

# Health Insurance Enrollment Application

Individual Market - California

**Application Number:** APP-2025-001

**Submitted Date:** 2025-12-18

**Effective Date:** 2026-01-01

**Primary Applicant:** John Smith

**Products:** Medical

# Enrollment Application Form

## Application Information

Application Number:

Effective Date:

Total Premium:

## Primary Applicant

First Name: Last Name:

Date of Birth: Gender:

SSN:

## Mailing Address

Street:

City: State: Zip:

## Spouse (if applicable)

First Name: Last Name:

Date of Birth:

## Dependents

Dependent 1:

First: Last: DOB: Gender:

Dependent 2:

First: Last: DOB: Gender:

# Coverage Summary

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Application Number: APP-2025-001

Effective Date: January 1, 2026

Total Monthly Premium: \$450.00

## Covered Individuals (1):

- John Smith - PRIMARY (Age 40)

Coverage: Gold PPO (\$450.0/mo)

This is a summary of your coverage. Please review all policy documents for complete details.

## Terms and Conditions

### 1. Enrollment Terms

By submitting this enrollment application, you agree to the following terms and conditions. Your enrollment is subject to approval by HealthCare Plus Inc and compliance with all applicable regulations.

### 2. Effective Date

Coverage will become effective on , provided that:

- Your enrollment application is approved
- All required premiums have been paid
- You meet all eligibility requirements
- No material changes occur before the effective date

### 3. Premium Payment

The total monthly premium for your selected coverage is **\$450.00**. Premiums are due on the first day of each month. Failure to pay premiums may result in termination of coverage.

### 4. Covered Individuals

This policy covers the following individuals:

- John Smith - PRIMARY

### 5. Cancellation Policy

You may cancel this policy at any time by providing written notice to HealthCare Plus Inc. Cancellation will be effective as of the end of the premium period for which payment has been made.

### 6. Certification

I certify that the information provided in this application is true, accurate, and complete to the best of my knowledge. I understand that any false statements or material misrepresentations may result in denial of coverage or cancellation of my policy.

### 7. Privacy Notice

Your personal information is protected in accordance with HIPAA regulations and our privacy policy. We will not share your information with third parties without your consent, except as required by law.

### 8. Contact Information

For questions or assistance, please contact us:

#### HealthCare Plus Inc

Phone:

Email:

Website:

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