnectiCare, Inc. = HMO Benefit Plans and ConnectiCare Insurance Company, Inc. = POS Benefit Plans | | | | | | | | | |
| POS Benefit Plans (Select one) (In-Network Deductible=Individ./Family): <input type="checkbox"/> POS Hospital Deductible \$2,500/\$5,000 – C <input type="checkbox"/> POS Hospital Deductible \$5,000/\$10,000 – C <input type="checkbox"/> POS Upfront Deductible \$500/\$1,000 – C <input type="checkbox"/> POS Upfront Deductible \$750/\$1,500 – C <input type="checkbox"/> POS Upfront Deductible \$1,000/\$2,000 – C <input type="checkbox"/> POS Upfront Deductible \$1,000/\$2,000 – 50% – C <input type="checkbox"/> POS Upfront Deductible \$1,500/\$3,000 – 20% – C <input type="checkbox"/> POS Upfront Deductible \$2,000/\$4,000 – C <input type="checkbox"/> POS Upfront Deductible \$2,500/\$5,000 – C <input type="checkbox"/> POS Upfront Deductible \$2,500/\$5,000 – 20% – C <input type="checkbox"/> POS Upfront Deductible \$2,500/\$5,000 – 50% – C <input type="checkbox"/> POS Upfront Deductible \$5,000/\$10,000 – 50% – C <input type="checkbox"/> POS Copay and Deductible \$5,000/\$10,000 – 20% – C <input type="checkbox"/> POS Upfront Deductible \$10,000 Combined – C | | | | | | OR | | HSA Compatible Plans (Select one HMO plan or POS plan) (Deductible=Individual/Family): HMO HDHP <input type="checkbox"/> \$5,000/\$10,000 Deductible – C POS HDHP <input type="checkbox"/> \$1,500/\$3,000 Deductible – C <input type="checkbox"/> \$2,000/\$4,000 Deductible – C <input type="checkbox"/> \$3,000/\$6,000 Deductible – C <input type="checkbox"/> \$5,000/\$10,000 Combined Deductible – C | |
| Pharmacy Co-Pay (Select one): <input type="checkbox"/> \$15 / 50% / 50% \$200 Deductible T2/T3 <input type="checkbox"/> No RX | | | | | | | | | |
| MEMBER(S): | | | | | | | | | |
| First Name/Middle Initial/Last Name | Add | Delete | Social Security Number or Current Member Identification Number | Sex | Date of Birth (mm/dd/yy) | Primary Care Physician | Provider ID Number (6 or 8 digits) | Existing Patient | |
| Applicant | | | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | / / | | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Spouse/Civil Union/Domestic Partner | | | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | / / | | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dependent 1 | | | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | / / | | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dependent 2 | | | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | / / | | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dependent 3 | | | _____ | <input type="checkbox"/> M <input type="checkbox"/> F | / / | | _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Race/Ethnicity (optional): This information is designed for the purpose of data collection and will not be used to determine eligibility, rating or claim payment. | | | | | | | | | |
| Applicant: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown | | | | | | | | | |
| Spouse/Civil Union/Domestic Partner: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown | | | | | | | | | |
| Dependent 1: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown | | | | | | | | | |
| Dependent 2: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown | | | | | | | | | |
| Dependent 3: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Amer. Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown | | | | | | | | | |
| Tell us about your other insurance: Do you have any other health insurance policy or certificate in force? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |
| Name of other insurance company | | | Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual | | | Last date of coverage | | | |
| Do you intend to replace your current medical or health policy with this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | |

| | |
|-----------------------|-----------------|
| AGENT SECTION: | |
| Agency Name | Phone Number |
| Agent Name (Print) | Agent Signature |

| | |
|-------------------------------|-------|
| FOR BUSINESS USE ONLY: | |
| Effective Date | |
| Account # | Other |

