Post Office Box 27788
Austin TX 78755
(512) 614-4780 (888) 459-3366

APPLICATION FOR HMO COVERAGE

INCOMPLETE INFORMATION MAY DELAY PROCESSING.

The Consumer Choice of Benefits Health Maintenance Organization health care plans, either in whole or part, do not provide state-mandated health benefits normally required in Evidences of Coverage in Texas. The standard health benefit plan may provide a more affordable health plan for you, although at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits are excluded in the Evidence of Coverage. (This disclosure does not apply to Vista360health Plan Zero Deductible HMO.)

SECTION 1: Enrollment Information ☐ New Application ☐ Reinstatement

Application Date: (mm/dd/yyyy) _____

Postmark date on envelope is the Application Date. If there is no postmark date, the Application Date is the date we confirm receipt of the application.

Select one option. I am applying for:

☐ Open Enrollment

☐ Special Enrollment (If applying for Special Enrollment, we must be notified within 60 days of the Qualifying Event to be eligible for Special Enrollment. Special Enrollment ONLY applies to individuals who experience a Qualifying Event.)

- ☐ for a birth, adoption or placement for adoption
- ☐ as a qualified individual gaining a spouse/dependent or becoming a spouse/dependent through marriage
- ☐ as a qualified individual or dependent that has lost minimum essential coverage for any reason other than fraud, misrepresentation, or failure to pay premium
- ☐ as an individual, who was not previously a citizen, national, or lawfully present individual that has gained such status
- ☐ due to loss of employer sponsored insurance
- ☐ as a qualified individual gaining access as a result of a permanent move
- ☐ as a Native American or Alaska Native, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month

Date of Qualifying Event: (mm/dd/yyyy) _____(Include proof of date of Qualifying Event)

SECTION 2: Coverage Information

Coverage for: ☐ Applicant only ☐ Applicant and Spouse ☐ Applicant and Child(ren) ☐ Family

Has Applicant or any dependent to be covered previously applied for insurance coverage with Vista360health? ☐ Yes ☐ No

Total Payment Submitted: _____ Monthly

Select Premium Payment Option: ☐ Direct Monthly ☐ ACH Monthly

SECTION 3: Coverage Selection			
Choose the plan that best meets your needs.			
Traditional HMO	**Gold:** ☐ 10% Copayment $1,500 Individual Deductible $5,000 Ind. Maximum Out of Pocket	**Silver:** ☐ 20% Copayment $3,000 Individual Deductible $7,150 Ind. Maximum Out of Pocket	**Bronze:** ☐ 40% Copayment $5,000 Individual Deductible $7,150 Ind. Maximum Out of Pocket
Choice HMO	**Gold:** ☐ 10% Copayment $1,500 Individual Deductible $4,500 Ind. Maximum Out of Pocket	**Silver:** ☐ 0% Copayment $3,700 Individual Deductible $3,700 Ind. Maximum Out of Pocket	**Bronze:** ☐ 0% Copayment $6,550 Individual Deductible $6,550 Ind. Maximum Out of Pocket
SECTION 3: Coverage Selection (Continued)			
Select HMO	**Gold:** ☐ 10% Copayment $1,000 Individual Deductible $3,500 Ind. Maximum Out of Pocket	**Silver:** ☐ 20% Copayment $3,000 Individual Deductible $6,500 Ind. Maximum Out of Pocket	**Bronze:** ☐ 50% Copayment $6,900 Individual Deductible $7,150 Ind. Maximum Out of Pocket
Zero Deductible HMO	**Gold:** ☐ No ($0) Individual Deductible $7,150 Ind. Maximum Out of Pocket		

SECTION 4: General Information	
Primary Applicant Name:	Current Residence Address:
Email Address:	City State ZIP
Social Security Number:	Mailing Address (if different from residence address):
☐ Male ☐ Female	City State ZIP
Current Age: _____	Date of Birth (mm/dd/yyyy): _____
Home Phone Number (_____)_____ - _____ (area code)	Phone number during regular business hours (_____)_____ - _____ (area code)
Best time to call: _____ am _____ pm	

