Friday Health Plans • 700 Main Street• Alamosa, CO 81101

APPLICATION FOR HEALTH COVERAGE – INDIVIDUAL PLAN

Contact us online: www.fridayhealthplans.com/members/resources/ok or by phone at 1-844-817-1600
Apply for coverage online at www.fridayhealthplans.com/or submit by mail to the address above.

To avoid potential delays, please print legibly.

COVERAGE INFORMATION	
Application Type:	☐ Open Enrollment ☐ Special Enrollment*
Requested Effective Date (required):	_____/_____/_____(MM/DD/YYYY) Coverage will be effective on the first day of the month following receipt of this completed Application, provided that this completed Application is received by FHP by the 15th of the previous month, unless a later effective date is requested.

*Proof of eligibility is required for special enrollment. Eligibility information for special enrollment periods is available at www.fridayhealthplans.com

PRIMARY INSURED

Instructions: Please type or print using black or blue ink. Please fill out 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. **For child-only coverage, please list the youngest child as the Primary Applicant.**

First Name:	Middle Initial:		Last Name:		
Social Security Number:	Date of Birth:		Current Age:		Sex: ☐ M ☐ F
Physical Address:			City:		
County:	State:		Zip:		
Mailing Address (if different):			City:		
County:	State:		Zip:		
Primary Phone:	Alternate Phone:		Email:		

Preferred spoken language if other than English:

Ethnicity (optional): ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic ☐ White ☐ Multiracial

Dependent Information

Complete ONLY if your spouse/partner and/or child(ren) under the age of 26 (older if medically disabled) are applying for coverage. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet. Social Security Numbers (or document numbers for any legal immigrants) are **required** for anyone applying for health insurance. *Proof of eligibility for Court-Ordered Dependents will be required.

Name (First, MI, Last)	Gender	Social Security Number	Relationship to applicant?	Disabled?	Tobacco?	Birth Date (MM/DD/Y)
	☐ M ☐ F		☐ SPOUSE/PARTNER	☐ Y☐ N	☐ Y☐ N	
	☐ M ☐ F		☐ CHILD ☐ COURT ORDER	☐ Y☐ N	☐ Y☐ N	
	☐ M ☐ F		☐ CHILD ☐ COURT ORDER	☐ Y☐ N	☐ Y☐ N	
	☐ M ☐ F		☐ CHILD ☐ COURT ORDER	☐ Y☐ N	☐ Y☐ N	
	☐ M ☐ F		☐ CHILD ☐ COURT ORDER	☐ Y☐ N	☐ Y☐ N	

Are all applicants U.S. citizens or U.S. nationals? ☐ Y ☐ N* Applicant Name: _____

*If No, proof of eligible immigration status for applicant is required.

Immigration document type:_____ Document ID number:

Will you or any applicants listed have other medical coverage in addition to this plan? ☐ Y ☐ N

If yes, name:_____ Type of coverage: ☐ Medicare ☐ Medicaid ☐ Other Individual Coverage ☐ Employer Group Coverage ☐Other: _____

Marital Status: ☐Single ☐Married

Primary Applicant Name: _____

Name of the legal guardian or parent responsible for carrying health insurance for the child:			
If the primary applicant is under the age of 18, provide the name and mailing address of the legal guardian or custodial parent:			
Legal Guardian or Custodial Parent's Name:	Mailing Address (if different):		
City:	County:	State:	Zip:
Home Phone:	Alternate Phone:	Email:	

PLAN SELECTION (required, select only one)	
All family members listed on this application must be enrolled on the same plan. Please use a separate application if a different plan is requested for a family member.	
Friday Gold EPO	☐ Friday Gold ☐ Friday Gold Copay
Friday Silver EPO	☐ Friday Silver ☐ Friday Silver Copay
Friday Bronze EPO	☐ Friday Bronze ☐ Friday Bronze Plus ☐ Friday Bronze HSA ☐ Friday Bronze Copay
Friday Catastrophic EPO	☐ Only for individuals under 30 years of age, or a person 30 years of age or over holding a Certificate ofExemption.

PAYMENT INFORMATION

Coverage will not be effective until the first month's premium payment is received. How will you make your first month's premium payment?

☐ Check or Cashier's Check – please submit with yourapplication

☐ Automatic monthly bankdraft

☐ Debit Card orVisa/MasterCard

☐ Visa ☐ MasterCard ☐Discover

Card number_____ Expiration date_____ Security code _____

How will you make your future payments? (Email addresses are required for electronicpayments. Email:_____)

☐ Automatic monthly bankdraft

☐ Debit Card orVisa/MasterCard

I hereby authorize Friday Health Plans (FHP) to initiate debit entries to the checking or savings account indicated below and request the financial institution named below to debit the same to such account. This information will be kept for ongoing payments and the account listed will be drafted for the monthly premium amount. I am an authorized signor on the account indicatedbelow:

Account Type: Checking ☐ Savings ☐ (Account will be drafted on the first business day of the month.)

Name of Financial Institution	Address of Financial Institution
Name of Account/Name on Account	
Financial Institution Transit Routing Number (9 digits – see diagram below)	Account Number (See diagram below)

FOR CHECKING ACCOUNTS ONLY:

If using a checking account, you must attach a voided check for financial institution and account information verification.

Your Name Check #123

Your Address

Your City, State, Zip Date:_____

Pay to the order of:

Please attach an unsigned voided check here (if applicable)

In the amount of: Dollars

Financial Institution Name

For:

|: 123456789 :| 00998765432

This is your bank's TransitRouting Number. This is your Account Number.

This authorization will remain in effect until Friday Health Plans has received written notification of its termination in such time and in such manner as to afford Friday Health Plans a reasonable opportunity to act upon it.

Primary Applicant Name: _____

TERMS AND CONDITIONS

By signing this application, it is consented by all applicants, to the extent permitted by applicable law, to the release of or use of Protected Health Information (PHI)* (as defined below) by any person or entity including, without limitation, practitioners, pharmacies or pharmacy benefit managers, providers, health information exchanges, and insurance companies to FHP or its designees for any permitted purpose, including but not limited to insurance eligibility, quality assurance, utilization review, processing of claims, financial audits or other purposes related to the treatment, payment, or healthcare operations activities of FHP. It is understood that it may be necessary for the parties administering the plan in which I/we are enrolling to obtain and/or provide to others this PHI. Therefore:

1. It is authorized that any person or entity having PHI to provide any such PHI upon request to FHP and its participating providers, or any entity performing a service for the purpose of eligibility determination under the plan, the administration of the plan, the performance of any FHP program or operation or assessing of healthcare services and supplies.
2. It is authorized for FHP to disclose any PHI to any person, company, or entity when it determines that such disclosure is necessary or appropriate for the administration of the Plan, the performance of FHP programs or operations, assessing quality and accessibility of healthcare services and supplies, or reporting to third parties involved in plan administration.
3. I know that I must tell FHP if anything changes (and is different than) what I wrote on this application. I can visit www.fridayhealthplans.com/members/resources/ok or call 844-817-1600 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.

*Protected Health Information includes, with respect to me and/or a covered dependent/minor child, any individually identifiable health information, including but not limited to medical, dental, mental health, substance abuse, communicable disease, Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) related information, as well as any disability- or employment-related information.

By completing this form:

- I understand that I represent my current and continuing authority to act on behalf of myself and all dependent(s) listed on this form.
- I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of myknowledge.
- 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 carrier on the certificate orpolicy.
- I understand that any intentional misrepresentation relied upon by the carrier 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 this application. I acknowledge that no one applying for coverage on this application is incarcerated (detained orjailed).
- **ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRADULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILITY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.**
- At any time when Friday Health Plans is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Policy due to an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on this application, Friday Health Plans may at its option make an offer to reform the policy already in force and/or change the rating category/level.
- I understand this Authorization is valid for two years from today, or until I terminate coverage. I understand that I have the right to revoke the Authorization at any time, in writing, by contacting Friday Health Plans. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.
- I understand that I may request a copy of this Application by contacting Friday Health Plans by phone at 844-817-1600. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.
- I understand that covered benefits, utilization management procedures, and plan exclusions and limitations are subject to the plan's Evidence of Coverage (EOC) and/or Summary of Benefits and Coverage (SBC). These documents are available at www.fridayhealthplans.com/members/resources/ok . I also may contact Friday Health Plans at 844-817-1600, Monday through Friday, 8:00 a.m. to 5:00 p.m., to request a printed copy of these documents.

_____ _____

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans Required

Date Signed

_____

Printed Name

Name:	Agent ID (NPN):
Agency Name:	Phone: