



1277 Deming Way | Madison, Wisconsin 53717

We've got you covered

Thank you for your interest in our Individual health insurance plans. Dean Health Plan offers a variety of plan designs to fit your specific health insurance needs. Enclosed is your policy application as well as information regarding plan options and membership benefits. **Please note the following important information regarding our Individual plans:**

Eligibility for our Individual plans is limited to U.S. citizens or resident legal aliens, ages 18 to 64, residing within the Dean Health Plan service area. Please see deancare.com for additional eligibility requirements with the Association & ChamberOne plan options.

Our Underwriting department may review the applicant(s) medical information. Please provide a phone number on your application to minimize the review time.

Plan options and riders are available for selection on your application. Please select a plan option as well as any optional benefit riders you want covered.

Please be aware the online rate quotes are for illustrative purposes only. Final rates are determined based on the information you provide on your application. Dean Health Plan will contact you with an application decision and final rates, before you accept the policy.

Checklist for enrolling in an Individual health insurance plan:

- ✓ **Policy application** (completed, signed and sent to Dean Health Plan)
- ✓ **Authorization for automatic transfer of funds** (required if your monthly premium will be paid through an automatic transfer from your bank account)
- ✓ **Premium payment** (A personal check for your first month's premium is required with your application. You can obtain your premium using the online rating calculator at deancare.com or by calling our Customer Care Center.)

Our Customer Care Center is here to help you. If you have any questions, please call (800) 279-1301 or TTY at (877) 733-6456 between the hours of 7:30 a.m. – 5:00 p.m. Monday – Thursday and 8:00 a.m. – 4:30 p.m. Friday.

IND1010-1110



Individual Policy Application Worksheet

AGENT/OFFICE USE ONLY	
Agency Name/Code	Underwriter Initials/Date/Decision
	Approved
Writing Agent's Name	Denied
	Closed Out
PCP Location	Effective Date

Thank you for your interest in a Dean Health Plan individual insurance policy. Please use this worksheet to choose your desired plan and provide information that will help us serve you better.

The application process requires you to complete the four steps listed to the right.

Please complete this entire application in ink.

Requested Effective Date

If issued, Dean Health Plan, Inc (DHP) will assign your effective date as the first of the month following DHP's underwriting approval.

Please select only one plan option

- 1 This Individual Policy Worksheet
- 2 The State of Wisconsin Application
- 3 Authorization Forms
- 4 Select One of the Payment Methods for First Month's Premium

- Personal Check *(required with application)*
- or*
- Automatic Transfer of Funds *(Form D)*

Standard Plan Options	Deductible (Single/Family)	Coinsurance	Out-of-Pocket (Single/Family)
<input type="checkbox"/> Dean Copay	\$0/\$0	0%	\$0/\$0
<input type="checkbox"/> Dean 500	\$500/\$1,000	0%	\$1,500/\$3,000
<input type="checkbox"/> Dean 1000	\$1,000/\$2,000	0%	\$2,000/\$4,000
<input type="checkbox"/> Dean 1500	\$1,500/\$3,000	20%	\$2,500/\$5,000
<input type="checkbox"/> Dean 2000	\$2,000/\$4,000	20%	\$3,000/\$6,000
<input type="checkbox"/> Dean 3500	\$3,500/\$7,000	20%	\$4,500/\$9,000
<input type="checkbox"/> Dean 5000	\$5,000/\$10,000	0%	\$5,000/\$10,000

Optional Standard Plan Rider Benefits

- Maternity**
\$1,000 deductible, then 20% coinsurance
- Prescription Drug 1**
\$10/30%/50% copay/coinsurance
- Prescription Drug 2**
\$250 deductible, then \$5/\$25/\$60

HSA Plan Options	Deductible (Single/Family)	Coinsurance	Out-of-Pocket (Single/Family)
<input type="checkbox"/> Dean 1500 HSA	\$1,500/\$3,000	20%	\$2,500/\$5,000
<input type="checkbox"/> Dean 2000 HSA	\$2,000/\$4,000	20%	\$3,000/\$6,000
<input type="checkbox"/> Dean 3500 HSA	\$3,500/\$7,000	20%	\$4,500/\$9,000
<input type="checkbox"/> Dean 5000 HSA	\$5,000/\$10,000	0%	\$5,000/\$10,000

Optional HSA Plan Riders

- Prescription Drug 1** \$10 / 30% / 50% copay/coinsurance

Please indicate the reason for submitting this application:

- New Applicant
- Birth/Adoption
- Policy Change
- Marriage
- Add Dependent(s)

How did you hear about Dean?