Important: [The applicant, spouse/partner and all dependents aged 18 and over must sign this form]. By [selecting I (we) agree] signing here I acknowledge and agree that I have read and understand the information on the front **and back** of this form and Part 2: Health Statement. I also agree that the Member Consent below is valid as long as I am enrolled in a ConnectiCare health plan. I certify that I have personally completed this application on behalf of myself and on behalf of my dependents listed on the application who are under the age of 18. I represent that the answers and statements made herein and in Part 2 Health Statement are true, complete and correctly recorded to the best of my knowledge and belief. I understand that I have an obligation to notify ConnectiCare of any new conditions or changes in health condition that may occur after this application is signed and before any approval of my application. I acknowledge that I have received a copy of the Outline of Coverage for the Plan I have selected above. I acknowledge and agree that with respect to any dependents under age 18 that I am authorized to make these statements on their behalf. I further understand and agree that: (1) ConnectiCare may decline my application and that this application and the initial premium do not give me immediate coverage; (2) the broker has no authority to promise coverage or to modify ConnectiCare’s underwriting policy and is only authorized to submit this application and the initial premium payment; (3) if I have provided incorrect or incomplete information on this application and/or Health Statement that ConnectiCare may rescind any policy issued. This means that ConnectiCare will cancel coverage as if the policy never existed; and (4) I have personally read and completed this application and Health Statement and that if I am accepted that this application/Health Statement will become part of the contract between ConnectiCare and me and I agree to abide by the terms of that contract.

This plan is issued on an individual basis and is regulated as an individual health insurance plan.

| | | |
|---|---|------|
| Applicant Signature | | Date |
| Print name of parent/guardian (if applicable) | Dependent Signature (age 18 years-over) | Date |
| Spouse/Partner Signature (if applicable) | Dependent Signature (age 18 years-over) | Date |

STATEMENT OF ACCOUNTABILITY

To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Application/Health Statement for the applicant named below because: Applicant does not read English Applicant does not speak English Applicant does not write English
 Other (explain): _____

I am qualified to translate the contents of this form and translated this information to: _____.

To the best of my knowledge I obtained and listed all the requested personal and medical history disclosed by this applicant. I also translated and fully explained the statements above.

| | |
|------------------------------------|--------------|
| Signature of Translator (required) | Today's Date |
|------------------------------------|--------------|

IMPORTANT: MEMBER CONSENT

On my behalf and on behalf of my spouse and/or dependent(s), I hereby authorize any physician, hospital, provider, insurer, ConnectiCare Inc., (CCI) or a CCI affiliate, or other organization or person having records, data or information concerning health history or medical insurance for me or my family member(s), including but not limited to information concerning mental health, alcohol/substance abuse or HIV or AIDS-related conditions, to transfer to any person or company such records, data or information as may be required for the purpose of providing treatment, paying claims, and performing other operations to administer my Benefit Plan. I understand that CCI’s privacy notice contains a more complete description of the purposes for which information about me and my dependent(s) may be used or disclosed and that I have a right to review the privacy notice prior to signing this consent. I understand that CCI may change such notice at any time but will provide me a copy of any amended notice. I understand that I have a right to request restrictions on how information about me and my dependent(s) may be used or disclosed to carry out the plan administration purposes and that CCI is not required to agree to the requested restrictions. I understand that this authorization is valid for the term of my and my dependents’ coverage under the Plan. I understand that I can revoke this authorization (but will be terminated from the Plan) at any time by giving written notice to CCI as long as CCI or others have not taken action relying on this authorization. I acknowledge that I have retained a copy of this authorization.

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime punishable by penalties, imprisonment and restitution depending on applicable laws.

Any new conditions or changes occurring after the application is submitted but prior to approval, must be reported to ConnectiCare.

P.O. Box 4058, Farmington, CT 06034-4058 ■ www.connecticare.com ■ 1-800-251-7722

| PLEASE PRINT IN INK AND COMPLETE BOTH SIDES OF FORM FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE. | | | | | | |
|---|---------------------------|----------------|---------------|----------------------------|--|-------------------|
| First Name/Middle Initial/Last Name | | Height (ft/in) | Weight (lbs.) | Date of Birth (mm/dd/yyyy) | Sex | Social Security # |
| Applicant | | | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| Spouse/Partner | | | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| Occupation Applicant | Occupation Spouse/Partner | | | | | |
| Dependent 1 | | | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| Dependent 2 | | | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| Dependent 3 | | | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| Dependent 4 | | | | / / | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |

IF YOU ANSWER "YES" TO ANY QUESTION, YOU MUST PROVIDE COMPLETE DETAILS IN THE HEALTH HISTORY SECTION.

