



MAJOR MEDICAL INSURANCE PLAN FOR MEMBERS OF THE LOUISIANA DENTAL ASSOCIATION

PLEASE PRINT IN INK OR TYPE (BE SURE TO COMPLETE ENTIRE FORM)

I. Applicant Information

Social Security #: _____

LAST FIRST INITIAL

PLACE OF BIRTH:

EMPLOYER NAME

CITY STATE OR PROVINCE

EMPLOYER STREET ADDRESS

PHONE NUMBERS: () HOME

CITY

() WORK

STATE ZIP CODE

() FAX

APPLICANT'S HOME ADDRESS

COUNTRY OF RESIDENCE

CITY STATE ZIP CODE

EMAIL ADDRESS

MARITAL STATUS: [] SINGLE [] MARRIED [] LEGALLY SEPARATED [] DIVORCED [] WIDOWED

Table with 5 columns: LIST PERSONS PROPOSED FOR INSURANCE, DATE OF BIRTH, HEIGHT, WEIGHT, GENDER. Rows for APPLICANT, SPOUSE, CHILD(REN).

If more than two children are proposed for insurance, attach a separate sheet, signed and dated

- I am now a member of the LDA and working at least 30 hours per week. [] YES [] NO

Original Date of Hire: _____

II. Insurance Requested: Refer to brochure for eligibility, options and coverage description. (To be completed by ALL applicants.) I hereby apply for the following coverage:

2a. BENEFIT OPTION SELECTION

Table with 4 columns of insurance plan options: HIGH DEDUCTIBLE HEALTH PLAN (100% In-Network), HIGH DEDUCTIBLE HEALTH PLAN (80% In-Network), PREMIER COPAY PLAN (80% In-Network), BASIC COPAY PLAN (70% In-Network).

2b. BILLING OPTIONS: [] Monthly Draft (Requires Pre-Authorized Checking (PAC) Request) [] Monthly Premium Notice

2c. COVERAGE DESIRED: [] Insured Only [] Insured & Spouse [] Insured & Children [] Family

REMEMBER TO SIGN AND DATE APPLICATION

2d. What hospital, surgical, or medical insurance do you or your dependents now carry or have application pending for?

Company	Plan	Benefit

2e. What group hospital, surgical, or medical insurance terminated for you or your dependents within the past 63 days? (Please submit certificate of creditable coverage from the prior insurance coverage.)

Insured's Name	Company	Plan/Benefit	Termination Date

2f. Will the coverage you applied for replace any existing Individual Health Insurance Coverage?
 Group Health Insurance Coverage?

If coverage applied for replaces any individual or group health insurance, please provide the following:

The last date of coverage under that policy: _____

Name of carrier: _____ Policy #: _____

3. Statement of Health:

Please provide answers to the following as they pertain to all individuals proposed for insurance. Indicate if any of the individuals have or have had any of the following conditions in the past. Please circle conditions that apply and if you answer "yes" to any question, complete the information in the grid below.

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1) Epilepsy, stroke, paralysis | <input type="checkbox"/> | <input type="checkbox"/> | 16) Arthritis, lupus, gout, fibromyalgia, fractures, limb loss | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Head or spinal injuries, muscular dystrophy, cerebral palsy, multiple sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | 17) Cancer, tumors, cysts | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Migraines | <input type="checkbox"/> | <input type="checkbox"/> | 18) Genital herpes, syphilis, or other sexually transmitted diseases | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Blood disorders, sickle cell | <input type="checkbox"/> | <input type="checkbox"/> | 19) Currently pregnant Due date _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Bladder, kidney, prostate, renal failure, uterine, testicular, breast problems | <input type="checkbox"/> | <input type="checkbox"/> | 20) Liver disorder (including Hepatitis), Hepatitis A, B, C, D (circle one) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Vascular disease | <input type="checkbox"/> | <input type="checkbox"/> | 21) Any hospitalizations in the last 5 years | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Colitis, diverticulosis, ulcers, gall bladder, hernias | <input type="checkbox"/> | <input type="checkbox"/> | 22) Any planned surgeries | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Asthma, allergies, hay fever | <input type="checkbox"/> | <input type="checkbox"/> | 23) Any drug/alcohol problems. If yes, indicate when _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Emphysema, tuberculosis, lung disorder | <input type="checkbox"/> | <input type="checkbox"/> | 24) Rehabilitation | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Diabetes (Hb A1C) _____ | <input type="checkbox"/> | <input type="checkbox"/> | 25) Valid driver's license | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Thyroid, hormones, glandular disorders | <input type="checkbox"/> | <input type="checkbox"/> | 26) Alcohol use – how much per week _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 12) Cigarette use – how many per day _____ | <input type="checkbox"/> | <input type="checkbox"/> | 27) Eyes, ears, nose, or throat (not glasses) | <input type="checkbox"/> | <input type="checkbox"/> |
| 13) AIDS, HIV, autoimmune disease | <input type="checkbox"/> | <input type="checkbox"/> | 28) Had or are planning an organ transplant | <input type="checkbox"/> | <input type="checkbox"/> |
| 14) High blood pressure, heart disease, heart murmur, circulatory disorder, chest pain, mitral valve prolapse
Last blood pressure reading _____ | <input type="checkbox"/> | <input type="checkbox"/> | 29) Any illness or disease not listed above
_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 15) Are you on any medication not already mentioned? | <input type="checkbox"/> | <input type="checkbox"/> | 30) Mental or nervous problems, psychotherapy, psychiatric care | <input type="checkbox"/> | <input type="checkbox"/> |

If you checked "yes" to any of the above questions, fill out the following. Attach extra pages if necessary.				
Question Number	Person to whom it applies	Date	Names and addresses of Physicians and hospitals (if any)	Include all information as to nature of illness or injury, symptoms, number of attacks, duration, treatment and results

PLEASE INITIAL ANY CHANGES YOU MAKE ON THIS FORM

I request the group insurance shown on page 1. To the best of my knowledge and belief: (a) I am eligible for such insurance and (b) the statements I have made are true and complete. I understand that Nippon Life Insurance Company of America has the right to acquire additional information and, if necessary, an examination by a physician. I ask Nippon Life Insurance Company of America to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above and that any misstatements or failure to report information material to the risk may be used as the basis of rescission of my insurance subject to the incontestable period provision of the policy.

I understand that insurance will become effective on the first day of the month on or after the date received by Nippon Life Insurance Company of America, if the initial contribution is paid within 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age on the date insurance is to be effective. I also understand that (a) any person who was not performing his or her normal activities on the day insurance would otherwise become effective, will not become insured until the date he or she is performing such activities provided such date is within three months of the date insurance would have become effective and the person is still eligible for insurance, and (b) any dividend apportioned to the group policy will be paid to the Louisiana Dental Association.

I also understand that with respect to medical coverage, benefits will not be payable for up to twelve months for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date. The period of any Pre-existing Condition Exclusions will be reduced by the period of Creditable Coverage as of the enrollment date except that: a period of Creditable Coverage will not be counted if, after such period and before the enrollment date, there was a 63 day period exclusive of any waiting period during all of which the individual was not covered under such Creditable Coverage.

IMPORTANT NOTICE AND AUTHORIZATION

By my signature, I authorize disclosure of the types of information detailed in the AUTHORIZATION, for Nippon Life Insurance Company of America's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how Nippon Life Insurance Company of America underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed.

By my signature, I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or the MIB to release information to Nippon Life Insurance Company of America, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to Nippon Life Insurance Company of America, its subsidiaries or the plan administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance).

Nippon Life Insurance Company of America may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies and otherwise use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION, Nippon Life Insurance Company of America may release information covered by this AUTHORIZATION to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immunity Deficiency Syndrome (AIDS).

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this authorization at any time by notifying the Administrator, Nippon Life Insurance Company of America, in writing at the address given on this form. My revocation will not be effective to the extent Nippon Life Insurance Company of America or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that Nippon Life Insurance Company of America has a legal right to contest a claim under an insurance certificate or the certificate itself. The information Nippon Life Insurance Company of America obtains through this AUTHORIZATION may become subject to further disclosure. For example, Nippon Life Insurance Company of America may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing this AUTHORIZATION. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent will receive a copy of this signed AUTHORIZATION.

Applicant's Signature X _____ Date _____
(Please sign and date in ink)

To the best of my knowledge and belief the statements made regarding my health are true and complete

Spouse's Signature X _____ Date _____

Necessary only if spouse coverage is requested

Dependent's Signature X _____ Date _____

Necessary only if coverage is requested for dependent children 18 years of age and older X _____ Date _____

To Request Major Medical Insurance complete this form in ink and mail to LDA Administrator

14001 Dallas Parkway North, Suite 700
Dallas, Tx 75240
Phone: 1-800-969-5238

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.