

| 31. <input type="checkbox"/> Health | | 32. <input type="checkbox"/> Additional Health or <input type="checkbox"/> Dental | | 33. <input type="checkbox"/> Medicare | |
|---|-----------------|---|-----------------|--|--|
| Insured's/Member's Name | Date of Birth | Insured's/Member's Name | Date of Birth | Beneficiary Name | Beneficiary Name |
| Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired | | Employment Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired | | Entitlement Reason: | Entitlement Reason: |
| Name of Employer: | | Name of Employer: | | <input type="checkbox"/> Age 65 or older | <input type="checkbox"/> Age 65 or older |
| Policy # | Effective Date: | Policy # | Effective Date: | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> End Stage Renal Disease |
| Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family | | Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family | | <input type="checkbox"/> Other Disability | <input type="checkbox"/> Other Disability |
| Name of Insurance Company: | | Name of Insurance Company: | | Medicare HIC Number: | Medicare HIC Number: |
| Telephone Number: | | Telephone Number: | | Part A Effective Date: | Part A Effective Date: |
| Address of Claims Center | | Address of Claims Center | | Part B Effective Date: | Part B Effective Date: |
| Does the above insurance cover <u>all</u> family members, including yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list the names of all dependents not covered. | | Does the above insurance cover <u>all</u> family members, including yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please list the names of all dependents not covered. | | | |

34. Change Authorization

I hereby authorize the changes to my Capital Health Plan (CHP) contract. I understand and agree that the changes will not be effective until this application is accepted by CHP. I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company or other organization, institution, or person that has records or knowledge of me or my eligible family members to give that information to CHP (or other affiliated carrier). This release specifically includes, but is not limited to, authorization to release any and all medical records and information associated with reference to certain conditions. I authorize CHP to exchange benefit information with any insurance company, organization, or individual to determine the applicability of the coordination of benefits provision for myself and my eligible family members for treatment, payment, and/or health care operations purposes. I represent that my statements on this application are true and compete and understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

Acceptance of any Coverage/Membership:

I have read and understand the Change Authorization above.

Signature of Certificate Holder/Covered Employee Date

Signature of Employer Representative Date

35. Dependent's alternate address information:

| Name | Alternate Address |
|------|-------------------|
| | |
| | |
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FRAUD NOTICE: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.