

## **Member Information**

Name:

Address:

Phone:

Email:

Date of Birth:

Gender:

Height:

Weight:

## **Dependent Information**

### **1. Conditions or Treatments**

Have you and/or any of your family members listed above, seen a medical provider, had treatment recommended, received care, told you need to be treated for any of the following, had any diagnostic testing, surgeries or have been hospitalized for any of the following conditions listed below.

Alcohol or Drug Use, Abuse or Dependency, Cancer or Tumor - Any type (provide all details below), Heart Attack, Bypass, Stroke or Transient Ischemic Attack, Back/Spinal/Skeletal Disorder, Pre Diabetes/Diabetes Type I or II, Ear/Eye/Nose/Throat Disorders, Knee Injury or Disorder, Digestive Disorder, Osteoarthritis, ADHD/ADD, Anxiety/Depression

In the past 5 years, have you or any of your dependents included on this enrollment form been diagnosed or treated for any condition(s) not identified above, been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery? (If yes, please provide details below)

Are you and/or any of your family members listed above confined at home, incapacitated or incapable of self-support, currently hospitalized or hospital confined?

## **2. Pharmacy Assistance Program Income Qualification**

Yearly Income

### **3. Prescription Medications**

Are you and/or any of your family members listed above taking prescription medications?

Prescription Medication Details:

### **4. Pregnancy**

Are you and/or any of your dependents included on this form currently pregnant?

## 5. Coverage Type

Type of Coverage

Requested Effective Date

## Product Information

### Request A Quote

\$0.00 one-time for Pending UW Quote

### Terms and Conditions for Request A Quote

**Submitting this application is NOT an automatic enrollment. This is a request to receive an underwritten quote.**

### PHI Disclosure

By signing this application, I understand the following: That if any information submitted on this form constitutes fraud or there is an intentional misrepresentation of the material fact, the plan may rescind healthcare coverage. In any such case, I understand that the plan will return any contributions that have previously been paid as to the rescinded coverage, minus claims paid. I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information purposes only and does not bind coverage. I understand the Conquer Benefits gathers this information for statistical and actuarial uses only and it will not be used in connection with decisions or actions regarding employment. That if I am a resident in Michigan, I do not have to provide information regarding height or weight, and that this in compliance with requirements for GINA. That I have read the Client Privacy Notification provided to me in this application. That as a prospective member, I have the right to request restrictions on how my protected health information is used, and that the Conquer Benefits is not required by law to grant this request, but if the request is granted, the Conquer Benefits is bound by this agreement. I also understand that I have the right to revoke this consent in writing, except to the extent the Conquer Benefits has already used or disclosed the protected health information in reliance upon my consent. I further understand that the Conquer Benefits will notify the member of any health or enrollment related changes that occur after signing this form, up to the effective date of coverage.

By signing this PHQ, I acknowledge that I am self-employed and upon approval and payment of premium, I will automatically become a passive, non-voting certificate class member of IHA Services, LLC., a Manager Managed, LLC. This certificate of membership will remain in force for as long as I continue to participate in services or benefits offered through IHA Services, LLC. I further understand that while I have certificate membership in IHA Services, LLC., that affords me no managerial status, voting rights or rights to profits or liabilities. I grant full managerial duties to the duly appointed managers of IHA Services, LLC., a manager-managed LLC. Additionally, by becoming a Certificate managers of IHA Services, LLC., a manager-managed LLC. Additionally, by becoming a Certificate Member, I acknowledge that I will only have access to consulting services and products specifically designed for IHA Services, LLC. members. Member understands and agrees the Plan may modify health care fees or be terminated based on Member's experience and/or utilization. Any such modification or termination must be presented to the member 60 days prior to the members renewal date.

### **Client Privacy Notification**

Thank you for completing the requested information. Any information, including non-public personal health information, such as name, address and social security number, including detailed protected health information provided will be used for the sole purpose of providing a risk assessment to the health plan that will provide a health care benefit quote to your employer. The Conquer Benefits' actuary is a legally contracted underwriter acting as a Business Associate to the Conquer Benefits and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. The Conquer Benefits' actuary and underwriter will not sell, license, transmit or disclose this information outside of their offices except as: a) necessary for them to provide the services on behalf of Conquer Benefits, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.

### **Disclosures and Agreements**

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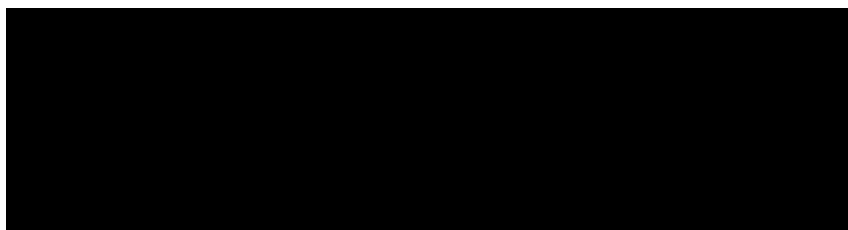
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### **Electronic Signature**

By electronically acknowledging this authorization, I acknowledge that I have read and agree to the terms and conditions set forth in this agreement.



Name:

Date:

IP Address:

System: