The Bridge Plan Application Form

Producer Number:_____

To be eligible for the Bridge Plan coverage, you must attest to the following statements:

❑ I attest that I am not eligible for Medicare or Affordable Care Act (ACA) compliant insurance.

❑ I attest that I have tried, but was unable to obtain short-term medical insurance.

Reason why: _____

Applicant's Name: First _____ M.I. _____ Last_____

Date of Birth: _____ / _____ / _____ Height: _____ Weight: _____ Sex: ❑Male ❑Female

Residence Address: _____

City _____ State_____ Zip Code_____

Email Address: _____ Telephone (_____) _____ - _____

Requested Start Date: _____ Date eligible for Medicare or ACA Coverage: _____

Plan Type: ❑ **Platinum** *($1,000,000 Max. & $1,000 Deductible)* ❑ **Gold** *($500,000 Max. & $2,500 Deductible)*

❑ **Silver** *($250,000 Max. & $5,000 Deductible)* ❑ **Bronze** *($100,000 Max. & $10,000 Deductible)*

Coverage Type: ❑ Bridge Part A & B ❑ Bridge Part A Only ❑ Bridge Part B Only

Primary Care Physician:

a. Name: _____

b. Address: _____

c. Date and reason last seen: _____

d. Results of last visit: _____

If "Yes" is answered, please provide full details in the area provided or attach a separate page if needed

1. Do you intend to engage in sports or any other pastimes that expose you to extra personal injury? ❑ Yes ❑ No
2. Have you ever been declined or accepted on special terms for life, accident or illness insurance? ❑ Yes ❑ No
3. Have you ever had any abnormal tests or blood work that have required additional evaluation or treatment? ❑ Yes ❑ No
4. Has your weight changed in the past year? ❑ Yes ❑ No
5. Have you ever undergone a surgical operation? ❑ Yes ❑ No
6. Have you taken any medicines in the past 12 months? ❑ Yes ❑ No
7. Have you ever been recommended to have any procedure(s), exam(s), treatment(s), and/or test(s) that have not been completed? ❑ Yes ❑ No
8. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)? ❑ Yes ❑ No
9. Date and results of last colonoscopy: _____
10. Date and results of last pap (female): _____
11. Date and results of last mammogram (female): _____
12. Date and results of last PSA (male): _____

Question # _____ Dates & Details: _____

Question # _____ _____

Question # _____ _____

Question # _____ _____

PLEASE INITIAL THE FOLLOWING

I have read or had read to me and understand each of the questions and statements on this entire application and no one has prevented me from spending as much time as I felt was necessary to understand this application. _____

Last Healthcare Provider Seen:

a. Name: _____

b. Address: _____

c. Date and reason last seen: _____

d. Results of last visit: _____

If "Yes" is answered, please provide full details in the area provided or attach a separate page if needed

13. Have you ever been evaluated or treated for any injury, condition or disorder involving the following:

a.	Eyes/Ears	❑ Yes ❑ No	o.	Back/spine/neck	❑ Yes ❑ No
b.	Gout	❑ Yes ❑ No	p.	Throat/Thyroid/Glands	❑ Yes ❑ No
c.	Skin	❑ Yes ❑ No	q.	Bones/Bone Density	❑ Yes ❑ No
d.	Hernia	❑ Yes ❑ No	r.	Arthritis/Joints (Hips Knees, Shoulders)	❑ Yes ❑ No
e.	Diabetes	❑ Yes ❑ No	s.	Fainting/Dizziness/Unconsciousness	❑ Yes ❑ No
f.	HIV/AIDS	❑ Yes ❑ No	t.	Fatigue/Tiredness/Paralysis/Weakness	❑ Yes ❑ No
g.	Sleep apnea	❑ Yes ❑ No	u.	Nervous System/Alzheimer's/Dementia	❑ Yes ❑ No
h.	Gallbladder	❑ Yes ❑ No	v.	Mental/Emotional/Psychiatric	❑ Yes ❑ No
i.	Concussions	❑ Yes ❑ No	w.	Respiratory System/Asthma	❑ Yes ❑ No
j.	Chronic Pain	❑ Yes ❑ No	x.	Circulatory system	❑ Yes ❑ No
k.	Lymph nodes	❑ Yes ❑ No	y.	Reproductive system	❑ Yes ❑ No
l.	Cancer/Growth	❑ Yes ❑ No	z.	Gastrointestinal System	❑ Yes ❑ No
m.	High blood pressure	❑ Yes ❑ No	aa.	Urinary system/Prostate	❑ Yes ❑ No
n.	Heart/Chest Pain/Stroke	❑ Yes ❑ No	ab.	Any other condition not listed above	❑ Yes ❑ No

Question#	Details of Conditions/Treatment	Date & Duration	Details and Degree of Recovery

14. To the best of your knowledge and belief, are you in good health and free from any mental or physical impairment, except as described in this application? ❑ Yes ❑ No - If No, please provide details: _____

_____

_____

IT IS UNDERSTOOD AND AGREED: 1) That all answers to the questions on this application, to the best of my knowledge and belief, are complete and true, 2) That all answers on this application shall form the basis of the issuance of any coverage hereunder, 3) That in the event that You, the Loss Payee, the Owner or any person on Your behalf commits fraud, a misstatement or concealment either in the application or by any other statement, this Certificate may become void and no benefits will be payable, 4) That except as amended by the answers to the above questions, any answer shown on any prior application for this coverage signed and dated by me are expressly reaffirmed, 5) I have read or had read to me and understand each of the questions and statements on this entire application, 6) No one has prevented me from spending as much time as I felt was necessary to understand this application, 7) I understand the terms and conditions of this product, and 8) I also understand that since this is a temporary policy it is exempt from the Patient Protection and Affordable Care Act (PPACA) so pre-existing conditions are not covered by this policy.

Proposed Insured_____ Signature _____ Date_____

Please Print

Authorization to Release Personal Information

In Compliance with HIPAA & Financial Privacy Regulation

I, the proposed insured, authorize all Healthcare Providers that have been involved in my care, diagnosis or treatment including, but not limited to Physicians, Medical Practitioners, Hospitals, Clinics, Medically related facilities, Rehabilitation facilities, Laboratories, Pharmacy, Insurance or Reinsurance Company, or Consumer Reporting Agency, to disclose my medical records to Petersen International Underwriters, or its assigned authorized agent/representative including, but not limited to: Secure Image Solutions, for the purpose of insurance underwriting or claims administration.

For purposes of this authorization, medical records shall include all health information pertaining to any medical history or physical condition and treatment received including, but not be limited to patient histories, progress notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, HIV Tests/Test Results, and any other pertinent medical information.

I understand and agree that Petersen International Underwriters may disclose my medical records and the information contained in those records to third parties such as insurance companies or insurance underwriters, attorneys, or to representatives of such third parties (including reinsurers and information agencies) for the purpose as stated in the above. Additionally, it is understood that disclosure of medical conditions as they relate to my insurability may be disclosed to persons with a direct insurable interest. Medical or financial information, as it affects my insurability or any claim, may also be discussed with my insurance agent or broker. I also understand that when my medical records are disclosed pursuant to this Authorization, my medical records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

I understand that I may revoke this Authorization, except to the extent that any health care provider or Petersen International Underwriters, has acted in reliance upon this Authorization. My revocation of this Authorization must be in writing to Petersen International Underwriters.

A copy of this signed Authorization is valid as the original. I have the right to a copy of this Authorization. This Authorization will expire 2 years after the date that I have signed this Authorization.

Proposed Insured Name	Date of Birth
Legal Representative*	Relationship
Email	

**If the individual whose information is being disclosed is a minor, a parent or legal guardian must sign.*

Signature of Proposed Insured _____ Date _____

Signature of Legal Representative (if other than Proposed Insured) _____ Date _____

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