P.O. BOX 27788
AUSTIN, TX 78755
FAX: 512-717-5588
EMAIL: enrollment@vista360health.com

Please email application to onlinehealthexchange@gmail.com

New Application/Change for Individual HMO Coverage

[You have the option to choose a Consumer Choice health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This 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 in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits, if any are excluded in this evidence of coverage.]

SECTION 1:

PRIMARY APPLICANT			
FIRST NAME, MIDDLE INITIAL, LAST NAME	**SOCIAL SECURITY NUMBER**	**SEX** ○ M ○ F	**DATE OF BIRTH**
PRIMARY ADDRESS - STREET, CITY, STATE, ZIP		**COUNTY**	
MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)			
PRIMARY PHONE	**SECONDARY PHONE**		
EMAIL ADDRESS			
PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" NAME (REQUIRED)	**PCP#** (REQUIRED. OBTAIN FROM PROVIDER DIRECTORY)		
You have the right to choose an obstetrician-gynecologist (OB/GYN) to provide obstetrical or gynecological care in addition to a Primary Care Physician. Name of OB/GYN to provide obstetrical or gynecological care: (You are not required to elect and OB/GYN, you may receive OB/GYN services from your PCP.)			
IS THE PRIMARY APPLICANT AN? **UNITED STATES CITIZEN** ○ Y ○ N **OR** **PERMANENT LEGAL RESIDENT OF THE UNITED STATES** ○ Y ○ N (If "no" to the questions above, coverage cannot be issued)	**PRIMARY APPLICANT'S PRIMARY LANGUAGE**		
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. ○Y ○ N			
DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) ○ Y ○ N **IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:**			

SECTION 2:

ENROLLMENT INFORMATION	○ NEW COVERAGE	○ ADD DEPENDENT	○ CHANGE IN COVERAGE

PLAN EFFECTIVE DATE (First of the month only): (mm/dd/yyyy) _____

COVERAGE FOR: ○ APPLICANT ONLY ○ APPLICATION & SPOUSE ○ APPLICANT & CHILD(REN) ○ FAMILY

SELECT ONE OPTION: ○ OPEN ENROLLMENT ○ SPECIAL ENROLLMENT PERIOD

If applying for coverage during a Special Enrollment Period (SEP), you may request coverage if you have experienced one or more of the qualifying events below. We must be notified within 60 days of the qualifying event and you must provide acceptable proof of the qualifying event along with this application. Failure to provide acceptable proof of a qualifying event with this application will delay or prevent the processing of your application and enrollment in coverage.

○ As a qualified individual or dependent that has lost Minimum Essential Coverage ○ Involuntary loss due to reasons other than failure to make payment ○ Due to reaching the maximum age, divorce, or death of policy holder ○ Due to loss of employer sponsored insurance, State Continuation or COBRA benefits ○ No longer residing or working in my prior health insurance plan's HMO service area	DATE OF EVENT
○ for a birth, adoption or placement of adoption	DATE OF EVENT
○ as a qualified individual gaining a spouse/dependent or becoming a spouse/dependent through marriage	DATE OF EVENT
○ as a qualified individual gaining access as a result of a permanent move	DATE OF EVENT
○ as a qualified individual, who was not previously a citizen or permanent legal resident that has gained such status	DATE OF EVENT

SECTION 3:

PLAN SELECTION	
○ **FUSION BRONZE:**	$5,000 Individual [Deductible] 50% Copayment $7,350 Individual Out of Pocket Maximum
○ **SELECT HMO BRONZE:**	$6,900 Individual [Deductible] 50% Copayment $7,350 Individual Out of Pocket Maximum
○ **TRADITIONAL HMO SILVER:**	$4,000 Individual [Deductible] 30% Copayment $7,350 Individual Out of Pocket Maximum
○ **CHOICE HMO SILVER:**	$4,000 Individual [Deductible] 10% Copayment $5,0000 Individual Out of Pocket Maximum
○ **CHOICE HMO BRONZE:**	$6,650 Individual [Deductible] 0% Copayment $6,6550 Individual Out of Pocket Maximum
○ **ZERO DEDUCTIBLE GOLD:**	$0 Individual Deductible 25% Copayment $7,350 Individual Out of Pocket Maximum

SECTION 4:

SPOUSE TO BE COVERED

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX ○ M ○ F	DATE OF BIRTH

RELATIONSHIP	IS THE APPLICANT A UNITED STATES CITIZEN OR PERMANENT LEGAL RESIDENT OF THE UNITED STATES? If "no", coverage cannot be issued) ○ Y ○

EMAIL ADDRESS	

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" NAME (REQUIRED)	PCP# (REQUIRED. OBTAIN FROM PROVIDER DIRECTORY)

You have the right to choose an obstetrician-gynecologist (OB/GYN) to provide obstetrical or gynecological care in addition to a Primary Care Physician. Name of OB/GYN to provide obstetrical or gynecological care: (You are not required to elect and OB/GYN, you may receive OB/GYN services from your PCP.)

PRIMARY APPLICANT'S PRIMARY LANGUAGE

HAS THE 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. ○Y ○ N

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) ○ Y ○ N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

DEPENDENT CHILDREN TO BE COVERED

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX ○ M ○ F	DATE OF BIRTH

RELATIONSHIP	IS THE APPLICANT A UNITED STATES CITIZEN OR PERMANENT LEGAL RESIDENT OF THE UNITED STATES? (If "no", coverage cannot be issued) ○ Y ○ N

EMAIL ADDRESS	

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" NAME (REQUIRED)	PCP# (REQUIRED. OBTAIN FROM PROVIDER DIRECTORY)

You have the right to choose an obstetrician-gynecologist (OB/GYN) to provide obstetrical or gynecological care in addition to a Primary Care Physician. Name of OB/GYN to provide obstetrical or gynecological care: (You are not required to elect and OB/GYN, you may receive OB/GYN services from your PCP.)

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HAS THE 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. ○Y ○ N

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) ○ Y ○ N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

SECTION 4: (continued)

DEPENDENT CHILDREN TO BE COVERED

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX ○ M ○ F	DATE OF BIRTH
RELATIONSHIP	IS THE APPLICANT A UNITED STATES CITIZEN OR PERMANENT LEGAL RESIDENT OF THE UNITED STATES? (If "no", coverage cannot be issued) ○ Y ○ N		
EMAIL ADDRESS			
PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" NAME (REQUIRED)	PCP# (REQUIRED. OBTAIN FROM PROVIDER DIRECTORY)		

You have the right to choose an obstetrician-gynecologist (OB/GYN) to provide obstetrical or gynecological care in addition to a Primary Care Physician. Name of OB/GYN to provide obstetrical or gynecological care: (You are not required to elect and OB/GYN, you may receive OB/GYN services from your PCP.)

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DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) ○ Y ○ N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

DEPENDENT CHILDREN TO BE COVERED

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX ○ M ○ F	DATE OF BIRTH
RELATIONSHIP	IS THE APPLICANT A UNITED STATES CITIZEN OR PERMANENT LEGAL RESIDENT OF THE UNITED STATES? (If "no", coverage cannot be issued) ○ Y ○ N		
EMAIL ADDRESS			
PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" NAME (REQUIRED)	PCP# (REQUIRED. OBTAIN FROM PROVIDER DIRECTORY)		

You have the right to choose an obstetrician-gynecologist (OB/GYN) to provide obstetrical or gynecological care in addition to a Primary Care Physician. Name of OB/GYN to provide obstetrical or gynecological care: (You are not required to elect and OB/GYN, you may receive OB/GYN services from your PCP.)

PRIMARY APPLICANT'S PRIMARY LANGUAGE

HAS THE 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. ○Y ○ N

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) ○ Y ○ N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

SECTION 4: (continued)

DEPENDENT CHILDREN TO BE COVERED

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX ○ M ○ F	DATE OF BIRTH

RELATIONSHIP	IS THE APPLICANT A UNITED STATES CITIZEN OR PERMANENT LEGAL RESIDENT OF THE UNITED STATES? (If "no", coverage cannot be issued) ○ Y ○ N

EMAIL ADDRESS	

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" NAME (REQUIRED)	PCP# (REQUIRED. OBTAIN FROM PROVIDER DIRECTORY)

You have the right to choose an obstetrician-gynecologist (OB/GYN) to provide obstetrical or gynecological care in addition to a Primary Care Physician. Name of OB/GYN to provide obstetrical or gynecological care: (You are not required to elect and OB/GYN, you may receive OB/GYN services from your PCP.)

