Friday Health Plans of North Carolina Inc.•700 Main Street• Alamosa, CO 81101

INDIVIDUAL APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's initial application for coverage.

Contact us online: www.fridayhealthplans.com/members/resources/nc or by phone at 1-844-465-5500

Apply for coverage online at www.fridayhealthplans.com/or submit by mail to the address above

Federal financial assistance may be available for coverage purchased through healthcare.gov. If purchasing coverage through healthcare.gov you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.healthcare.gov.

COVERAGE INFORMATION

Application Type:	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*
Requested Effective Date(required):	_____/_____/_____ (MM/DD/YYYY) Coverage will be effective on the first day of the month following receipt of this completed Application, provided that this completed Application is received by FHP by the 15th of the previous month, unless a later effective date is requested.

* Proof of eligibility for special enrollment will be required.

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name		Middle Initial:		Last Name:	
Social Security #:		Date of Birth:	/ /	Current Age:	Sex: ☐ M F ☐
Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No

* A common law, civil union, or designated beneficiary certification may be required.

Employer Name and Address:		Work Phone:	

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26(older if medically disabled) are applying for coverage. If a dependent child is applying an as individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information.

Please sign and date the additional sheet.

*Social Security Numbers (or document numbers for any legal immigrants) are needed for anyone applying for health insurance, missing numbers will be requested after enrollment

Name (First, MI, Last)	Sex	Social Security #	Relationship	Disabled	Birth Date (MM/DD/YY)	Employer Name and Position
	☐ M ☐ F		SPOUSE/PARTNER			
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)'s Name:			Mailing Address (If different):				
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Primary Applicant Name:

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 if different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

TOBACCO USE (For applicants age 19 and older)

Please answer the following questions to the best of your knowledge. For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used.

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		

MEDICARE/MEDICAID INFORMATION

Is any applicant enrolled in Medicare? ☐ Yes ☐ No

Name of person covered by Medicare: _____. For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program? ☐ Yes ☐ No

Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐ Yes ☐ No

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted? ☐ Yes ☐ No

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only O=Other, please explain:_____

PLAN SELECTION (required, select only one)	
All family members listed on this application must be enrolled on the same plan. Please use a separate application if a different plan is requested for a family member.	
Friday Gold	☐ Friday Gold ☐ Friday Gold Copay
Friday Silver	☐ Friday Silver ☐ Friday Silver Copay
Friday Bronze	☐ Friday Bronze ☐ Friday Bronze Plus ☐ Friday Bronze HSA ☐ Friday Bronze Copay
Friday Catastrophic	☐ Only for individuals under 30 years of age, or a person 30 years of age or over holding a Certificate ofExemption.

PAYMENT INFORMATION

Coverage will not be effective until the first month's premium payment is received. How will you make your first month's premium payment?

☐ Check or Cashier's Check – please submit with yourapplication

☐ Automatic monthly bank draft

☐ Debit Card or Visa/MasterCard

☐ Visa ☐ MasterCard ☐ Discover

Card number_____ Expiration date_____ Security code _____

How will you make your future payments? (Email addresses are required for electronic payments. Email:_____)

☐ Automatic monthly bank draft

☐ Debit Card or Visa/MasterCard

I hereby authorize Friday Health Plans of North Carolina Inc. (FHP) to initiate debit entries to the checking or savings account indicated below and request the financial institution named below to debit the same to such account. This information will be kept for ongoing payments and the account listed will be drafted for the monthly premium amount. I am an authorized signor on the account indicated below:

Account Type: Checking ☐ Savings ☐ (Account will be drafted on the first business day of the month.)

Name of Financial Institution	Address of Financial Institution
Name if Account/Name on Account	
Financial Institution Transit Routing Number (9 digits -see diagram below)	Account Number (See diagram below)

If using a checking account, you must attach a voided check for financial institution and account information verification.

Your Name Check #123

Your Address

Your City, State, Zip Date:_____

Pay to the order of:

Please attach an unsigned voided check here (if applicable)

This is your bank's Transit Routing Number. This is your Account Number.

This authorization will remain in effect until Friday Health Plans of North Carolina Inc. has received written notification of its termination in such time and in such manner as to afford Friday Health Plans of North Carolina Inc. a reasonable opportunity to act upon it.

Primary Applicant Name:

CERTIFICATION OF DENTAL INSURANCE COVERAGE	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by Friday Health Plans Of North Carolina Inc. on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved.

I understand that any intentional misrepresentation relied upon by Friday Health Plans Of North Carolina Inc. may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I understand I can change this designation at a later date by contacting Friday Health Plans Of North Carolina Inc. directly, and understand it is my responsibility to notify Friday Health Plans Of North Carolina Inc. of any changes.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:
Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

These authorizations will remain in effect for 30 months from the date this application is signed.

All products, services, and policies are issued or administered by or through operating subsidiaries of Friday Health Plans Of North Carolina Inc., Inc., including Friday Health Plans Of North Carolina Inc. of North Carolina, Inc., and Friday Health Plans Of North Carolina Inc. Management Services Company, Inc.

Primary Applicant Name:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print):	Name (print):
Agent ID # (NPR):	Agent ID # (NPR):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐Yes ☐No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature. I certify that I have truly and accurately recorded on the application or enrollment form the information supplied by the insured.	
Writing Agent Signature	Date

DISCLOSURES

If you have questions about the content of this document please contact our offices at 844-465-5500 or visit our website at www.fridayhealthplans.com.

Signature of Primary Applicant: _____ Date Signed: _____