PreferredOne®
INSURANCE COMPANY

Individual Insurance Enrollment and Special Enrollment Application

When to Apply

- Applications will be accepted during an annual open enrollment period (November 1, 2018 - December 15, 2018).
- You may be eligible to enroll in a PreferredOne Insurance Company (PreferredOne) individual plan outside the open enrollment period if you experience a special enrollment event. You must elect coverage timely. The timeframe for electing coverage varies with the type of event, but is generally no later than 60 calendar days after the date on which the event occurs. Refer to section IV. Additional information is available at PreferredOne.com.

How to Apply

- Complete all sections of the application thoroughly and accurately, including signatures for all adults and dependents age 18 and older. Applications with missing or inaccurate information will be returned for completion, which may delay the effective date of your coverage.
- You can apply online at PreferredOne.com. Applying online may reduce processing time.

How to Submit Application

- Your application cannot be processed without the initial month's premium payment.
- Mail the completed application including additional documentation or written proof required to PreferredOne Insurance Company, Individual Product Department, PO BOX 59212, Minneapolis, Minnesota, 55459-0212, or fax it to (763) 847-4011.
- PreferredOne will deposit or debit your initial month's premium payment upon issuance of coverage.
- This application will become a part of your contract. Make a copy of the completed application for your own records.

Effective Date of Coverage

- Applying during Open Enrollment (November 1, 2018 – December 15, 2018): Coverage effective date as January 1, 2019. Your application must be received by the December 15, 2018 in order to begin coverage on January 1, 2019.
- Applying outside Open Enrollment (Special Enrollment): The coverage effective date depends on the type of special enrollment event. Refer to section IV.
- Do not cancel any existing coverage until we issue your policy and you accept it.

Additional Information

- To be eligible for coverage, you must be a Minnesota resident in the county of Anoka, Dakota, Hennepin, Ramsey, Sherburne, Scott or Washington.
- This policy does not include pediatric dental services. Pediatric dental coverage is an essential health benefit that can be purchased as a stand-alone plan through MNsure. Please contact your broker or MNsure (MNsure.org or 1-855-366-7873).
- You may qualify for financial assistance to pay your monthly premium or reduce your health care out-of-pocket costs. To see if you qualify, visit mnsure.org.
- The Supplemental Accident Only Contract is available to PreferredOne individual plan applicants at initial enrollment. This optional contract may reduce your medical expenses arising from an accident. See PreferredOne.com for more information.

Contact Us

- Please contact PreferredOne Individual Product Sales Department at (763) 847-3020 or 1 (855) 717-5267 if you have questions or need assistance completing your application.

PreferredOne
INSURANCE COMPANY

Individual Insurance Open Enrollment and Special Enrollment Application
P.O. Box 59212
Minneapolis, MN 55459-0212
763.847.3020 1.855.717.5267

AGENT INFORMATION

Agent Name

OFFICE USE ONLY
Application ID# ______________________

I. APPLICANT INFORMATION

❑ I am a new applicant. ❑ I am currently a PreferredOne member, adding a dependent. Current Member ID: ______________________

❑ I am currently a PreferredOne member and I want to enroll in a different plan. Current Member ID: ______________________

PRIMARY APPLICANT *(If you are applying on behalf of a minor, indicate their name here)*

First Name	Middle initial	Last name

PARENT/GUARDIAN *(Only if applying on behalf of a minor)*

First Name	Middle initial	Last name

APPLICANT'S HOME ADDRESS *(Enter street address/apartment number)*

Street

City	State	Zip Code	County

APPLICANT'S BILLING ADDRESS *(if different than home address)*

Street

City	State	Zip Code

MAILING PREFERENCE

Please send all mail (other than billing statements) such as my welcome kit, ID cards and claims information to:

❑ Home address ❑ Billing address ❑ Other mailing address: ______________________

MARITAL STATUS	PREFERRED TELEPHONE NUMBER	ALTERNATIVE TELEPHONE NUMBER
❑ Single ❑ Married		

EMAIL ADDRESS

PRIMARY APPLICANT

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1]
				❑ Yes ❑ No

PRIMARY APPLICANT'S SOCIAL SECURITY NUMBER[2]	MEDICARE STATUS	SEX
	❑ Covered ❑ Eligible ❑ None	❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Some Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Cushite ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Amharic ❑ Karen ❑ German ❑ Arabic ❑ Mon-Khmer Cambodian ❑ French ❑ Korean ❑ Tagalog ❑ Other: ______________________