- TV
- Radio
- Internet
- Mail
- Friend
- Insurance Agent
- I am a Dean member

Are you currently a member of a Dean partnering association or chamber? YES NO

If answering YES, please enter the name of Association/Chamber Here

name

**INDIVIDUAL UNIFORM APPLICATION
FOR INDIVIDUAL MAJOR MEDICAL
HEALTH INSURANCE FORM**



**State of Wisconsin
Office of the Commissioner of
Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov**

Ref: Section Ins 3.33, Wis. Adm. Code,
and s. 601.41 (10), Wis. Stat.

This form is designed for an individual's initial application for coverage. Please contact the insurer with questions regarding this form.

Instructions: Please complete 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.

I. INFORMATION

Primary Applicant/Insured Information:

First, Middle and Last Name				
Social Security No.*	Place of Birth	Birth Date	Gender	Height _____ Weight _____
Residential Address				
City	County	State	Zip Code	
Mailing Address, if different from residential address				
City	County	State	Zip Code	
Home Phone	Alternative Phone		Email (Optional)	
*If you have a Social Security Number.				
The Primary Applicant is:				
[] Single [] Married [] Under the age of 18**				
**If primary applicant is under the age of 18, please complete sections – II. C. and V.				
Employment Information:				
Primary job duties:				
Self-Employed: [] Yes [] No				

II. ADDITIONAL APPLICANTS

A. Please complete ONLY if your spouse and/or children under the age of 27 are applying for coverage. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet.

Spouse Name (First; M.I.; Last)	Gender	Social Security Number*/ Place of Birth	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

Child Name (First; M.I.; Last)	Gender	Social Security Number*	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

B. Does the child(ren) named within this application live with you at the address shown above?
 Yes No If "No," please list the child(ren)'s name and mailing address(es):

Mailing Address Named Applicant

City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child.			

C. If the primary applicant is under the age of 18, provide the name and mailing address of the legal guardian or custodial parent:

Mailing Address Legal Guardian or Custodial Parent

City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child			

III. CURRENT AND PREVIOUS COVERAGE

Please provide information about you or your dependent's individual or group health insurance coverage or other health coverage (either prior or current). It will help us determine whether you will have any waiting periods for preexisting conditions for the health insurance you are applying for. By providing this information you are not reducing your health insurance.

Does anyone applying for coverage have current health coverage?
 Yes No If "Yes," please indicate insurer and applicant _____.

Has any applicant had health insurance coverage within the last 18 months?

Yes No If "Yes," please indicate insurer and applicant _____.

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted?

Yes No

Is any applicant enrolled in Medicare?

Yes No If "Yes," name of applicant _____. For this applicant, please stop here – this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid or other governmental health programs (i.e. BadgerCare, TRICARE, Veterans services)?

Yes No If "Yes," name of applicant _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

IV. MEDICAL INFORMATION

NOTICE TO APPLICANT:

The insurance company does not use or collect genetic information for any Underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the insurance company in any manner. For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.

You are required to disclose information regarding any disease or condition for which:

- Any applicant has been diagnosed or treated by any healthcare provider.
- Any applicant has had testing with abnormal results.
- Any applicant is awaiting test results.
- Any applicant has been recommended or scheduled for diagnostic testing, consultation, treatment, follow-up, or surgery.
- Any applicant has taken or has been advised to take any prescription medication.
- Any change in health status for which any applicant has not sought medical care or treatment.

Within the last FIVE (5) YEARS has anyone, including you or any family member requesting coverage, received counseling, care or treatment, medication, medical advice or been told a diagnosis for any of the conditions or illnesses listed below? (Please check all conditions that apply.)

Please mark "Yes" or "No" for each item, for you and any family members requesting coverage. Provide additional information for each question you answer "Yes" to on the Additional Medical Details page that follows the health questions.

Answers to the medical questions should be complete, true and correct to the best of your knowledge. You are required to promptly notify us if there is a change in your or your family's health prior to the effective date of coverage and provide updated information. If at any time during the underwriting process prior to the effective date of coverage, you or your health history changes, please notify us immediately as this may impact your coverage.

