MyPriority®
Short-term application

PriorityHealth

This plan does not cover pre-existing conditions. Benefits will be excluded for each illness or injury or condition for which, during the five year period prior to your effective date, medical advice, diagnosis, care or treatment was recommended or received.

Section 1: Subscriber information

Last name	First name	Middle initial	Social Security number – –
Street address	City	State	ZIP
County	Gender ☐ Male ☐ Female	Birth date / /	Age
Phone number that we may use to contact you: ( ) ☐ Landline (home phone) ☐ Cell phone	Alternate phone number that we may use to contact you (optional): ( ) ☐ Landline (home phone) ☐ Cell phone	Email address	
Requested effective date of coverage (date you would like coverage to begin) / /	Note: Effective date is assigned by Priority Health and will be the later of: 1. Effective date requested, OR 2. Underwriting approval date		
Desired length of coverage ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months	Deductible ☐ $500 ☐ $1,000 ☐ $2,500		

Please list your spouse and all eligible dependent(s) who are applying for coverage under your policy.
If you have more than three (3) dependents complete an additional application and include it with this application.

Spouse/dependent last name	First name	Social Security Number – –	
Email address	Gender ☐ Male ☐ Female	Birth date / /	Age
Dependent last name	First name	Social Security Number – –	
Email address	Gender ☐ Male ☐ Female	Birth date / /	Age
Dependent last name	First name	Social Security Number – –	
Email address	Gender ☐ Male ☐ Female	Birth date / /	Age

Section 2: Health and other information

Note: The plan cannot be issued if YES is answered to question 1 and 2.

Under no circumstances can coverage become effective prior to the date this application is signed.

1. ☐ Yes ☐ No Are you, your spouse, or any person to be insured:
   - Over 300 lbs (if male) or over 250 lbs (if female)?
   - Now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?

2. For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:

☐ Yes	☐ No	Any heart disorder?
☐ Yes	☐ No	Any emphysema or chronic obstructive pulmonary disease (COPD)?
☐ Yes	☐ No	Any Crohn's disease, ulcerative colitis or hepatitis B, C, D or other?
☐ Yes	☐ No	Any AIDS or tested positive for HIV?
☐ Yes	☐ No	Any stroke?
☐ Yes	☐ No	Any diabetes or except gestational diabetes?
☐ Yes	☐ No	Any cancer or tumor (except basal cell skin cancer) which has been removed?
☐ Yes	☐ No	Any alcoholism, chemical dependency, drug or alcohol abuse?

Section 3: Payment information

Priority Health has an electronic fund transfer process for collecting short-term health insurance premiums. Based on the amount of coverage you are applying for, an electronic funds transfer is required for the full amount of premium for the coverage period.

Choose how often you pay:

☐ Monthly

☐ The full amount of my premium

Your first payment will be drafted within 24 hours of Priority Health processing your enrollment. Ongoing payment will be drafted on the first business day of the month. If your account does not have enough money to pay your premium we will get a "non-sufficient funds" (NSF) notice from your account, and we will charge you a $50 fee. If we try a second time to collect your premium and get a second NSF notice, we will end your policy.

Upon approval of my application, I authorize Priority Health to deduct the premium from the checking or savings account listed below.

Name of financial institution	Account type ☐ Checking ☐ Savings
ABA/routing number (9 digits on the bottom of check for a checking account)	Account number
Print name	
Account holder's signature	Date / /

We must receive all required information to enroll you in coverage. If your application is approved, your coverage will be effective on the requested effective date or the underwriting approval date, whichever is the later. Once approved, Identification Cards (ID Cards) with your subscriber numbers will be mailed to you. Please allow 7 to 10 business days to receive your ID cards. If you have additional questions on the automatic bill payment plan, please call Customer Service at 800.528.8762.

Section 4: Important authorization and verification information. Please read, sign, and date as indicated.

The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or any misleading information is guilty of a felony of the third degree. The undersigned also understands that this is not a continuation of any previous medical plan, including any prior Short-term medical plan. If I am self-employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (Internal Revenue Code section 106, 125, 162 or 213). I agree that I, along with my dependents, will accept and receive member materials online. The undersigned realizes that this plan does not cover pre-existing conditions. Benefits will be excluded for each illness or injury or condition for which, during the five year period prior to your effective date, medical advice, diagnosis, care or treatment was recommended or received.

Subscriber (Primary applicant)	Date / /

Section 5: For agent

If an agent assisted with the sale or completion of this application, the agent is required to complete the following information:

Agent name	Agent number	Email address
Agency name		Agent contract number
Agent phone number		Agent fax number
Agent signature		Date / /

Mail all required forms using either the enclosed business reply envelope, or address to:

Priority Health
Individual Operations
27777 Franklin Rd
Suite 1300
Southfield, MI 48034

Fax all forms to: 248.324.2973

Email all forms to: *mypriority@priorityhealth.com*

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.