In the last 10 years, has any person applying for coverage on this application: 1) had any signs or symptoms, 2) seen a health care provider, 3) had treatment recommended, including prescription medications, 4) received treatment, 5) had the diagnosis of or 6) been hospitalized for, any of the following conditions?

DO NOT INCLUDE ANY GENETIC INFORMATION IN YOUR RESPONSE. "GENETIC INFORMATION" INCLUDES:

- INFORMATION ABOUT GENETIC TESTING OF ANY APPLICANT OR OF ANY APPLICANT'S FAMILY MEMBERS;
- ANY MEDICAL HISTORY INFORMATION ABOUT ANY FAMILY MEMBER NOT APPLYING FOR COVERAGE; AND
- ANY GENETIC SERVICES REQUESTED OR RECEIVED BY ANY APPLICANT OR ANY APPLICANT'S FAMILY MEMBERS.

- Brain/Nervous System** – such as frequent and/or severe headaches, migraines, seizures, epilepsy, recurrent numbness/tingling, restless leg syndrome, head injury with loss of consciousness, paralysis, stroke, memory loss, narcolepsy, use of a sleep monitoring device? Yes No
- Heart/Circulatory** – such as chest pain, angina, heart disease, heart attack, heart murmur, valve problem/replacement, pace-maker, defibrillator, or blood clot, phlebitis, varicose veins, rheumatic fever, Raynaud's, irregular heart beat? Yes No
- Blood Disorder/Problems** – such as high blood pressure, blood clotting problem, bleeding disorder, anemia or other blood disorders? Yes No
- Lungs/Respiratory** – such as sleep apnea, emphysema, asthma, allergies, difficulty breathing, shortness of breath, pneumonia, tuberculosis, chronic cough, spitting/coughing up blood, sinusitis, bronchitis, use of portable oxygen? Yes No
- Digestive** – such as colitis, hepatitis, liver disease, cirrhosis, rectal bleeding, infections of the mouth/throat, jaw/chewing problems, gastric reflux (GERD), frequent heartburn, ulcers, hernia, polyps, hemorrhoids, gallbladder disease including gallstones, pancreatitis, jaundice, unexplained weight loss? Yes No
- Urinary** – such as kidney, bladder, urinary tract infections, stones, urinary incontinence, blood in urine, prostate problems? Yes No
- Muscle/Bone/Joint** – such as bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/joint, amputation, physical handicap, polio, arthritis, gout, sprain/strain, prosthesis, joint replacement, internal fixations or hardware (i.e., pins, plates, screws), fractures, TMJ disease of the jaw, chronic back, neck, shoulder, hip, knee, hand or foot pain? Yes No
- Endocrine/Hormonal** – such as diabetes, thyroid disease, adrenal disorders or pituitary disorders? Yes No
- Infectious/Immune** – such as Lupus, HIV, immune disorders, scleroderma, Epstein-Barr virus/chronic fatigue syndrome, chronic Lyme Disease or lymph node disorder? Yes No
- Skin Disorder** – such as any kind of skin cancer, melanoma, psoriasis, actinic keratosis, disfiguring birthmarks, 3rd-degree burns, acne, fungal infections, eczema, dermatitis, herpes, shingles, scars/keloids, or revisions of cosmetic or reconstructive surgery, chronic skin infections? Yes No
- Ears, Eyes, Nose and Throat** – such as any infections, deafness, crossed eyes, chronic dry eye requiring treatment, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, problems with tonsils or adenoids, sleep apnea? Yes No
- Mental, Emotional, Behavioral, Substance Use** – such as schizophrenia, bi-polar, chemical imbalance, obsessive-compulsive disorder, panic disorder, anxiety, attention deficit disorder (ADD), depression, psychological or psychiatric counseling, anorexia/bulimia, eating disorder, or alcohol or substance use/abuse/dependency? Yes No

(continued on next page)

IF YOU ANSWER "YES" TO ANY QUESTION, YOU MUST PROVIDE COMPLETE DETAILS IN THE HEALTH HISTORY SECTION.