SECTION 4: General Information (Continued)

Is the Primary Applicant a United States citizen or a permanent legal resident of the United States? ☐ Yes ☐ No
(If "no," coverage cannot be issued.)
Primary Applicant's primary language: _____

Is the Primary Applicant currently a resident of the state in which he is applying for coverage? ☐ Yes ☐ No

Has the Primary Applicant used tobacco in any form in the past 6 Months?
(On Average Four (4) or More Times Weekly within the Past Six (6) Months) ☐ Yes ☐ No

Please designate the Primary Applicant's Primary Care Physician: PCP ID#_____PCP Name_____

You have the right to choose a physician to provide obstetrical or gynecological care. Name of physician to provide obstetrical or gynecological care: _____

Does the Primary Applicant' have a disability affecting his or her ability to communicate or read? ☐ Yes ☐ No

If the Primary Applicant is under 18 years of age, please provide the name of the guardian with whom he resides:

Name (First/Middle/Last): _____

Relationship to Primary Applicant: ☐ Parent ☐ Legal Guardian ☐ Grandparent ☐ Other _____

Spouse Information:

Name (First/Middle/Last): _____

Date of Birth (mm/dd/yyyy): _____ Current Age: _____ ☐ Male ☐ Female

Social Security Number: _____

Is the spouse a United States citizen or a permanent legal resident of the United States? ☐ Yes ☐ No
(If "no," coverage cannot be issued.)
Spouse's primary language: _____

Has the spouse used tobacco in any form in the past 6 months?
(On Average Four (4) or More Times Weekly within the Past Six (6) Months ☐ Yes ☐ No

Please designate the spouse's Primary Care Physician: _____
The spouse has the right to choose a physician to provide obstetrical or gynecological care. Name of physician to provide obstetrical or gynecological care: _____
Does the spouse have a disability affecting his or her ability to communicate or read? ☐ Yes ☐ No

Dependent Information: * If "no," coverage cannot be issued.

First & Last Name of Dependent Child	Social Security Number	Date of Birth (mm/dd/yyyy)	Age	Sex (M/F)	US Citizen or Permanent Legal Resident* (Yes/No)	Primary Language	Tobacco User (Yes/No)

Does any Dependent Child have a disability affecting his or her ability to communicate or read? ☐ Yes ☐ No

If "yes," please list Dependent Child(ren)'s names here: _____

SECTION 4: General Information (Continued)

First & Last Name of Dependent Child	
	PCP ID#_____PCP Name_____ Name of physician to provide obstetrical or gynecological care:
	PCP ID#_____PCP Name_____ Name of physician to provide obstetrical or gynecological care:
	PCP ID#_____PCP Name_____ Name of physician to provide obstetrical or gynecological care:
	PCP ID#_____PCP Name_____ Name of physician to provide obstetrical or gynecological care:
	PCP ID#_____PCP Name_____ Name of physician to provide obstetrical or gynecological care:

SECTION 5: Billing Information

IMPORTANT: *When choosing to pay initial premium by Automated Bank Account Withdrawal,* ***THE FIRST PREMIUM WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY WHEN YOUR POLICY IS ISSUED. You may also submit your first month premium with your application.***

I would like my monthly premium payment to come from my account (check one) on the ☐ 1st ☐ 10th ☐ 15th ☐ 20th day of the month:

☐ **Checking (Please attach a voided check.)** ☐ **Savings (Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.)**

Financial Institution Name:	
Financial Institution Address:	
Transit Routing #:	Account #:

I hereby request and authorize Vista360healthh to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after the first premium has been paid, on any policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order. I have the right to stop payment of a charge by giving notice to Vista360health or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Vista360health rights in respect to each charge shall be the same as if it were a check made payable to Vista360health and personally signed by me. If any charge is dishonored for any reason, Vista360health shall not be under any liability even though such dishonor results in the forfeiture of insurance.

Signature as it appears on financial institution records

Print name of account owner (if other than Primary Applicant)

Date

Relationship of account owner to Primary Applicant

NOTE: Payment is accepted from the Primary Applicant or payor ONLY. The plan applied for is NOT an employer sponsored group health plan.

