

Member Information

Name:

Address:

Phone:

Email:

Date of Birth: 10-07-1970

Gender: F

Height: 65"

Weight: 164 lb

Employee Coverage

Network Option

PHCS

Plan Option

3500Classic

Type of Coverage

MemberIndividualOnly

Requested Effective Date

01/01/2022

Cancer

Have your and/or any of your family members listed above seen a medical provider, had treatment or receiving ongoing care in the last five years for cancer? (If No, move down to Cardiac or Health Disease/Disorder)

No

Cardiac or Heart Disease/Disorder

Have you and/or any of your family members listed above seen a medical provider, had treatment or receiving ongoing care for the last five years for Cardiac or Heart Disease/Disorder? (If No, move down to Diabetes)

No

Diabetes

Have you and/or any of your family members listed above seen a medical provider, had treatment or receiving ongoing care for the last five years for Diabetes? (If No, move down to High Cholesterol)

No

High Cholesterol

Have you and/or any of your family members listed above seen a medical provider, had treatment or receiving ongoing care for the last five years for High Cholesterol? (If No, move down to High Blood Pressure)

No

High Blood Pressure

Have you and/or any of your family members listed above seen a medical provider, had treatment or receiving ongoing care for the last five years for High Blood Pressure? (If No, move down to Conditions or Treatment)

Yes

If yes, provide most recent reading:

Aug 10 101/70, Jun 21 112/81

Additional Details: High Blood Pressure Name of individual, date of onset, treatment plan, medications, degree of recovery.

Lisinopril + HCTZ

Prescription Medication

Are you and/or any of your family members listed above taking prescription medications? (If Yes provide additional information in the chart below)

Yes

Medication 1

Who takes medications? (First/Last) Please list all prescription medications. If additional data fields are required please contact our support team at 1-844-892-7410.

Name of Medication

Lisiniopril HCTZ

Dosage (mg/mcrg)

12.5mg -20mg

Frequency

once a day

Prescribed For (Condition)

high blood pressure

Medication 2

Who takes medications? (First/Last)

Name of Medication

escitalopram

Dosage (mg/mcrg)

10 mg

Frequency

once a day

Prescribed For (Condition)

anxiety

Serious Illness Hospitalization Surgery

Have you and/or any of your family members listed above experienced any of the following related to a serious illness in the past 10 years? (Note: We are only looking for a 10 year history)

Yes

Please provide additional details for any hospitalization or surgeries (Name of individual, type of surgery, ongoing treatments if applicable. If more than one family member please include the additional information above.)

, oophorectomy, 2017

Are you and/or any of your family members listed above currently hospitalized or hospital confined?

No

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

No

Pregnancy

Are you and/or any of your family members listed above pregnant?

No

Pending Tests Biopsies Procedures Scans Therapies

Are you or any individual on this application receiving treatment, follow up care, scheduled for or awaiting results of any tests, biopsies, procedures, lab work, scans or therapies or have been advised to have a test or have been advised of a condition that will require attention in the next twenty-four (24) months?

No

Past 5 Years

In the past (5) years has any person enrolling consulted a health care provider, been diagnosed, received treatment (including prescription medications), or been hospitalized for Hepatitis?

No

In the past five (5) years has any person enrolling consulted a health care provider, been diagnosed,

received treatment (including prescription medications), or been hospitalized for HIV/AIDS? (If No, move down to the next question).

No

In the past 5 years has anyone enrolling in the plan had treatment or symptoms of any serious medical condition not yet indicated?

No

Confirm

Accept Terms and Conditions

Yes

Enter your full name to accept terms and conditions

Product Information

Disclosures and Agreements

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 a

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 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.

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.