WITHIN THE LAST FIVE (5) YEARS:

1. Infectious and Parasitic Diseases

- a. AIDS (acquired immunodeficiency syndrome), ARC (AIDS-related complex), HIV positive [The reporting of HIV test results is limited to FDA-licensed tests, and you need not report results of tests conducted at an anonymous counseling and testing site or through the use of a home test kit.] Yes No

b. Lyme's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Sexually transmitted disease(s).....	<input type="checkbox"/> Yes <input type="checkbox"/> No

2. Blood, Gland, Endocrine, Metabolic and Immune Disorders (other than HIV, ARC, AIDS)

a. Anemia/blood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Diabetes/high or low blood sugar. (If "Yes," record last HGA1C reading and date on the Additional Medical Details page.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Adrenal disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Enlargement of lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Endocrine/gland/hormone system	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Cancer, Cyst and Tumors

c. Cancer. (If "Yes," include the stage, type and location of the tumor on the Additional Medical Details page.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Tumors, cyst, lump, polyp.....	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Mental/Nervous/Behavioral Disorders

a. Alcohol/chemical/drug abuse/dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Has any applicant used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Eating disorders such as, but not limited to, anorexia or bulimia	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Mental/emotional condition/depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Suicide attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Alcohol, chemical, drug abuse therapy, treatment or counseling within last 5 years..... (if "Yes," record date of last session in on the Additional Medical Details page)	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Brain and Nervous System

a. Brain disease or injury/concussion	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Convulsion/seizures/epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Chronic headaches/migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Neurological condition/disease/injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Sleep apnea/chronic sleep disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Skin Disorders

a. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
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7. Eyes, Ears, Nose

a. Chronic ear/nose condition/disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
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b. Chronic eye condition/disease.....	[] Yes [] No
c. Cataracts/glaucoma	[] Yes [] No

8. Mouth, Throat or Jaw

a. Chronic throat/tonsil/adenoid/disease/disorder	[] Yes [] No
b. TMJ/jaw joint.....	[] Yes [] No

9. Heart or Circulatory System

a. Blood/circulatory disorder	[] Yes [] No
b. Heart attack/chest pain/murmur/angina.....	[] Yes [] No
c. Elevated/High cholesterol	[] Yes [] No (if "Yes," record last reading and the date on the Additional Medical Details page)
d. Elevated/High or low blood pressure.....	[] Yes [] No (if "Yes," record last 3 readings and dates in past 12 months on the Additional Medical Details page)
e. Phlebitis/blood clot.....	[] Yes [] No
f. Heart disease/disorder	[] Yes [] No

10. Respiratory System

a. Asthma.....	[] Yes [] No
b. Emphysema/Chronic obstructive pulmonary disease (COPD).....	[] Yes [] No
c. Chronic respiratory/lung condition	[] Yes [] No
d. Pneumonia/bronchitis	[] Yes [] No

11. Digestive System

a. Appendicitis/chronic abdominal pain	[] Yes [] No
b. Blood in stool	[] Yes [] No
c. Colon/rectum/intestine/bowel/Crohn's disease.....	[] Yes [] No
d. Ulcer/esophageal reflux.....	[] Yes [] No
e. Gallbladder	[] Yes [] No
f. Liver condition/hepatitis/pancreas	[] Yes [] No

12. Urinary System

a. Bladder/urinary tract	[] Yes [] No
b. Kidney/kidney stones.....	[] Yes [] No

13. Male or Female Reproductive Systems

a. Breast (lumps or masses).....	[] Yes [] No
b. Prostate/elevated PSA/prostatitis	[] Yes [] No
c. Reproductive system disorder/infertility/dysfunction.....	[] Yes [] No
d. Abnormal pap smear or mammography	[] Yes [] No

14. Pregnancy, Birth or Congenital Abnormalities

a. Birth defect/congenital deformities	[] Yes [] No
b. Pregnancy complications	[] Yes [] No

c. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date _____.) [] Yes [] No

15. Muscular or Skeletal System

- a. Back/neck/spine disorder [] Yes [] No
- b. Bone/orthopedic disorder [] Yes [] No
- c. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia..... [] Yes [] No
- d. Osteoarthritis/osteoporosis/osteopenia [] Yes [] No
- e. Rheumatoid arthritis..... [] Yes [] No
- f. Knee/shoulder/hip/joint surgery/disorder [] Yes [] No
- g. Hernia [] Yes [] No

16. Miscellaneous

- a. Cosmetic surgery/implants [] Yes [] No
- b. Use of prosthetic devices/limbs [] Yes [] No
- c. Had chronic fatigue [] Yes [] No
- d. Is any person to be insured now disabled, on disability, or unable to perform normal work or age-related activities [] Yes [] No
- e. Any fluctuations in weight (+/- 20lbs) in the past 12 months [] Yes [] No
- f. Implantable devices/stents/shunts/pace maker..... [] Yes [] No
- g. Allergies [] Yes [] No
- h. Transplants [] Yes [] No

17. Other Injury, Illness, Treatment or Condition

a. Within the last 5 years, has any applicant had any other injury, illness, treatment, or condition not already listed; been hospitalized or scheduled to be hospitalized; had surgery or had surgery scheduled; had a test or a test scheduled; been recommended to have a test or surgery that was not performed for any reason not already mentioned; been prescribed medication for a condition or injury not already mentioned? (We are NOT seeking the results of HIV Antibody test.) [] Yes [] No

18. Tobacco Use

a. Has any applicant used tobacco products in any form within the last 12 months?.. [] Yes [] No
 If "Yes", provide the name of applicant(s), amount of tobacco used and frequency:

19. Other Activities

a. Has any applicant been involved in or participated in organized motorized racing or other extreme activities? [] Yes [] No
 If "Yes", provide the name of applicant(s), activity and frequency of the activity:

ONLY complete this section if you need assistance with completing the medical information portion of this Application. Please note that this may require additional time to process your application.

Please contact me at this phone number during business hours:

I am unavailable during business hours, please contact me at this number during evenings or weekends:

Additional Medical Details Page
 For any "Yes" responses in the medical information questions, please provide complete details below. Not providing complete details will delay the application process. Within the last five years has anyone been prescribed medications that were recommended or received from a licensed health care professional? Use an additional sheet(s) of paper if necessary.
All additional pages must be signed and dated by the primary applicant.

Question # or additional information								
Applicant Name								
Specific Diagnosis & Type of Treatment								
Duration of Condition	Began mm/yy		Began mm/yy		Began mm/yy		Began mm/yy	
	End mm/yy		End mm/yy		End mm/yy		End mm/yy	
Name/ Dosage/ Frequency of medication & Dates of Medication Use	Name of Rx		Name of Rx		Name of Rx		Name of Rx	
	Dose		Dose		Dose		Dose	
	Began mm/yy	End mm/yy	Began mm/yy	End mm/yy	Began mm/yy	End mm/yy	Began mm/yy	End mm/yy
Was surgery performed								
Description of surgery/ Procedures/ Tests/Result & Dates								
Current Status/ O-Ongoing/ R-Resolved								
Readings for Blood Pressure, Cholesterol & Diabetes	Date	Reading	Date	Reading	Date	Reading	Date	Reading
Physician/ Hospital Name, City, State								

V. TERMS AND CONDITIONS

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified the person(s) who assisted me. I agree that the answers are, to the best of my knowledge and ability, complete and true.

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 the insurance company on the certificate or policy.

I understand that any intentional misrepresentation relied upon by the insurer 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 the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application that is intended to mislead an insurer or conceal significant information about the applicant.

I understand that I may request a copy of this Application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original.

Signature (or e-signature) of Primary Applicant (If Primary Applicant is under the age of 18, Signature of legal guardian or custodial parent)	Date Signed
Signature (or e-signature) of Spouse	Date Signed

Signature (or e-signature) of each listed child who has attained the age of 18

Signature (or e-signature) of an Adult Child Applicant	Date Signed
Signature (or e-signature) of an Adult Child Applicant	Date Signed
Signature (or e-signature) of an Adult Child Applicant	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:



Individual Policy (Form B)

Authorization for Disclosure of Information for Enrollment or Eligibility

Name of Individual(s) Authorizing Disclosure

Date(s) of Birth

By signing this form, I authorize the disclosure and use of protected health information described below for pre-enrollment underwriting or risk-rating of health insurance coverage or to determine eligibility for enrollment or benefits under this health plan. This authorization is a condition of my enrollment in, or eligibility for, benefits under this health plan. If I decide not to sign this authorization, Dean Health Plan, Inc. (DHP) may decline to enroll me in this health plan or provide me the benefits. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA Privacy Regulation and could be re-disclosed by the person or entity that receives it.

