HERITANCE
HEALTH & WELLNESS

HEALTH COVERAGE APPLICATION

Health Program I am applying for: ☐ Heritance Basic ☐ Heritance Plus ☐ Heritance Legacy

I. MEMBER INFORMATION

Last Name	First Name	MI	Social Security Number	Marital Status ☐ Single ☐ Married

Street Address	City	State	Zip

Cell Phone Number	Work Phone Number	Desired Coverage Date

Email Address	Referring Member or Group
	DDR-702

II. APPLICANT INFORMATION

Are you a member of a Native American Indian Tribe or Community? ☐ Yes ☐ No (If **Yes**, please submit a copy of Tribal ID or CIB.)

Note: To be eligible for coverage, Dependents must be under the age of 26 and unmarried.

I elect medical coverage for: ☐ Myself ☐ Myself and Spouse ☐ Myself, Spouse, and Dependents ☐ Myself and Dependents

FOR INDIVIDUALS 16 YEARS OF AGE OR OLDER, PLEASE ATTACH ONE OF THE FOLLOWING FORMS OF PHOTO ID: PASSPORT, DRIVER'S LICENSE, OR OTHER GOVERNMENT ISSUED PHOTO ID.

Relationship to member	Names of Member and Dependents to be Covered	Photo ID Attached	Gender	Birth Date MM/DD/YYYY	Age	Height	Weight	Hip	Waist
Member		☐ Y ☐ N	☐ Male ☐ Female						
Spouse		☐ Y ☐ N	☐ Male ☐ Female						
Dependent		☐ Y ☐ N	☐ Male ☐ Female						
Dependent		☐ Y ☐ N	☐ Male ☐ Female						
Dependent		☐ Y ☐ N	☐ Male ☐ Female						
Dependent		☐ Y ☐ N	☐ Male ☐ Female						
Dependent		☐ Y ☐ N	☐ Male ☐ Female						

III. EMPLOYMENT INFORMATION

Member Employer:	Description of Duties:

Spouse Employer:	Description of Duties:

IV. PREVIOUS OR CURRENT COVERAGE

Name of Insurer	Policy Number	Effective Date	Termination Date

In order to verify that Applicant remains qualified for participation based upon the Program's standard guidelines, the Heritance Health & Wellness™ Program reserves the right to request an updated application and/or blood panel tests. Such requests may be made at any time during the first year and within 60 days of each anniversary of the application date. Findings shall be cause for any change in offering.

Applicant Signature: _____ Date: _____
(signature required)

Spouse Signature (If applicable): _____ Date: _____
(signature required)

VIVICARE™
administrator of
Heritance™ Health & Wellness

20 S Main Street - Suite 100 | Bountiful, UT 84010 | Phone: 800.422.4004

V. HEALTH INFORMATION

Instructions: Answer each question for each individual applying for coverage. Circle any specific item(s) in the question that applies. Give full details to any "yes" answer provided for Section V in Sections VI and VII.

Note: You must provide the name, address, and phone number of the Provider or hospital that treated any health condition. Failure to provide this information will delay or reject your application for membership.

1. Is anyone currently under medical care?	Y / N ☐☐	14. Does anyone currently smoke or has anyone smoked within the last 36 months?	Y / N ☐☐
2. Has anyone consulted, been tested by, or had treatment by a doctor, chiropractor, therapist, or other healthcare provider within the past three years?	Y / N ☐☐	15. Has anyone ever had cancer, tumors, cysts, or growths (except for warts), breast lumps, breast augmentation or reduction, or any kind of skin disorder, or required medical treatment for such?	Y / N ☐☐
3. Is anyone taking any medicine, drugs, or shots?	Y / N ☐☐	16. Has anyone had any back, neck, or spinal problems, or a joint disorder, or required medical treatment for such?	Y / N ☐☐
4. Has anyone been advised to be hospitalized, take tests, undergo surgery, or receive medicine but has not done so?	Y / N ☐☐	17. Has anyone had diabetes, gout, arthritis, a thyroid disorder, or a disorder of the lymph nodes or lymph system?	Y / N ☐☐
5. Has anyone in the past five years been hospitalized or had surgery?	Y / N ☐☐	18. Has anyone been unable to work or to perform routine daily functions for longer than two weeks?	Y / N ☐☐
6. Is anyone pregnant?	Y / N ☐☐	19. Has anyone had any surgery or treatment for obesity, bulimia, anorexia, or weight control?	Y / N ☐☐
7. Has anyone been evaluated for infertility, or is anyone infertile?	Y / N ☐☐	20. Has anyone been turned down for other health or life insurance or been given a modified or rated policy?	Y / N ☐☐
8. Has anyone ever had a C-Section or a miscarriage?	Y / N ☐☐	21. Has anyone had or does anyone currently have recurring problem for which they have not sought medical advice or active treatment?	Y / N ☐☐
9. Has anyone had or does anyone currently have any birth defect, developmental or learning disability, or physical or mental impairment?	Y / N ☐☐	22. Has anyone had any circulatory problems including, but not limited to, a rapid, slow, or irregular heartbeat, chest pain, heart trouble, heart attacks, or high blood pressure?	Y / N ☐☐
10. Has anyone had gallbladder problems, ulcers, chronic diarrhea, colitis, rectal disease, other digestive problems, pancreas problems, hepatitis, cirrhosis, liver problems, hernias, stomach stapling, or gastric bypass?	Y / N ☐☐	23. Has anyone been treated for or been diagnosed with a disease or disorder of the immune system including, but not limited to, AIDS or AIDS Related Complex (ARC), or has anyone tested positive for AIDS antibodies?	Y / N ☐☐
11. Has anyone been treated for use of drugs or alcohol or for substance abuse, or been told by any professional to reduce the use of alcohol, drugs, or other substance?	Y / N ☐☐	24. Has anyone ever had any disorder of the lungs or respiratory system including, but not limited to, tuberculosis, emphysema, asthma, or pleurisy?	Y / N ☐☐
12. Has anyone ever had a disorder of the reproductive system or any infectious disease including, but not limited to, urinary problems, pelvic inflammatory disease, incontinence, or venereal disease?	Y / N ☐☐	25. Has anyone had any mental or nervous disorder including, but not limited to, depression, stress, or anxiety that interfered with daily life, and received any counseling or psychotherapy?	Y / N ☐☐
13. Has anyone been unconscious or had epilepsy, seizures, or convulsions?	Y / N ☐☐		