SECTION 6: PLEASE READ AND SIGN BELOW

TRUE AND COMPLETE

My answers to the questions on this application and any additional information I have provided are true and complete and accurately recorded. I understand that under no circumstances is anyone including a producer or company representative allowed to permit me to answer any question inaccurately or untruthfully and I represent that such did not occur. A producer or company representative is not authorized to alter any terms of the Health Plan. I understand that I must make checks payable to Vista360health.

OPEN ENROLLMENT EFFECTIVE DATE

Coverage Effective Dates for initial open enrollment period for a qualified individual—

(a) An Application Date between December 1-31 will have a coverage Effective Date of January 1st ;
(b) An Application Date between January 1-31 will have a coverage Effective Date of February 1st.

SPECIAL ENROLLMENT EFFECTIVE DATE

Coverage Effective Dates for special enrollment for a qualified individual except as specified in paragraphs (a) and (b). In order to be eligible for coverage, a qualified individual or enrollee must submit an application within 60 days of a Qualifying Event.

Coverage Effective Date will be the first day of the following month Application Date.

a) In the case of birth, adoption or placement for adoption, the coverage Effective Date is on the date of birth, adoption, or placement for adoption;
(a) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, the coverage Effective Date is on the first day of the following month.

LOSS OF MINIMUM ESSENTIAL COVERAGE

I understand that Loss of minimum essential coverage does not include termination or loss due to (1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or (2) Situations allowing for a rescission as specified in 45 CFR 147.128.

APPLICATION INFORMATION

Prior to the effective date of coverage, I understand that I am responsible for communicating any changes to the information I provided on this application. Application changes will be considered in the final coverage approval decision. I will call Vista360health at [(888)-459-3366] to inform them of any changes to my information.

APPLICATION

I understand that I am applying as an individual for the Health Plan and am responsible for ensuring that all premium payments are met. I understand that the plan applied for is not an employer sponsored group health plan that it will in no way be related to any employer/employee relationship, and it is not offered pursuant to and does not comply with state or federal small employer laws. If premium will be paid from a business/employer account, I hereby certify that no person to be insured under this plan will receive favorable tax treatment under sections 162, 125 or 106 of the United States Revenue Code, unless such favorable tax treatment would not make the plan subject to any state or federal small employer laws.

AUTHORIZATION TO RELEASE INFORMATION

I authorize any physician, medical or health care practitioner, hospital, clinic, other medically related facility, insurance company, third party administrator, employer or consumer reporting agency having information regarding me and all dependents applying for coverage, including information concerning advice, diagnosis, treatment or care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness or injury, and copies of all hospital records, medical records, pharmaceutical records or non-medical information, to give to Vista360health, its reinsurers, or its legal representatives, and its affiliates, any and all such information. However, such information does not include psychotherapy notes (as defined by 45 C.F.R. §164.501). This information will be used by Vista360health to determine eligibility for insurance and make benefit determinations. I understand that there is a possibility of redisclosure of any information pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand failure to sign this authorization may result in the denial of my application for coverage or eligibility for benefits. I understand that I can revoke this authorization by submitting a signed request to Vista360health, as described in Vista360health Insurance Company's HIPAA Notice of Privacy Practices for Protected Health Information (PHI), at any time by giving written notice to Vista360health and my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. I know that I may request to receive a copy of this authorization. This authorization shall remain valid for two years from the date shown below. A photocopy of this authorization shall be considered as valid as the original.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may guilty of a crime and may be subject to civil fines and criminal penalties.

Signature of Primary Applicant

Signature of Spouse

Signature of Dependent Child (age 18 years of age or older)

Signature of Dependent Child (age 18 years of age or older)

Signature of Dependent Child (age 18 years of age or older)

Date

HIPAA Compliant Authorization for Release of Health-Related Information

Records and information obtained will be disclosed to Vista360health so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

By signing this authorization, I authorize any and all who are involved in my care, diagnosis or treatment (including, but not limited to, medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, pharmacy benefit managers, the MIB, Inc., the Veterans Administration, other insurance companies and other medically related facilities) to release any and all medical records and information (including, but not limited to, patient histories, progress notes, test results, X-rays, pharmacy records and other diagnostic information) to be exchanged between Vista360health and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and its assigns as necessary to fulfill the purpose of this disclosure.

