

**AMERICAN COMMUNITY MUTUAL  
INSURANCE COMPANY**

Application for an Individual Health Insurance Policy

Thank you for applying to American Community Mutual Insurance Company (herein referred to as American Community or AC). Please take the time to carefully review this application. Your answers have and will be utilized in the underwriting process and will become part of your insurance contract.

**A. Personal Information**

Full Name:

\_\_\_\_\_ (first-middle-last)

Sex:

M \_\_\_ F \_\_\_

Date of Birth:

\_\_\_\_\_ (mm/dd/yyyy)

Social Security Number:

\_\_\_\_\_

**Home Address:**

Street:

\_\_\_\_\_

City:

\_\_\_\_\_

State:

\_\_\_\_\_

Zip Code:

\_\_\_\_\_

County:

\_\_\_\_\_

**Billing Address:**

Street:

\_\_\_\_\_

City:

\_\_\_\_\_

State:

\_\_\_\_\_

Zip Code:

\_\_\_\_\_

**Contact Information:**

Phone Number:

( ) \_\_\_\_\_

Email Address:

\_\_\_\_\_ (email@domain.com)

**B. Current and Prior Coverage**

Are you currently covered by other health insurance?

yes \_\_\_ no \_\_\_

**Provide details of your current coverage:**

Insurance Company Name:

\_\_\_\_\_

Group or Individual Coverage:

\_\_\_\_\_

Certificate or Policy Number:

\_\_\_\_\_

Effective Date:

\_\_\_\_\_

Is American Community's policy intended to replace your current coverage?

yes \_\_\_ (If yes, see Notice to Applicant below.)  
no \_\_\_



**D. Premium Payment Information**

Monthly Premium:

Initial Payment Received Via:

\_\_\_\_ Electronic Funds Transfer  
 \_\_\_\_ Credit Card

If any premium payment is returned for insufficient funds, a nonrefundable service fee may be charged.

**E. Underwriting Questions and Responses**

We base our offer of insurance on your responses to the following questions and to any additional information shown in Section F.

**Our Questions**

**Your Responses**

**Getting Started**

The following questions allow us to provide you with accurate rates and policy provisions. Most people will complete the questions in a matter of minutes.

Unless you separately choose to register, you will answer the questions anonymously. It is still very important, however, for the following reasons, for you to answer the questions completely and truthfully:

- 1) These questions allow us to provide you with accurate rates and policy provisions.
- 2) If you decide to buy one of our policies, your answers will be automatically included in your application for insurance.
- 3) The formal application for insurance will ask you to verify that you have been truthful in your responses.
- 4) If your answers are inconsistent with other information that we gather, we may not accept your application.
- 5) Fraud or the intentional misrepresentation of a material fact can void your policy, leaving you without insurance protection.

Do you understand the importance of providing complete and true answers?

yes \_\_\_ no \_\_\_

Have you been covered by an American Community health insurance plan at any time in the last six months?

yes \_\_\_ no \_\_\_

**Basic Information**

When were you born? (You must be under the age of 65)	
Year (YYYY)	
Month	
Day	
How tall are you?	
Feet	
Inches	
How much do you weigh?	
Pounds	
What is your sex?	male ___ female ___
Which Texas county do you live in?	