When I sign below, I authorize any health care provider, physician, medical practitioner, hospital, clinic, medically-related facility, or other institution, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, pharmaceutical benefits manager, or other organization, institution, or person that has any record or knowledge of me or my minor children, to disclose such information either in original or photographic copies, to DHP or its representatives (including, but not limited to, Claims, Medical Affairs, and Underwriting Departments).

This information includes, but is not limited to: identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and/or services, test results (excluding genetic tests and FDA-licensed blood tests for the presence of HIV, but including x-rays), summary reports, including without limitation, treatment, diagnostic, therapeutic information or history, regardless of type of injury or illness, including pregnancy and treatment or service, if any, for mental or nervous conditions (but not including psychotherapy notes), alcohol abuse, or drug abuse.

When I sign below, I authorize any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer, or personal or business associates having medical and non-medical information about me or my minor child(ren) to disclose to DHP, or its representative(s), (including, but not limited to, Claims, Medical Affairs, and Underwriting Departments) all such information, including photographic copies, thereof.

I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Customer Service. I am aware that my withdrawal will not be effective until received by DHP and will not be effective regarding the uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this authorization. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand this authorization will remain valid for two years from the date I, or my legal representative, execute this authorization. I further understand that I am entitled to receive a copy of this completed, signed authorization and that a photographic copy of this authorization is as valid as the original.

Applicant's Signature

Date

Spouse's Signature

Date

Signature of Parent for Minor Children

Date

Signature of Child Age 18 or Older

Date

Signature of Child Age 18 or Older

Date

Signature of Child Age 18 or Older

Date

If this authorization is signed by a personal representative on behalf of an individual, please complete the following:

Name of Personal Representative

- Legal representative of minor
- Legal representative of incompetent
- Power of Attorney
- Other (please specify) _____



Individual Policy (Form C)

Notice Regarding Replacement of Accident/Sickness Insurance

This Policy provides ten (10) days within which you can decide, at no cost to you, whether you desire to keep this Policy.

If you intend to lapse or otherwise terminate your present policy and replace it with a Policy issued by Dean Health Plan, Inc. (DHP), the following facts should be considered before you make this change:

1. You may have health conditions covered under your present policy that may not be covered under the DHP Policy. This could result in the denial of future benefit claims relating to these health conditions under the DHP Policy.
2. Even if some of your present health conditions would be covered under the DHP Policy, these conditions may be subject to certain waiting periods under the DHP Policy before coverage is effective.
3. Questions in the Application for the DHP Policy must be answered truthfully and completely; otherwise, the validity of the Policy, and the payment of any benefits thereunder, may be voided.
4. The DHP Policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the DHP Policy, depending upon the benefits, may be higher than you are paying for your present policy.
5. The renewal provisions of the DHP Policy should be reviewed, as they may differ from your present policy.

It may be to your advantage to secure the advice of your present insurer, or its agent, regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage

Applicant's Signature

Date



Individual Policy (Form D)

Authorization for Automatic Transfer of Funds

Dean Health Plan, Inc. offers an easy way to make monthly premium payments, called the **Direct Premium Payment Program**. This service allows Dean Health Plan to automatically transfer funds from your checking or savings account on a monthly basis to pay your monthly premiums. This program ensures your monthly premiums will be paid timely even if you are traveling and there is no cost to you for this service.

To participate, simply sign this authorization and attach a voided check that shows the bank and account number. Please be sure to fill in your financial institution name, routing number and account number below. We will take care of the rest!

The Direct Premium Payment Program will generally start on the 23rd of the month following acceptance of your application. You will receive a letter prior to the first transfer notifying you of the amount that will be transferred from your account and when the first transfer will occur. Thereafter, your monthly premium will be transferred from your account on the 23rd of each month or the business day following. If your account has insufficient funds for the transfer, you are responsible for the monthly premium.

If you have any questions, please contact the Customer Care Center at (800) 279-1301.

By signature below, I authorize Dean Health Plan to instruct my financial institution to deduct my premium payments from the account designated below. I authorize the financial institution to debit the amount of my premium from my designated account. This authorization is to remain in full force and in effect until Dean Health Plan has received written notification from the individual member of their termination in such time and in such manner as to afford Dean Health Plan and the financial institution a reasonable opportunity to act on it.

Name of Financial Institution

Routing number																Type	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings
Account number																		

Applicant's Signature

Date