II. COMPLETE THIS SECTION FOR EACH PERSON, OTHER THAN THE PRIMARY SUBSCRIBER

DEPENDENT ONE

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1] ❑ Yes ❑ No

RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER[2]	MEDICARE STATUS ❑ Covered ❑ Eligible ❑ None	SEX ❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Some Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Cushite ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Amharic ❑ Karen ❑ German ❑ Arabic ❑ Mon-Khmer Cambodian ❑ French ❑ Korean ❑ Tagalog ❑ Other: ______________________

DEPENDENT TWO

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1] ❑ Yes ❑ No

RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER[2]	MEDICARE STATUS ❑ Covered ❑ Eligible ❑ None	SEX ❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Some Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Cushite ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Amharic ❑ Karen ❑ German ❑ Arabic ❑ Mon-Khmer Cambodian ❑ French ❑ Korean ❑ Tagalog ❑ Other: ______________________

DEPENDENT THREE

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1] ❑ Yes ❑ No

RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER[2]	MEDICARE STATUS ❑ Covered ❑ Eligible ❑ None	SEX ❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Some Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Cushite ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Amharic ❑ Karen ❑ German ❑ Arabic ❑ Mon-Khmer Cambodian ❑ French ❑ Korean ❑ Tagalog ❑ Other: ______________________

DEPENDENT FOUR

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1] ❑ Yes ❑ No

RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER[2]	MEDICARE STATUS ❑ Covered ❑ Eligible ❑ None	SEX ❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Some Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Cushite ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Amharic ❑ Karen ❑ German ❑ Arabic ❑ Mon-Khmer Cambodian ❑ French ❑ Korean ❑ Tagalog ❑ Other: ______________________

DEPENDENT FIVE				
First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1] ❏ Yes ❏ No

RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER[2]	MEDICARE STATUS	SEX
		❏ Covered ❏ Eligible ❏ None	❏ Male ❏ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❏ White ❏ Black or African American ❏ Asian ❏ American Indian or Alaska Native ❏ Native Hawaiian or Other Pacific Islander ❏ Some Other Race ❏ Two or More Races

HISPANIC/LATINO: ❏ Yes ❏ No

PREFERRED LANGUAGE: ❏ English ❏ Spanish ❏ Hmong ❏ Cushite ❏ Vietnamese ❏ Chinese ❏ Russian ❏ Laotian ❏ Amharic ❏ Karen ❏ German ❏ Arabic ❏ Mon-Khmer Cambodian ❏ French ❏ Korean ❏ Tagalog ❏ Other: ______________________________

If an individual's last name is different from the applicant's, explain the reason:

Do all of the dependent(s) listed reside at the same address as the primary applicant? ❏ Yes ❏ No

If No, list dependent(s) name and address: ____

OTHER TYPES OF COVERAGE[3]

For each listed in sections I and II who, at any time in the three month period before the date of this application, **had or continues to have health coverage of any type**, provide the following information.

FIRST AND LAST NAME	NAME OF INSURER	TYPE OF COVERAGE[3]	COVERAGE START DATE	COVERAGE END DATE (IF APPLICABLE)

TOBACCO USER[1]

Tobacco user is defined as using tobacco products (for example cigarettes, cigars, smokeless tobacco, e-cigarettes) four or more times a week on average (other than for religious or ceremonial purposes) within the last six months. This only applies to individuals age 18 and over.

SOCIAL SECURITY NUMBER[2]

Federal law requires that we ask for Social Security Numbers for mandatory reporting to the IRS each year. This field is requested but not required. Please note that the numbers are not used in determining eligibility for coverage.

TYPE OF HEALTH COVERAGE[3]

Choose from the following: Employer-sponsored group coverage (Group), COBRA or state continuation coverage (COBRA), individual medical coverage, Basic Health Plan (e.g. MinnesotaCare), Medicare, Medicaid, state CHIP or other health coverage (explain):

III. EFFECTIVE DATE

OPEN ENROLLMENT (NOVEMBER 1, 2018 - DECEMBER 15, 2018)

Your effective date of coverage is January 1, 2019. Your application and initial premium must be received by the 15th of December in order to begin coverage on January 1, 2019 as set forth herein. We cannot back date coverage.

SPECIAL ENROLLMENT

Your effective date of coverage depends on the type of special enrollment event. See section IV for details on available effective dates.

I AM REQUESTING MY COVERAGE START ON (month, day, year): ______ / ______ / ______

IV. SPECIAL ENROLLMENT AND LIMITED OPEN ENROLLMENT EVENT ELECTION INFORMATION

Below is a chart of special enrollment and limited open enrollment events that allow you to apply for coverage under a PreferredOne individual plan outside of the annual open enrollment period (November 1, 2018 - December 15, 2018). If you are applying under a special enrollment event, please check the appropriate box and provide a copy of the required written proof/documentation with your completed application and applicable premium.

PLEASE PROVIDE THE DATE OF EVENT (month, day, year): ______ / ______ / ______

Special Enrollment or Limited Open Enrollment Event	Election Period & Examples of Required Proof/Documentation	Coverage Effective Date
Involuntary Loss of Minimum Essential Coverage (MEC): ❑ 1. Loss of eligibility for employer-sponsored group coverage that is not COBRA/continuation (e.g., due to termination of employment). ❑ 2. Employer discontinued benefit plan. ❑ 3. Employer discontinued premium contributions for coverage that is not COBRA/continuation. ❑ 4. COBRA/continuation coverage is exhausted. ❑ 5. Divorce or legal separation from subscriber. ❑ 6. Death of subscriber. ❑ 7. Child loses dependent status (eg. Due to turning age 26). ❑ 8. Loss of eligibility for Medicaid, state CHIP or loss of pregnancy-related coverage under Medicaid or state CHIP or a loss of access to health care services through coverage provided to the pregnant woman's unborn child through Medicaid or state CHIP. ❑ 9. Loss of individual or employer sponsored group coverage due to a move outside your HMO service area. (For loss of group coverage, no other benefit package is available to you).	Coverage must be elected during the period that begins 60 days before or 60 days after the date coverage ends. 1. COBRA notice or letter from employer and Certificate of Creditable Coverage. 2. Letter from employer. 3. Letter from prior insurer or letter from COBRA administrator. 4. Court documents and Certificate of Creditable Coverage. 5. Letter from employer and death certificate. 6. Letter from prior insurer and Certificate of Creditable Coverage. 7. Written notice from government program. 8. Letter from employer and Certificate of Creditable Coverage. Examples of documentation PreferredOne may require for proof of recent residency change: • Current utility bill from both old and new address. • Change of address document from the U.S. Post Office. • Current and prior driver's license. **In addition to the above required proof, an individual must provide proof of enrollment in MEC, proof that you lived in a foreign country or U.S. territory for at least 1 day during the 60 day period prior to the loss of MEC or proof that you lived in a service area where no qualified health plan was available through MNsure for at least 1 day during the 60 day period prior to the loss of MEC during the most recent open enrollment or special enrollment period.**	If you timely elect coverage before the date of the loss of MEC, your coverage effective date will be the first day of the month following the loss of MEC. If you elect coverage after the date of the loss of MEC, your coverage effective date will be the first day of the month following receipt of your completed application and applicable premium.
You experience a loss of coverage as follows: ❑ Non-renewal or expiration of a non-calendar year individual plan coverage or non-calendar year employer-sponsored group coverage.	Coverage must be elected during the period that begins 60 days before and ends 60 days after the date coverage ends. Examples of documentation PreferredOne may require for this event: • Letter from employer and Certificate of Creditable Coverage. • Letter from employer and letter from prior insurer. • Renewal notice from employer or prior insurer.	If you timely elect coverage before the date of the loss of coverage, your coverage effective date will be the first day of the month following the loss of coverage. If you elect coverage after the date of the loss of coverage, your coverage effective date will be the first day of the month following receipt of your completed application and applicable premium.
You newly gain a spouse or eligible dependent through: ❑ Birth of a newborn. ❑ Adoption/placement for adoption. ❑ Marriage. ❑ Issuance of court ordered health coverage (e.g., medical child support order or other court order).	Coverage may be elected within 60 days after the date of the event. • Birth Certificate including child's full name, date of birth and county. • Court order for adoption or adoption placement documents. • Marriage certificate. • Issuance of court order or other child support order. **In addition to the above required proof, an individual must provide proof of enrollment in MEC, proof that you lived in a foreign country or U.S. territory for at least 1 day during the 60 day period prior to the loss of MEC or proof that you lived in a service area where no qualified health plan was available through MNsure for at least 1 day during the 60 day period prior to the loss of MEC during the most recent open enrollment or special enrollment period.**	**Birth/Adoption/Placement or Court Order:** Effective the date of the event or court order; or the 1st day of the month following plan selection and receipt of the completed application and applicable premium. **Marriage:** The first day of the month after receipt of the completed application and applicable premium.
Gaining access to a new qualified health plan: ❑ You made a permanent move to a Minnesota service area or to a new service area in Minnesota, which caused you to gain access to a new qualified health plan.	Coverage must be elected within 60 days before or 60 days after the date of the event. Examples of documentation PreferredOne may require for proof of recent residency change: • Current utility bill from both old and new address. • Change of address document from the U.S. Post Office. • Current and prior driver's license. **In addition to the above required proof, an individual must provide proof of enrollment in MEC, proof that you lived in a foreign country or U.S. territory for at least 1 day during the 60 day period prior to the loss of MEC or proof that you lived in a service area where no qualified health plan was available through MNsure for at least 1 day during the 60 day period prior to the loss of MEC during the most recent open enrollment or special enrollment period.**	If you timely elect coverage before the date of a permanent move your coverage effective date will be the first day of the month following receipt of your completed application and applicable premium, but not earlier than the date you gained access to a new qualified health plan as a result of your permanent move. If you timely elect coverage after the date of the permanent move, your coverage effective date will be the first of the month following receipt of your completed application and applicable premium.
❑ Other (Explain):	• Depends on the type of event.	Effective date depends on the type of event.

Note: If you fail to elect coverage timely, you must wait until the next annual open enrollment period to elect coverage, unless you experience another special enrollment event. Written proof of your qualifying event must be submitted with your completed application form and applicable premium.

V. COVERAGE SELECTION

1. You must be a resident in one of the following counties in Minnesota in order to apply for coverage; Anoka, Dakota, Hennepin, Ramsey, Scott, Sherburne or Washington.

By completing this enrollment form I attest that I am a resident of a Minnesota country listed above at the time of completing this form.

2. Select a Plan Option.

3. Current Member with a Special Enrollment Event (check one):

a. ❑ I want to keep my current plan option but am adding a dependent.

b. ❑ I want to enroll in a different plan option - select your option below.

Preferred*Health* Network

As part of the enrollment process, PreferredOne sends demographic information to the Preferred*Health* Network. A representative may contact you once you are enrolled in a plan to help coordinate your entry into the Preferred*Health* Network.

4. Make Your Election

	Plan Options (check one)	Network	In-network Coinsurance	In-network Deductible		In-network Out-of-Pocket	
				Individual	Family	Individual	Family
❑	**Bronze** Preferred*Health* Align (HSA qualified)	Preferred*Health*	100%	$6,750	$13,500	$6,750	$13,500
❑	**Silver** Preferred*Health* Focus (HSA qualified)	Preferred*Health*	80%	$3,500	$7,000	$6,750	$13,500
❑	**Gold** Preferred*Health* View (HSA qualified)	Preferred*Health*	90%	$1,700	$3,400	$6,750	$13,500

This policy does not include pediatric dental services. Pediatric dental coverage is an essential health benefit that can be purchased as a stand-alone plan through MNsure. Please contact your broker or MNsure (MNsure.org or 1-855-366-7873).

VI. INITIAL PAYMENT AND ONGOING PAYMENT ELECTIONS (You must complete both steps)

Step 1. Initial Month's Premium Payment *(you must select and complete one)*

I am a new applicant and elect to make my initial premium payment as follows:

❑ **I enclosed a check (personal or cashier's) with my application**

❑ **I authorize initial payment via automatic Electronic Payment Plan (EPP)***

Name on Bank Account ____________________

Bank ABA/Routing Number ____________________

Bank Account Number ____________________

Bank Name ____________________

Print Name of Applicant ____________________

Signature of Bank Account Holder ____________________ Date ____________________

Signature of Bank Account Holder (if joint account) ____________________

Step 2. Ongoing Payment *(you must select and complete one)*

❑ **Monthly bill to my home address** **or** ❑ **Monthly bill to the following address**

Name ____________________ Street ____________________

City ____________________ State __________ Zip __________

❑ **Monthly Electronic Payment Plan (EPP)***

Name on Bank Account ____________________

Bank ABA/Routing Number ____________________

Bank Account Number ____________________

Bank Name ____________________

Print Name of Applicant ____________________

Signature of Bank Account Holder ____________________ Date ____________________

Signature of Bank Account Holder (if joint account) ____________________

***Electronic Payment Plan (EPP)**

Electronic Payment Plan premium collection option, which utilizes the Automated Clearing House (ACH) system to effectively and accurately debit your designated account each payment cycle. The ACH funds transfer system is used nation-wide by member financial institutions. On or around the 8th of each month we will initiate a transfer from your account for the monthly premium payment due. This process will continue on a monthly basis during the contract period. In the event your account lacks sufficient funds, you may be charged a processing fee of up to $25 fee for each occurrence. If you have questions, please contact PreferredOne at 763.847.3020 or 1.855.717.5267.