**Your Lifestyle**

<p>What do you do in a typical week?</p> <p>Work, including volunteer work</p> <p>Go to school</p> <p>Care for family</p>	<p><input type="checkbox"/> 35+ hours  <input type="checkbox"/> 21-34 hours  <input type="checkbox"/> 10-20 hours  <input type="checkbox"/> &lt; 10 hours  <input type="checkbox"/> No work</p> <p><input type="checkbox"/> not a student  <input type="checkbox"/> full-time student  <input type="checkbox"/> part-time student</p> <p><input type="checkbox"/> no family responsibilities  <input type="checkbox"/> full-time family responsibilities  <input type="checkbox"/> part-time family responsibilities</p>
<p>In the last six months, how many days have you missed from your typical activities due to injury or illness?</p>	<p><input type="checkbox"/> 0  <input type="checkbox"/> 1-3  <input type="checkbox"/> 4-7  <input type="checkbox"/> 8+</p>
<p>How many intervals of injury or illness were involved?          (Consecutive days missed due to illness or injury are one interval.)</p>	<p><input type="checkbox"/> 0  <input type="checkbox"/> 1  <input type="checkbox"/> 2  <input type="checkbox"/> 3  <input type="checkbox"/> 4+</p>
<p>Why did you miss these days?</p>	
<p>Other than the time missed from your typical activities as noted above, have you been physically and mentally able to engage in full-time work and the normal social and leisure activities of your age group during the past six months? (Answer this question "Yes" if you have been able to work full-time, even if you have not worked full-time.)</p>	<p>yes ___ no ___</p>
<p>Describe why you have not been able to physically or mentally engage in full-time work and/or the typical social and leisure activities of your age group.</p>	
<p>Have you smoked more than 1 pack of cigarettes in a week at any time in the last six months?</p>	<p>yes ___ no ___</p>
<p>In the last six months, how much alcohol have you consumed in a typical week?</p>	<p><input type="checkbox"/> none  <input type="checkbox"/> 1-9 drinks  <input type="checkbox"/> 10+ drinks</p>
<p>In the last six months, how much moderate-to-vigorous exercise have you engaged in per week?</p>	<p><input type="checkbox"/> 2 or more hours  <input type="checkbox"/> less than 2 hours</p>
<p>What kinds of exercise do you engage in?</p>	<p><input type="checkbox"/> team sport(s)  <input type="checkbox"/> health club  <input type="checkbox"/> competitive individual sport  <input type="checkbox"/> physically demanding job  <input type="checkbox"/> home-based regimen  <input type="checkbox"/> other</p>
<p>In the last six months, have you used illegal drugs, including the non-medical use of prescription drugs?</p>	<p>yes ___ no ___</p>
<p>What drugs have you used?</p>	<p><input type="checkbox"/> marijuana only <input type="checkbox"/> other drug(s)</p>
<p>How many days in the last six months have you used marijuana?</p>	<p><input type="checkbox"/> less than 10 <input type="checkbox"/> 10 or more</p>
<p>In the last two years, have you been charged with a driving violation involving alcohol or illegal drugs, been the driver in any motor vehicle accidents, or been charged in any other moving violations?</p>	<p>yes ___ no ___</p>
<p>How many times have you been charged with a driving violation involving alcohol or illegal drugs?</p>	<p><input type="checkbox"/> 0  <input type="checkbox"/> 1  <input type="checkbox"/> 2+</p>

How many accidents and moving violations, excluding violations involving alcohol or illegal drugs, have you had?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4+
In the last two years, have you engaged in any of the following activities? (Check either "none" or all that apply.)	<input type="checkbox"/> none <input type="checkbox"/> motorcycle driving <input type="checkbox"/> boat or motorized vehicle racing <input type="checkbox"/> piloting a private plane <input type="checkbox"/> rock or mountain climbing <input type="checkbox"/> scuba diving <input type="checkbox"/> competitive horse riding or rodeo participation <input type="checkbox"/> competitive skiing/snow boarding <input type="checkbox"/> other high height or high speed activities
How many years of college have you completed?	<input type="checkbox"/> none <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+
Do you have a high school diploma or GED?	<input type="checkbox"/> yes <input type="checkbox"/> no
What is your current annual income?	<input type="checkbox"/> \$0 - \$5,000 <input type="checkbox"/> \$5,001-\$10,000 <input type="checkbox"/> \$10,001-\$20,000 <input type="checkbox"/> \$20,001-\$40,000 <input type="checkbox"/> \$40,001-\$75,000 <input type="checkbox"/> Over \$75,000 <input type="checkbox"/> Choose not to answer

### Questions for Our Female Applicants

Do you understand that, although American Community plans cover certain complications of pregnancy, the plans do not cover normal deliveries, the care of a newborn (even if the newborn is sick), and many other pregnancy related costs? American Community plans also do not cover sterilizations, fertility treatments, sterilization reversals, and voluntary abortions.	yes <input type="checkbox"/> no <input type="checkbox"/>
Have you reached menopause or been surgically sterilized?	yes <input type="checkbox"/> no <input type="checkbox"/>
Have you ever been pregnant other than a pregnancy which ended in a voluntary abortion?	yes <input type="checkbox"/> no <input type="checkbox"/>
How many live children do you have?	
In what year were you last pregnant?	
Have you ever had a caesarean section (c-section)?	yes <input type="checkbox"/> no <input type="checkbox"/>
Have you had more than one miscarriage, ectopic pregnancy, still birth, or delivery prior to 7 months gestation?	yes <input type="checkbox"/> no <input type="checkbox"/>
Have you ever had a medical condition, diagnosed either before or during pregnancy, which complicated your pregnancy or do you currently have a medical condition which you have been advised is likely to complicate a future pregnancy?	yes <input type="checkbox"/> no <input type="checkbox"/>

What medical conditions have complicated your pregnancy(ies)? (Check either "none" or all that apply.)	<input type="checkbox"/> none <input type="checkbox"/> diabetes diagnosed prior to pregnancy <input type="checkbox"/> diabetes diagnosed during pregnancy <input type="checkbox"/> pre-eclampsia <input type="checkbox"/> high blood pressure diagnosed prior to pregnancy <input type="checkbox"/> high blood pressure diagnosed during pregnancy <input type="checkbox"/> eclampsia <input type="checkbox"/> infection <input type="checkbox"/> asthma <input type="checkbox"/> epilepsy/seizure disorder <input type="checkbox"/> thyroid problem <input type="checkbox"/> anemia <input type="checkbox"/> heart problems <input type="checkbox"/> other
What other conditions?	
What medical conditions do you currently have which are likely to complicate a future pregnancy? (Check either "none" or all that apply.)	<input type="checkbox"/> none <input type="checkbox"/> diabetes <input type="checkbox"/> high blood pressure <input type="checkbox"/> asthma <input type="checkbox"/> epilepsy/seizure disorder <input type="checkbox"/> thyroid problem <input type="checkbox"/> anemia <input type="checkbox"/> heart problems <input type="checkbox"/> other
What other complications?	
Are you currently pregnant?	yes <input type="checkbox"/> no <input type="checkbox"/>
<p>Note: You may exclude pregnancy-related care from your answers on the remainder of this application. This includes the questions regarding hospital stays, emergency room visits, surgeries, doctor visits, diagnostic tests, and prescription drugs. Excluding pregnancy care from your remaining answers will make it more likely that you will get an immediate rate.</p>	

### Your Health History

Have you ever been diagnosed by a physician as having or tested positive for any of the following conditions? (Check either "none" or all that apply.)	<input type="checkbox"/> none <input type="checkbox"/> HIV or AIDS <input type="checkbox"/> bipolar disorder <input type="checkbox"/> chronic fatigue syndrome <input type="checkbox"/> diabetes/blood sugar <input type="checkbox"/> fibromyalgia <input type="checkbox"/> heart disease or any irregular heart function <input type="checkbox"/> kidney disease <input type="checkbox"/> schizophrenia <input type="checkbox"/> chronic immune or autoimmune condition (examples: lupus, psoriasis, scleroderma, sarcoidosis) <input type="checkbox"/> chronic disease of the intestines (examples: Crohn's disease, ulcerative colitis, chronic diverticulitis, irritable bowel syndrome) <input type="checkbox"/> chronic disease of the blood (examples: clotting disorders, sickle cell anemia) <input type="checkbox"/> chronic condition of the nervous system (examples: multiple sclerosis, ALS, neuropathy, Parkinson's) <input type="checkbox"/> chronic condition of the bones or joints (examples: rheumatoid or osteo arthritis, ankylosing spondylitis) <input type="checkbox"/> permanently decreased lung capacity (possible reasons: asthma, muscular dystrophy, COPD)
Please provide more information regarding the above condition(s).	
Have you ever been diagnosed with cancer?	yes <input type="checkbox"/> no <input type="checkbox"/>

What kind of cancer? (Check one.)	<input type="checkbox"/> skin not spread to other organs <input type="checkbox"/> blood or lymph nodes <input type="checkbox"/> thyroid not spread to other organs <input type="checkbox"/> testes not spread to other organs <input type="checkbox"/> breast not spread to other organs <input type="checkbox"/> cervical not spread to other organs <input type="checkbox"/> bone not spread to other organs <input type="checkbox"/> colorectal not spread to other organs <input type="checkbox"/> brain not spread to other organs <input type="checkbox"/> lung not spread to other organs <input type="checkbox"/> pancreatic not spread to other organs <input type="checkbox"/> other (including more than one cancer and cancer that spread to other organs)
What other kind of cancer?	
What year was your last cancer treatment?	
Have you ever had an organ transplant?	yes ___ no ___
What organ and when?	
In the last two years, have you been admitted to the hospital, received care in an emergency room, or had any outpatient surgery? (Check either "no" or all that apply.) Note: Surgery includes all outpatient surgery, including cosmetic and other surgeries not covered by insurance.	<input type="checkbox"/> no <input type="checkbox"/> inpatient admission(s) <input type="checkbox"/> emergency room visit(s) <input type="checkbox"/> outpatient surgery(s)
Provide information about your hospital admissions in the last two years, starting with the most recent admission and working back in time.	
Most recent admission:	
What was the reason for the admission?	<input type="checkbox"/> pre-scheduled surgery <input type="checkbox"/> emergency care: due to injury (other than self-inflicted) <input type="checkbox"/> emergency care: infection, including appendicitis <input type="checkbox"/> emergency care: due to asthma or allergies <input type="checkbox"/> emergency care: due to self-inflicted injury <input type="checkbox"/> mental health, emergency or non-emergency <input type="checkbox"/> alcohol or drug abuse, emergency or non-emergency <input type="checkbox"/> other
What other reason?	
Are you fully recovered?	yes ___ no ___
In what way are you not fully recovered?	
Did you have another hospital admission?	yes ___ no ___
Next most recent admission:	
What was the reason for the admission?	<input type="checkbox"/> pre-scheduled surgery <input type="checkbox"/> emergency care: due to injury (other than self-inflicted) <input type="checkbox"/> emergency care: infection, including appendicitis <input type="checkbox"/> emergency care: due to asthma or allergies <input type="checkbox"/> emergency care: due to self-inflicted injury <input type="checkbox"/> mental health, emergency or non-emergency <input type="checkbox"/> alcohol or drug abuse, emergency or non-emergency <input type="checkbox"/> other
What other reason?	
Are you fully recovered?	yes ___ no ___
In what way are you not fully recovered?	
Did you have any other hospital admissions?	yes ___ no ___

Describe each additional hospital admission you have had in the last two years including whether you are fully recovered.	
Provide information about your emergency room visits in the last two years, starting with the most recent visit and working back in time. Exclude any emergency room visits during which you were admitted to the hospital.	
Most recent visit:	
Reason for visit	<input type="checkbox"/> injury (other than self-inflicted injury) <input type="checkbox"/> flu, cold, sinus problem, sore throat, or cough <input type="checkbox"/> other infections <input type="checkbox"/> asthma or allergies <input type="checkbox"/> pain not related to injury or infection (example migraine) <input type="checkbox"/> self-inflicted injury <input type="checkbox"/> mental health crisis <input type="checkbox"/> alcohol or drug overdose <input type="checkbox"/> other
What other reason?	
Are you fully recovered?	yes ___ no ___
In what way are you not fully recovered?	
Did you have another emergency room visit?	yes ___ no ___
Next most recent visit:	
Reason for visit	<input type="checkbox"/> injury (other than self-inflicted injury) <input type="checkbox"/> flu, cold, sinus problem, sore throat, or cough <input type="checkbox"/> other infections <input type="checkbox"/> asthma or allergies <input type="checkbox"/> pain not related to injury or infection (example migraine) <input type="checkbox"/> self-inflicted injury <input type="checkbox"/> mental health crisis <input type="checkbox"/> alcohol or drug overdose <input type="checkbox"/> other
What other reason?	
Are you fully recovered?	yes ___ no ___
In what way are you not fully recovered?	
Did you have any other emergency room visits?	yes ___ no ___
Describe each additional emergency room visit you have had in the last two years including whether you are fully recovered.	
Provide information about your outpatient surgeries in the last two years, starting with the most recent visit and working back in time. Exclude any surgeries that were part of an emergency room visit. Include surgeries in a doctor's office.	
Most recent surgery:	

Type of surgery	<input type="checkbox"/> cosmetic reasons <input type="checkbox"/> vision correction <input type="checkbox"/> remove gall bladder or kidney stones <input type="checkbox"/> remove tonsils and/or adenoids <input type="checkbox"/> remove tumor or growth: cancer <input type="checkbox"/> remove tumor or growth: pre-cancer <input type="checkbox"/> remove tumor or growth: benign <input type="checkbox"/> biopsy of tumor or growth without removal: cancer <input type="checkbox"/> biopsy of tumor or growth without removal: pre-cancer <input type="checkbox"/> biopsy of tumor or growth without removal: benign <input type="checkbox"/> sterilization to prevent future pregnancies <input type="checkbox"/> bone, joint, or muscle surgery: within 10 days of an injury <input type="checkbox"/> bone, joint, or muscle surgery: 10+ days after an injury <input type="checkbox"/> bone, joint, or muscle surgery: not related to a known injury <input type="checkbox"/> voluntary abortion <input type="checkbox"/> other
What other type?	
Are you fully recovered from both the surgery and from the problem that required the surgery?	yes ___ no ___
In what way are you not fully recovered?	
Did you have another surgery?	yes ___ no ___
Next most recent surgery:	
Type of surgery	<input type="checkbox"/> cosmetic reasons <input type="checkbox"/> vision correction <input type="checkbox"/> remove gall bladder or kidney stones <input type="checkbox"/> remove tonsils and/or adenoids <input type="checkbox"/> remove tumor or growth: cancer <input type="checkbox"/> remove tumor or growth: pre-cancer <input type="checkbox"/> remove tumor or growth: benign <input type="checkbox"/> biopsy of tumor or growth without removal: cancer <input type="checkbox"/> biopsy of tumor or growth without removal: pre-cancer <input type="checkbox"/> biopsy of tumor or growth without removal: benign <input type="checkbox"/> sterilization to prevent future pregnancies <input type="checkbox"/> bone, joint, or muscle surgery: within 10 days of an injury <input type="checkbox"/> bone, joint, or muscle surgery: 10+ days after an injury <input type="checkbox"/> bone, joint, or muscle surgery: not related to a known injury <input type="checkbox"/> voluntary abortion <input type="checkbox"/> other
What other type?	
Are you fully recovered from both the surgery and from the problem that required the surgery?	yes ___ no ___
In what way are you not fully recovered?	
Did you have any other surgeries?	yes ___ no ___
Describe all other surgeries in the last two years including whether you are fully recovered.	

Have you ever received treatment, been recommended for treatment, or participated in a 12-Step program, for drug and/or alcohol abuse?	yes ___ no ___
When was the last time you used drugs or alcohol? Year (YYYY) Month	

### Your Recent Prescription Drugs

Have you filled any prescription drugs in the last six months (either new prescriptions or refills of existing prescriptions)?	yes ___ no ___
Describe each drug that you have filled, one drug at a time, including oral contraceptives. If you have multiple fillings of one drug, describe that drug once. If you have had two or more drugs for the same condition, describe each drug separately.	
Most recent drug filled	
Reason for drug	<input type="checkbox"/> birth control <input type="checkbox"/> infection <input type="checkbox"/> asthma <input type="checkbox"/> allergies <input type="checkbox"/> pain <input type="checkbox"/> depression <input type="checkbox"/> acid reflux <input type="checkbox"/> thyroid <input type="checkbox"/> stop smoking <input type="checkbox"/> acne <input type="checkbox"/> anxiety or sleeping problem <input type="checkbox"/> attention deficit and/or hyperactivity disorder <input type="checkbox"/> diabetes <input type="checkbox"/> high blood pressure <input type="checkbox"/> high cholesterol or lipid disorder <input type="checkbox"/> migraine headaches <input type="checkbox"/> nausea or vomiting <input type="checkbox"/> other
What other reason?	
Name of drug	
Number of times you have filled this prescription in the last 6 months	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+
Number of days of drug per filling	<input type="checkbox"/> 10 or less <input type="checkbox"/> 11-27 days <input type="checkbox"/> 28-31 days (1 month) <input type="checkbox"/> 56-62 days (2 months) <input type="checkbox"/> 84-93 days (3 months) <input type="checkbox"/> 112-124 days (4 months) <input type="checkbox"/> 140-155 days (5 months) <input type="checkbox"/> 168-186 days (6 months) <input type="checkbox"/> 186 + days (more than 6 months)
Have been advised to continue taking this drug?	<input type="checkbox"/> no <input type="checkbox"/> yes, but have been advised to discontinue within the next 10 days (example: will finish bottle of antibiotics) <input type="checkbox"/> yes, have been advised to take whenever needed in the future (example: seasonal allergy medicine) <input type="checkbox"/> yes, have been advised to take on a daily basis or other scheduled basis in the future (example: chronic allergy medicine)

Next Drug	
Reason for drug	<input type="checkbox"/> birth control <input type="checkbox"/> infection <input type="checkbox"/> asthma <input type="checkbox"/> allergies <input type="checkbox"/> pain <input type="checkbox"/> depression <input type="checkbox"/> acid reflux <input type="checkbox"/> thyroid <input type="checkbox"/> stop smoking <input type="checkbox"/> acne <input type="checkbox"/> anxiety or sleeping problem <input type="checkbox"/> attention deficit and/or hyperactivity disorder <input type="checkbox"/> diabetes <input type="checkbox"/> high blood pressure <input type="checkbox"/> high cholesterol or lipid disorder <input type="checkbox"/> migraine headaches <input type="checkbox"/> nausea or vomiting <input type="checkbox"/> other
What other reason?	
Name of drug	
Number of times you have filled this prescription in the last 6 months	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6+
Number of days of drug per filling	<input type="checkbox"/> 10 or less <input type="checkbox"/> 11-27 days <input type="checkbox"/> 28-31 days (1 month) <input type="checkbox"/> 56-62 days (2 months) <input type="checkbox"/> 84-93 days (3 months) <input type="checkbox"/> 112-124 days (4 months) <input type="checkbox"/> 140-155 days (5 months) <input type="checkbox"/> 168-186 days (6 months) <input type="checkbox"/> 186 + days (more than 6 months)
Have been advised to continue taking this drug?	<input type="checkbox"/> no <input type="checkbox"/> yes, but have been advised to discontinue within the next 10 days (example: will finish bottle of antibiotics) <input type="checkbox"/> yes, have been advised to take whenever needed in the future (example: seasonal allergy medicine) <input type="checkbox"/> yes, have been advised to take on a daily basis or other scheduled basis in the future (example: chronic allergy medicine)
Please describe all remaining prescription drugs that you have filled in the last six months.	
You have indicated that you have taken prescription vitamins in the last 6 months. Please affirm that you know that vitamins are not covered under American Community plans.	yes <input type="checkbox"/> no <input type="checkbox"/>

You have indicated that you have taken anti-depressants, anti-anxiety drugs, and/or sleeping drugs in the last 6 months. Please affirm that you know that mental health care, including anti-depressants, anti-anxiety drugs, sleeping drugs, and other mental health drugs, are not covered under American Community plans except for the treatment of organic brain disease. Even coverage for organic brain disease may be subject to a pre-existing condition exclusion.	yes ___ no ___
You have indicated that you have used prescription acne drugs in the last 6 months. Please affirm that you know that acne drugs are not covered under American Community plans.	yes ___ no ___
You have indicated that you have taken prescription drugs for attention deficit and/or hyperactivity disorder in the last 6 months. Please affirm that you know that such drugs are not covered under American Community plans.	yes ___ no ___
You have indicated that you have taken prescription drugs for sexual performance in the last 6 months. Please affirm that you know that such drugs are not covered under American Community plans.	yes ___ no ___
You have indicated that you have taken prescription drugs for smoking cessation in the last 6 months. Please affirm that you know that such drugs are not covered under American Community plans.	yes ___ no ___
Have you had a blood pressure reading by a medical professional in the last 6 months?	yes ___ no ___
Has your blood pressure been within the normal range each time it has been measured by a medical professional in the last six months?	yes ___ no ___
Have you had any cholesterol measurement in the last six months?	yes ___ no ___
Has each cholesterol measurement in the last six months been within the normal range?	yes ___ no ___

**Your Recent Healthcare**

How many times have you visited medical or mental health professionals in the last six months? This includes medical doctors, osteopathic doctors, chiropractors, physician assistants, nurse practitioners, all types of physical therapists (physical, occupational, speech, etc), and all types of mental health doctors and counselors for all kinds of care, including routine/preventative care. Do not count dental care or routine eye care.	<input type="checkbox"/> 0 <input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-9 <input type="checkbox"/> 10+
Why have you had these visits to medical and/or mental health professionals? Please specify the kind of professional, the number of visits, and the reason.	
Other than dental x-rays, have you had any diagnostic imaging tests in the last six months? (Diagnostic imaging tests include x-rays, CAT and PET scans, MRI's, ultrasound exams, and all exams requiring the insertion of a scope into your body.)	yes ___ no ___
Describe each diagnostic exam in the last six months, starting with your most recent exam and working back in time.	
Most recent test	
What kind of test?	<input type="checkbox"/> X-ray <input type="checkbox"/> CAT scan <input type="checkbox"/> PET scan <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> Laproscopy

On what part of the body?	<input type="checkbox"/> whole body <input type="checkbox"/> head <input type="checkbox"/> spine <input type="checkbox"/> arm <input type="checkbox"/> leg <input type="checkbox"/> chest <input type="checkbox"/> abdomen <input type="checkbox"/> other
Why did you have this exam?	<input type="checkbox"/> routine preventative care <input type="checkbox"/> injury <input type="checkbox"/> illness
Was there an abnormal finding?	yes ___ no ___
What was the finding?	
Are you fully recovered?	yes ___ no ___
What are your ongoing problems?	
Have you had another test in the last six months?	yes ___ no ___
Next most recent test	
What kind of test?	<input type="checkbox"/> X-ray <input type="checkbox"/> CAT scan <input type="checkbox"/> PET scan <input type="checkbox"/> MRI <input type="checkbox"/> ultrasound <input type="checkbox"/> laproscopy
On what part of the body?	<input type="checkbox"/> whole body <input type="checkbox"/> head <input type="checkbox"/> spine <input type="checkbox"/> arm <input type="checkbox"/> leg <input type="checkbox"/> chest <input type="checkbox"/> abdomen <input type="checkbox"/> other
Why did you have this exam?	<input type="checkbox"/> routine preventative care <input type="checkbox"/> injury <input type="checkbox"/> illness
Was there an abnormal finding?	yes ___ no ___
What was the finding?	
Are you fully recovered?	yes ___ no ___
What are your ongoing problems?	
Have you had other tests in the last six months?	yes ___ no ___
Describe all other tests that you have had in the last 6 months, including whether there was an abnormal finding and whether you recovered.	

### Your Current Health

Do you have now, or have you had, a medical condition or symptoms for which you have been advised by a medical professional to have future medical consultations or tests?	yes ___ no ___
Why do you require ongoing medical consultations or tests? (Check all that apply.)	<input type="checkbox"/> Routine care associated with prescription drugs listed above <input type="checkbox"/> Routine follow-up care for a hospital stay, emergency room visit, or surgery listed above <input type="checkbox"/> Other reason(s)
What other reason(s)?	
Are you currently experiencing any regular pain?	yes ___ no ___
Where is the pain and what is causing it?	

Do you have a cough which you have had for more than 4 weeks?	yes ___ no ___
Are you experiencing any problem with your menstrual cycles?	yes ___ no ___
What problems? Check all that apply.	<input type="checkbox"/> irregular menstruation/bleeding <input type="checkbox"/> no menstruation <input type="checkbox"/> menstruation more often then every 24 days <input type="checkbox"/> menstruation less often then every 35 days <input type="checkbox"/> excessive blood <input type="checkbox"/> menstrual pain interfering with typical activities <input type="checkbox"/> painful ovulation <input type="checkbox"/> other
What other problems?	
In the last six months, have you had any other medical problems or symptoms, for which you have not yet consulted a medical professional, but for which you may consult a medical professional in the future?	yes ___ no ___
What problem or symptom?	<input type="checkbox"/> low energy/lethargy <input type="checkbox"/> stomach or intestinal problems/ symptoms <input type="checkbox"/> allergy or asthma symptoms <input type="checkbox"/> unexplained fever <input type="checkbox"/> skin problem <input type="checkbox"/> other
What other problems or symptoms?	
In the last six months, has a medical professional recommended a prescription drug treatment that you have not yet filled?	yes ___ no ___
Reason for drug(s). (Check all that apply.)	<input type="checkbox"/> acid reflux <input type="checkbox"/> acne <input type="checkbox"/> allergies <input type="checkbox"/> anxiety or sleeping problem <input type="checkbox"/> ashtma <input type="checkbox"/> attention deficit and/or hyperactivity disorder <input type="checkbox"/> birth control <input type="checkbox"/> cold or flu <input type="checkbox"/> depression <input type="checkbox"/> diabetes <input type="checkbox"/> diarrhea or constipation <input type="checkbox"/> epilepsy or convulsions <input type="checkbox"/> erectile dysfunction <input type="checkbox"/> herpes or genital warts <input type="checkbox"/> high blood pressure <input type="checkbox"/> high cholesterol or lipid disorder <input type="checkbox"/> infection <input type="checkbox"/> inflammation <input type="checkbox"/> migraine headaches <input type="checkbox"/> pain <input type="checkbox"/> skin or eye irritation <input type="checkbox"/> stop smoking <input type="checkbox"/> thyroid <input type="checkbox"/> other
What other reasons?	
Why have you not taken this drug(s)?	

**Closing**

These are all the questions that we have for now. Thank you for your patience. We are now ready to evaluate your answers. Once the evaluation process starts, you cannot easily change your answers. Now is the time to make any corrections.	
Have you given complete and true answers?	yes ___ no ___

**F. Other Information**

The following is the additional information that you provided to us verbally subsequent to the above questions and responses. (To be completed by Home Office.)

**G. Consent, Terms and Conditions**

By signing below you agree to the following:

1. You represent that you have read this application and understand each of the questions, and that the answers to each of the questions you have given are complete and true to the best of your knowledge. You agree that any intentional material misrepresentation on this application may void the policy. You further agree that if a policy is issued, it will be issued by American Community in full reliance and in consideration of the information, answers and statements contained herein. You understand that this application will be medically underwritten. You agree to provide American Community with any additional information that may be necessary to complete the underwriting process.
2. No contract, waiver, modification or change of contract shall be binding upon American Community unless it is in writing and signed by an authorized officer of American Community.
3. You understand and agree that no agent or broker has the authority to (i) bind American Community by making promises regarding eligibility or benefits or by issuing a policy, (ii) waive any answer or any portion of any answer to any question on this application or any information American Community requests, (iii) approve coverage, (iv) make or alter any contract on behalf of American Community or (v) waive or alter any of American Community's other rights or requirements.
4. You provide consent to any consumer reporting agency that has any record or knowledge of your character, general reputation, personal characteristics, mode of living or type of risk to give to American Community, its legal representatives or its reinsurers any such record or knowledge for purposes of underwriting insurance. This includes, but is not limited to, motor vehicle driving records, credit records, and criminal history.
5. You provide consent to any physician, hospital, clinic, pharmacy or other medical or medically-related facility or insurance company, health information repository, its agents, business associates or legal representatives to give to American Community, its legal representatives or its reinsurers any information, records, or knowledge relating to your health (except for psychotherapy notes) in order to carry out treatment, payment and health care operations.
6. An unaltered copy of this authorization is as valid as the original for 24 months from the date signed. You or an authorized representative may request, and are entitled to receive, a copy of the consent.
7. You are signing this application on your own behalf. You understand that your statements and answers in this application must continue to be true as of the the effective date of the policy (the reinstatement date if this is an application for reinstatement). You understand that if your health or any of your answers or statements change prior to the effective date of the policy, you must inform American Community in writing. You understand that failure to do so may result in this application being denied or the policy being rescinded.