On behalf of all mentioned Applicants, I authorize any physician, medical practitioner, hospital, clinic, any other provider of healthcare, and any insurance company to disclose to Vivicare™ and the Heritanc Health & Wellness™ Program or its representatives all information and records for me and my Dependents relating to diagnosis, treatment, medical history, and physical or mental conditions and the evaluation thereof. I expressly waive my right as well as the right of my Dependents to engage in any legal action for such disclosure and release my rights under the Health Insurance Portability and Accountability Act (HIPAA).

A copy of this authorization shall have the same effect as the original. I understand that the data obtained by the use of this authorization will only be used to determine eligibility and risk determination for participation and program administration. All information will remain confidential. I understand that the governing program document may restrict benefits to healthcare providers whose services will be covered, and I agree that any services that are obtained without or contrary to required pre-authorization, pre-certification, or cost control practices outlined in the participation program document may be denied participation in full or in part. I understand that the participation for which I am applying may limit or exclude certain conditions for which a family member (including me) has received any medical treatment or taken any medications, or regarding the symptoms thereof that should have been disclosed, identified, or treated prior to his/her participation effective date, according to the pre-existing conditions provisions of the governing program document. If my plan document provides that contributions be made, I authorize my employer to deduct them from my pay.

NOTE: ANY DISPUTES ARISING UNDER THIS CONTRACT ARE SUBJECT TO COMPULSORY, BINDING RESOLUTION THROUGH A NATIVE AMERICAN TRIBAL COMMUNITY COURT AND ANY ARBITRATION PROGRAM INSTITUTED UNDER SAME ONLY AFTER EXHAUSTION OF OUR DISPUTE RESOLUTION (GRIEVANCE) PROCEDURES SET FORTH IN THE GOVERNING PROGRAM DOCUMENT, A COMPLETE COPY OF WHICH MAY BE OBTAINED FROM THE HH&W OFFICE IF REQUESTED IN WRITING.

▶ Applicant Signature: _____ Date: _____
(signature required)

▶ Spouse Signature (if applicable): _____ Date: _____
(signature required)

VI. ADDITIONAL INFORMATION - MUST BE COMPLETED FOR ANY "YES" ANSWER FROM SECTION V

NOTE: PRINT, ATTACH, AND SIGN ADDITIONAL COPIES OF THIS PAGE IF NEEDED. NOTE: IF ANY SECTION DOES NOT APPLY, WRITE **NONE** OVER FULL BOX.

First Name of Individual Referenced	Question No.	Start Date	End Date (if applicable)
Diagnosis		Current Symptoms	
Name of Doctor/Hospital			Phone Number
Address			

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Diagnosis		Current Symptoms	
Name of Doctor/Hospital			Phone Number
Address			

Applicant Signature: ______________________ Date: ______________
(signature required)

Spouse Signature (If applicable): ______________________ Date: ______________
(signature required)

VII. PRESCRIPTION DROGS / PRESCRIBED SUPPLEMENTS

NOTE: PRINT, ATTACH, AND SIGN ADDITIONAL COPIES OF THIS PAGE IF NEEDED. NOTE: IF ANY SECTION DOES NOT APPLY, WRITE **NONE** OVER FULL BOX.

First Name	Question No.	Name of Medication	Dosage
Reason for Prescription		Start Date	End Date (if applicable)
Diagnosis			
Remaining Symptoms			
Name of Doctor/Hospital		Phone Number	
Address			

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Reason for Prescription		Start Date	End Date (if applicable)
Diagnosis			
Remaining Symptoms			
Name of Doctor/Hospital		Phone Number	
Address			

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Reason for Prescription		Start Date	End Date (if applicable)
Diagnosis			
Remaining Symptoms			
Name of Doctor/Hospital		Phone Number	
Address			

I hereby apply to be enrolled, with my Spouse and/or Dependents, if applicable, for participation in the Heritance Health & Wellness™ Program. In connection with both this application and any plan participation that may be obtained, I am acting as agent and/or natural guardian for my Spouse and/or Dependents. I understand that participation is contingent upon satisfaction of applicable health assessment criteria and is subject to the terms and conditions of the Heritance Health & Wellness™ Program governing program document. I also understand that no participation shall be in force until each person listed above is approved by Vivicare™ and the Heritance Health & Wellness™ Program, that no benefits will be provided for any service begun before approval, acceptance, and participation is effective, and that, except as expressly provided in the governing program document, benefits will not extend beyond the termination of my participation in the program. I represent that all information provided in this application, including all health-related information, is true and complete. I understand that omissions or misrepresentations regarding information provided in this application could cause otherwise covered services to be denied, benefits to be reduced, and/or coverage issued to be voided.

Applicant Signature: ______________________ Date: ______________
(signature required)

Spouse Signature (If applicable): ______________________ Date: ______________
(signature required)