PRIMARY APPLICANT'S PRIMARY LANGUAGE

HAS THE 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. ○Y ○ N

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) ○ Y ○ N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

DEPENDENT CHILDREN TO BE COVERED

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX ○ M ○ F	DATE OF BIRTH

RELATIONSHIP	IS THE APPLICANT A UNITED STATES CITIZEN OR PERMANENT LEGAL RESIDENT OF THE UNITED STATES? (If "no", coverage cannot be issued) ○ Y ○ N

EMAIL ADDRESS	

PRIMARY CARE PHYSICIAN/PRACTITIONER "PCP" NAME (REQUIRED)	PCP# (REQUIRED. OBTAIN FROM PROVIDER DIRECTORY)

You have the right to choose an obstetrician-gynecologist (OB/GYN) to provide obstetrical or gynecological care in addition to a Primary Care Physician. Name of OB/GYN to provide obstetrical or gynecological care: (You are not required to elect and OB/GYN, you may receive OB/GYN services from your PCP.)

PRIMARY APPLICANT'S PRIMARY LANGUAGE

HAS THE 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. ○Y ○ N

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (REQUIRED) ○ Y ○ N
IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

SECTION 5:

BILLING INFORMATION	

○ **BANK DRAFT:**

When choosing to pay premium by Bank Draft, **the first premium will be deducted from your account immediately when your policy is issued.** After initial payment, deductions will automatically be taken out on the date of month selected. No coupons or email notices will be sent.

I would like my monthly payment to come from my account (check one) on the:

○ 1st ○ 10th ○ 15th ○ 20th day of each month

PLEASE CHECK ONE: ○ CHECKING (please attach voided check) ○ SAVINGS	**NAME OF DEPOSITOR IF OTHER THAN APPLICANT**
FINANCIAL INSTITUTION NAME:	
BANK ROUTING NUMBER:	**BANK ACCOUNT NUMBER:**

I hereby request and authorize Vista360health to initiate a change to my account at the name 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 Vista360health or the Financial Institution in such time as to afford 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 the health plan.

DEPOSITOR'S SIGNATURE	**DATE**	**RELATIONSHIP TO APPLICANT**

○ **PAY BY CHECK:** - Make checks payable to Vista360health.

When choosing to pay premium by CHECK, your first premium must accompany this application. You will be billed each month going forward.

PREMIUM AMOUNT: _____

SECTION 6:

OTHER COVERAGE INFOMRATION	

DOES ANY PERSON APPLYING FOR COVERAGE CURRENTLY HAVE HEALTH OR MAJOR MEDICAL INSURANCE COVERAGE WITH ANY OTHER INSURER, OR COVERAGE UNDER A TAX SUPPORTED OR GOVERNMENT PROGRAM, INCLUDING MEDICARE, TO THE EXTENT PERMITTED BY LAW, EITHER AS A PRIMARY INSURED, SPOUSE OR DEPENDENT? ○ Y ○ N

IF YES, PLEASE COMPLETE THE FOLLOWING:

APPLICANT NAME	**NAME ON PREVIOUS POLICY (IF APPLICABLE)**	**MEMBER/GROUP NUMBER**
APPLICANT NAME	**NAME ON PREVIOUS POLICY (IF APPLICABLE)**	**MEMBER/GROUP NUMBER**

SECTION 7:

READ AND SIGN BELOW

Acknowledgements:

- You do not have Medical Coverage until the effective date of the policy and the first month's premium is paid.
- Prior to the effective date of coverage, I understand I am responsible for communicating any changes to the information I provided on this application.
- If a spouse and/or dependent(s) is/are included for medical coverage, the premium will be calculated on the age of each individual covered.
- I understand that if any person makes a fraudulent misstatement of a material fact on the application, the fraudulent misstatement may be used to void the policy. Voiding the policy is defined as a cancellation of coverage that will have a retroactive effect.

Agreement:

- 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 an Agent, Producer or Broker allowed to permit me to answer any question inaccurately or untruthfully and I represent that such did not occur. An Agent, Producer or Broker is not authorized to alter any terms of the Health Plan.

Authorization:

- I authorize any medical professional, hospital, clinic or other medical or medical related facility, governmental agency, pharmacy benefit manager, retail pharmacy, pharmacy clearinghouse or other person or firm, to disclose to Vista360health or their authorized representative, information, including copies of records, concerning advice, diagnosis, care or treatment of physical, psychiatric, mental or emotional conditions, drug and alcohol abuse, illness or injury, and copies of all hospital records, medical records, pharmaceutical records or non-medical information provided to me and/or my dependents to give to Vista360health, its reinsurers, or its legal representatives, and its affiliates, any and all such information. In addition, I authorize Vista360health to review and research its own records for information.
- I understand that I have the right to revoke the Authorization at any time, in writing, by contacting 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 further understand that I or any representative will receive a copy of this authorization upon request.

Signature:

- I agree that individual coverage is intended to be paid as my personal expense and that this policy is offered on my representation that only I, a family member or permissible third party as outlined below will pay Vista360health directly. I understand that Vista360health does not accept payments of premium or cost-sharing payments directly from third parties except form family members, employers and certain required entities.
- In addition I acknowledge that this coverage is intended to be individual coverage and nothing in this document creates a group health plan under state and federal laws.
- Special Enrollment Period Acknowledgement. I understand that if I am applying for coverage outside of Open Enrollment, I must qualify for a Special Enrollment Period ("SEP"). I understand that in order to qualify for a SEP I must have experienced one of the qualifying events identified on page 2 of this application during the last 60 days, and I must provide proof of any qualifying event(s) with this application in order for Vista360health to verify eligibility.

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

PRIMARY APPLICANT'S SIGNATURE	**DATE**
SPOUSE'S SIGNATURE (IF APPLYING)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
PARENT OR LEGAL GUARDIAN OF A MINOR CHILD	**DATE**

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) Eric Boutin

Email Address eric@hsatexas.com Telephone Number 512-377-5500

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.

Vista Health Plan, Inc. (dba Vista360health)
Consumer Choice Individual

TEXAS DEPARTMENT OF INSURANCE
REQUIRED DISCLOSURE STATEMENT FOR ALL
CONSUMER CHOICE HEALTH BENEFIT PLANS ISSUED INTEXAS

Under Texas law, HMOs are permitted to market "Consumer Choice" plans, which do not have to comply with one or more state coverage requirements. They must also offer a plan that does comply with all state requirements. HMOs are required by law to obtain signatures of consumers showing they have been given this notice.

I have been informed that the consumer choice plan I am being offered does not include all of the health benefits usually required by Texas law. I understand that the following benefits are either excluded from the plan or provided at a reduced level:

Description of the State Requirements Reduced or Excluded - if additional space is needed, the HMO may add additional lines, or may continue the list on a subsequent page, but must clearly note that an additional page is attached.	**Benefit Reduced**	**Benefit Excluded**
Deductibles	Deductible Applied to Plan Benefits	Not applicable

[I understand that if I buy a consumer choice plan, the HMO may deny or limit coverage for these services for me and anyone else covered by my health plan when the health needs of anyone covered under my plan changes.]*

I understand that I can get more information about consumer choice plans from the Texas Department of Insurance (TDI) by visiting the TDI website at www.tdi.texas.gov/consumer/documents/ccpexplanation.pdf or by calling the TDI Consumer Help Line at 1-800-252-3439.

I acknowledge that HMO has offered me a health plan that contains all of the state requirements.**

Signature of Applicant

Name of Applicant

Name of Business, if applicable

Address

City / State / ZIP

Date

Note: The HMO issuing the policy must keep this disclosure statement and provide it to the commissioner of insurance on request. **You have the right to a copy of this written disclosure statement free of charge.** You must sign a new disclosure statement when you buy a consumer choice plan and each time your policy renews.

* This must be included for individual plans, but may be excluded for group plans.
** This paragraph is optional. 28 TAC Section 21.3542 allows an HMO to combine the written affirmation of an offer of a health benefit plan with all state-required benefits with the offer of a consumer choice health benefit plan.