8. You understand that the Health Insurance Portability and Accountability Act (HIPAA) and related state laws require state sponsored plans to offer coverage to eligible individuals. This means that an eligible individual cannot be declined coverage by the Texas Health Insurance Risk Pool (the "Pool"), and will be issued a policy by the Pool without a pre-existing condition exclusion. An eligible individual is a person who meets all of the following requirements:
- a. On the date of applying for coverage with American Community, has 18 months or more of creditable coverage, as defined below, without any breaks of 63 days or more;
  - b. The most recent prior creditable coverage was under a group health plan, governmental plan or church plan;
  - c. Does not have other health insurance coverage;
  - d. Has no right to other insurance, such as another group health plan, Medicare or Medicaid, COBRA, or continuation coverage under a state plan. If the individual was offered COBRA or state continuation they must have elected and exhausted the coverage;
  - e. With respect to the most recent creditable coverage, was not terminated for nonpayment of premium or fraud.

Creditable coverage includes coverage under a group health plan, health insurance coverage, Medicare or Medicaid, 10 U.S.C. 55 plans for certain members of Armed Forces, Indian Health Service or a tribal organization, public health plans, the Federal Employees Health Benefits Program, state health benefits risk pool, Church plan, or Peace Corps plan.

9. You have been conditionally accepted for health insurance coverage. Your coverage will become effective at 12:01am as of the Effective Date shown, provided that American Community does not discover any potential discrepancies between the information on your application and the information found via AC's application verification process.

If there are potential discrepancies, American Community will notify you within 10 days of the delivery of your application to us and your coverage will not become effective without a subsequent formal acceptance by AC. Likewise, if AC's verification process is complete in fewer than 10 days after your application delivery and AC finds no potential discrepancies, AC will notify you that you are accepted for coverage. If AC does not notify you of a potential discrepancy within 10 days of your application delivery, your coverage is accepted even without notification. Any premium that you have paid will be refunded if your coverage does not become effective.

Our acceptance of your application does not waive our rights to subsequently challenge your policy based on intentional material misrepresentation or fraud.

_____ Signature of applicant or, if applicant is a minor, signature of parent or guardian	_____ Date
---	---------------

**WARNING: Do not terminate any current health insurance coverage until your application is accepted and the policy is effective.**

**AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION**

In order to comply with HIPAA privacy regulations and other privacy laws, I authorize any physician, medical professional, hospital, clinic, pharmacy, or other medical or medically related facility, insurance company, health information repository, medical record retrieval service, and their agents, business associates and/or legal representatives to give to American Community Mutual Insurance Company, its legal representatives or its reinsurers, any protected health information including medical records, lab work, x-rays, consultation reports, or knowledge of my health for underwriting purposes. This authorization also includes confidential communicable disease related information, confidential HIV-related information, and information about drug and alcohol use. This authorization permits disclosure of medical documents for 5 years prior to the date signed. This authorization includes all health related information except psychotherapy notes.

This authorization is valid for 24 months from the date below. A photographic copy of this authorization shall be as valid as the original for 24 months from the date below.

1. Execution of this authorization is required for eligibility and enrollment onto this plan. Failure to execute this authorization will result in denial of my application for enrollment.
2. I have the right to revoke this authorization by notifying American Community in writing, except to the extent that American Community has taken action in reliance on this authorization.
3. American Community must comply with federal privacy laws when using or disclosing health information. There may be times when the health information may be disclosed to another entity and the health information may no longer be protected by federal privacy laws, and may be disclosed by that entity. Examples of the types of entities not subject to federal privacy laws include, but are not limited to, business associates American Community uses to administer its benefits, regulators, and law enforcement officials.
4. If there are specific state laws regarding specific health conditions for which we cannot use this form to obtain health information about you, we will ask you to sign a state-specific authorization form.

_____ Signature of applicant or, if applicant is a minor, signature of parent or guardian *		_____ Date
_____ Applicant's Name	_____ Social Security Number	_____ Date of Birth

\* If applicant is under the age of 18, the parent or legal representative must sign on the applicant's behalf and indicate their relationship to the applicant next to their signature. If you are the applicant's legal representative and are not the parent of the applicant, you must provide documentary evidence of your authority to act as the applicant's representative for this authorization to be valid.

**Applicant MUST retain a copy of this authorization.**