APPLICANT NAME: _____ APPLICANT SOCIAL SECURITY # _____

QUESTIONS, CONTINUED FROM PAGE 1. For "YES" answers, details must be provided below under the "Health History" section.

13. Developmental/Congenital Abnormalities, Birth Defects – such as Down’s syndrome, mental retardation, developmental delay, skull/facial deformities, heart/lung problems, cleft lip/palate, club foot, webbed fingers or toes, disfiguring birthmark? Yes No

14. Cancer, of any kind – such as skin cancer, colon cancer, breast cancer, throat cancer, ovarian cancer, uterine cancer, prostate cancer, leukemia, Hodgkin’s disease, lymphatic cancer, bone cancer, bone marrow cancer, any other cancers, tumors, or lymph node enlargement? Yes No

15. Male Reproductive System (all men must respond)

a) such as: infertility, low sperm count, impotence, sexual dysfunction, penile or scrotal implant, sexually transmitted disease, herpes, genital warts, undescended testes? Yes No

b) Are you expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not listed on this application? If yes, please provide the expected delivery/adoption date: _____ Yes No

16. Female Reproductive – (all females between ages 10-55 must respond)

a) such as breast disorder/cyst, lump, silicone breast implants, fibroid tumors, endometriosis, pelvic pain, menstruation disorders, abnormal/absent or irregular menstrual bleeding, uterine fibroids, ovarian cysts, infertility treatment/services, miscarriages, sexually transmitted disease, herpes, genital warts (HPV)? Yes No

b) Does any proposed female applicant menstruate? Yes No
If yes, indicate if: _____ Applicant _____ Spouse/Partner _____ Dependent(s)
Name(s): _____

c) Has it been more than 40 days since her/their last menstrual period? Yes No
Name(s): _____ Applicant _____ Spouse/Partner _____ Dependent(s)
If yes, explain: _____

d) Has any female applicant over age 16 had a pelvic exam/Pap smear? Yes No
If yes, provide the date and result of the last pelvic exam/Pap smear: Name(s): _____
Mo/Day/Yr: _____ Normal _____ Abnormal _____

e) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy? Yes No
If yes, please provide the expected delivery/adoption date: _____

17. In the last 10 years, has any applicant:

a. ever been a candidate for, or a recipient of a bone marrow transplant or organ transplant, including cornea transplant? Yes No

b. been placed on a waiting list and/or registered to donate an organ or bone marrow (excluding DMV donor card)? Yes No

c. ever had any non-malignant (benign) tumor/growth or cysts? Yes No

d. ever been diagnosed with obesity and/or have a problem with weight control? Yes No

e. been a patient in a hospital, clinic, surgicenter, or other medical facility as an inpatient or outpatient (excluding childbirth)? Yes No

f. had health, disability, long-term care or life insurance declined, modified, postponed or rated? Yes No

g. been disabled or unable to perform their normal activities, or require the use of any assistive devices including a wheelchair, walker, portable oxygen, etc.? Yes No

h. been told by a medical professional, or ever been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or AIDS-related conditions? Yes No

i. ever smoked or used tobacco? Yes No
If yes, who and for how long? _____
If no longer smoking/using tobacco, date of last cigarette/tobacco use? _____

j. had an abnormal physical exam, laboratory results, X-rays, EKG, MRI, CT Scan, PET Scan, ultrasound, cardiac testing, or been advised to undergo further testing, surgery, consultation or treatment? Yes No

k. had any surgical procedures? Yes No

18. In the past 5 years has any applicant taken, or been advised to take, any prescription medications or prescription food supplements on a long-term basis (for longer than 1 month)? Yes No

IF YOU ANSWER "YES" TO ANY QUESTION, YOU MUST PROVIDE COMPLETE DETAILS IN THE HEALTH HISTORY SECTION.

(continued on next page)

APPLICANT NAME: _____ APPLICANT SOCIAL SECURITY # _____

| QUESTIONS, CONTINUED FROM PAGE 2. | | | | |
|--|------------------|---------------|---------|---------|
| 19. In the past 12 months has any applicant been advised to see a dentist or oral surgeon (excluding routine checkups)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 20. Has any applicant applying for coverage had any medical problems which have not been disclosed on this Health Statement? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 21. In the past 12 months has anyone been treated for any injuries? If so, please provide date of injury, first date of treatment, recovery date and detail of injury/accident. <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| 22. Last doctor visit for any reason, including routine checkup in the last 3 years (excluding dental or eye exam). Provide information for all applicants. | | | | |
| Name | Reason For Visit | Date of visit | Results | Physian |
| Applicant | | | | |
| Spouse/Partner | | | | |
| Dependent 1 | | | | |
| Dependent 2 | | | | |
| Dependent 3 | | | | |
| Dependent 4 | | | | |

A detailed explanation must be provided below if you answered "YES" to any question (1-21). NOTE: Simply listing the name of a primary physician or referring to a physician's name will be not be considered a substitute for listing fully detailed answers to the questions. If additional space is needed, you may attach a separate page, which must be signed and dated.

| HEALTH HISTORY: | | | | | | |
|----------------------|-----------------|---------------------|----------------------------------|----------------------|-----------------------|--|
| Question Number/Ltr. | Person Affected | Condition/Diagnosis | Treatment (surgeries/medication) | Date Treatment Began | Date of Full Recovery | Physician Name, Address & Phone Number |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

INSTRUCTIONS: DID YOU REMEMBER TO ...

- Print clearly, complete all sections, and sign and date the application and underwriting authorization form (ages 18 and older)
- Select your primary care physician and include the 6- or 8-digit Provider ID number?
(It can be found at www.connecticare.com – click "Find a Doctor.")
- Attach EFT form with a check marked "Void" (if applicable), or a savings deposit slip?
- Attach Domestic Partner Verification Form or other satisfactory certification as we determine (if applicable)?
- Retain a signed copy for your records?

* By my signature on Part 1, I certify that the statements made herein and in Part 1 are true and complete to the best of my knowledge and belief. Any health conditions that change after the application is submitted but prior to notice of approval, must be reported to ConnectiCare and will be considered in the final underwriting decision.



175 Scott Swamp Road
Farmington, CT 06034
1-800-251-7722

BROKER AUTHORIZATION FORM

Note: This authorization form is not required as part of your application for individual coverage. By completing this form, you are giving permission for your broker to access your personal health information for purposes of checking the status of your application.

By signing below, I hereby authorize ConnectiCare, Inc., its affiliates, employees and agents (collectively “ConnectiCare”), to release to _____ [insert full name of broker/agency] my and/or my dependents’ (those who are under the age of 18 and applying for coverage) personal health information maintained by ConnectiCare (e.g., information relating to the diagnosis, treatment, claims information, and health care services provided or to be provided and which identifies either name, address, social security number or Member ID number) for the purpose of assisting me in my application for individual insurance coverage with ConnectiCare.

I understand that ConnectiCare cannot exclude any particular personal information, and that any personal information that is received by ConnectiCare in connection with my application may be accessible to the broker/agency identified above.

I understand that any personal health information or other information released to the broker/agency identified above may be subject to redisclosure by such broker/agency and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative’s signature below and shall expire one year after the date upon which ConnectiCare makes a determination with respect to my application for coverage. I understand that I have a right to revoke this authorization by providing written notice to ConnectiCare. However, this authorization may not be revoked if ConnectiCare, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

(continued on next page)

ConnectiCare

Broker Authorization Form

Page 2

Name of Applicant: _____

Signature of Applicant: _____

Date: _____

Name of Applicant: _____

Signature of Applicant: _____

Date: _____

Name of Applicant: _____

Signature of Applicant: _____

Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Applicant identified below and will provide written proof (e.g., Power of Attorney) that I am legally authorized to act on the Applicant's behalf with respect to this authorization form.

Name of Applicant: _____

Name of Legal Representative: _____

Signature of Legal Representative: _____

Relationship to Applicant: _____

Date: _____