I understand that the information in my health/medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include, but not be limited to information about behavioral or mental health services, alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, pharmacy prescriptions, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

I authorize Vista360health, or its reinsurers, to make a brief report of my protected personal health information to MIB, Inc.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by Vista360health and may no longer be protected by federal privacy laws. I understand Vista360health may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Vista360health at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand a photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Vista360health may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization. I acknowledge and agree that if there is more than one applicant on the application, all information provided on the application may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become a part of each applicant's policy. If the application has been completed by two individuals, their signature applies only to the section of the application they have completed.

_____

Name of Applicant (please print)

_____

Signature of Applicant (or Applicant's parent or legal guaradian if Applicant is under age 18)

_____

Date

NOTE: This form must be completed for EACH PERSON age 18 years of age or older applying for coverage.

Please keep this page for your records

NOTICE OF INFORMATION PRACTICES:

In order to properly administer your insurance coverage, we must collect personal information. You are our most important source of information, but we may also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see (and copy if you wish) items of personal information about you which appear in our files. You also have the right to seek correction, amendment, or deletion of information you believe to be inaccurate.

If you have questions or desire additional information about the items disclosed above, please write to us at Vista360health360health, [Post Office Box 27788, Austin, Texas 78755]

Requests for medical information will only be disclosed to your attending physician.

CONDITIONAL RECEIPT FOR HEALTH PLAN:

Coverage will become effective on the "Effective Date" (as defined below) if all of the following conditions are met: (1) On the Date of Application, the applicant and all proposed insureds must be a risk acceptable to Vista360health. (2) If Vista360health cannot determine the acceptability of the applicant(s) as defined in (1) above, due to the non-receipt (within 60 days of the date of application) of medical or other material information that Vista360health has requested from the applicant or other sources; then this condition has not been fulfilled and no coverage will be provided under the terms of this Conditional Receipt. (3) The initial premium, equal to one month of the first yearly premium has been paid, and the check, credit card or bank draft is honored on the first presentation for payment.

"Effective Date'' as used herein means:
For Open Enrollment: Coverage Effective Dates for initial open enrollment period for a qualified individual— (a) An Application Date between December 1-31 will have a coverage Effective Date of January 1st; (b) an Application Date between January 1-31 will have a coverage Effective Date of February 1st.

For Special Enrollment:
Coverage Effective Dates for special enrollment for a qualified individual except as specified in paragraphs (a) and (b). In order to be eligible for coverage, a qualified individual or enrollee must submit an application within 60 days of a Qualifying Event. Coverage Effective Date will be the first day of the following month Application Date. (a) In the case of birth, adoption or placement for adoption, the coverage Effective Date is on the date of birth, adoption, or placement for adoption; (b)In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, the coverage Effective Date is on the first day of the following month.

If no postmarked date, the effective date will be no earlier than 30 calendar days after the confirmed receipt date of the application. **NOTE: Metered mail is not an acceptable postmark.**

PRODUCER'S STATEMENT

TO BE COMPLETED BY PRODUCER(S) - PLEASE PRINT

PRODUCER'S

I certify that I have reviewed all enrollment materials and I have advised the individual not to terminate any existing coverage(s) until receiving a notice from Vista360health has accepted and approved this application. I have advised the individual that I have no authority to bind these coverages, to alter the terms of any Health plan(ies), this Application in any manner or to adjust any claims for benefits under the Health plan(ies).

Writing Producer's name (please print) _____

Email Address_____ Telephone Number_____

_____ _____
Writing Producer's Signature Date

Primary Producer's or Agency Name* (to whom commissions are to be paid): _____

*The Producer or agency name above to whom commissions are to be paid must exactly match the name on the appointment application.

Submit **Print**

*If you do not want to submit this form online, you can print and email it to enrollment@vista360health.com or you can fax it to 512-717-5588.