VII. AUTHORIZATIONS for PreferredOne and Others to Receive, Disclose and Use ("Share") Your Health Information

I, the applicant for myself and any minor dependents, or, if applicable, I the spouse or dependent age 18 or older, authorize PreferredOne, my health plan, my insurer, and my providers to Share my Health Information by and with, but not limited to, the following: • PreferredOne, for plan administration, payment or operations • My broker – about the status of my application • Providers – with respect to coverage and payment; so that individually and collectively they can better manage my health status and my health conditions and diseases, through care coordination, quality improvement, and disease management functions, and/or various payment arrangements; and in their role as accountable care-type organizations or networks or under other designated financial or contractual arrangements • Payers -- Medicare, Medicaid or any other public health care programs, any other insurance company, health maintenance organization, payer network organization including an accountable care-type organization or network or other payer, and the contractors and subcontractors of such entities, for the payment and operations purposes of PreferredOne and each of them • PreferredOne's contractor and subcontractor service providers, including but not limited to PreferredOne's controlled group affiliates ("affiliates") – that assist PreferredOne with plan administration, payment and operations functions–including but not limited to coordinating benefits, coordinating out-of-pocket payments for medical and pharmacy claims, pharmacy benefit management, disease and care management, utilization review and management, and other customer service and health claim-related activities.

I further understand and agree as follows: • I will execute and submit all authorizations required by any third party (e.g., providers) for the release of my Health Information to PreferredOne for plan administration, payment and/or operations purposes. • My "Health Information" includes, but is not limited to, my "protected health information" or "PHI" as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and my "health records" as defined by Minnesota Statutes section 144.293; and includes my past, present and future health records, which include but are not limited to, medical and pharmacy claims and related case notes, and information derived from them. These specifically include, if PreferredOne has them, claims and case notes about HIV/AIDS, mental health and psychotherapy, substance use, and/or chemical dependency treatment. • I am not allowed to modify the authorizations in this application; and if I do so, the application will not be valid. • This authorization shall remain valid as long as I am enrolled in health care coverage provided or administered by PreferredOne and its affiliates, unless I revoke it as described below. A copy of this authorization is valid as the original. • This authorization is effective notwithstanding any other authorizations or revocations of authorizations that I enter into or have already entered into with PreferredOne, its affiliates and/or any providers. This authorization and any expiration or revocation thereof does not affect or change the routine sharing of my Health Information by or between PreferredOne, its affiliates and/or any providers, that is permitted or required under HIPAA or applicable state law. • Information released pursuant to this authorization may be re-disclosed as permitted by law, in which case I understand that it may no longer be protected under federal privacy rules. I may revoke this authorization prospectively at any time, but only by submitting a valid written revocation to PreferredOne's Customer Service Department; and can obtain revocation information from the Customer Service Department by calling (763) 847-4477 or toll free at 1-800-997-1750. Such revocation will be effective only after PreferredOne receives it, and it will not affect PreferredOne's or others' actions taken prior to receipt of the revocation.

VIII. ACKNOWLEDGEMENTS

To the best of my knowledge and belief the answers to the questions and the statements made on this completed application are true and complete, and I agree that any telephone conversations required to clarify information on this completed application are part of this application.

I further understand and agree as follows: • If this form is submitted because of a special enrollment event, then this form amends my original application and will be incorporated into and made a part of the application and contract. • Payment of a claim does not prevent PreferredOne from denying future claims or taking any lawful action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid. • If PreferredOne approves this application, it will issue an individual contract for me and, if applicable, the dependents listed in Section II. • PreferredOne does not issue individual coverage through an arrangement with an employer. • In the event of a conflict between this application and the contract, the contract governs and PreferredOne will administer coverage in accordance with the contract. • PreferredOne is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law; and such employer is solely responsible for any such finding. • I am not allowed to modify the acknowledgements in this application; and if I do so, the application will not be valid. PreferredOne reserves and has the right to, in its sole discretion, request and/or rely on other documentation, to determine if any person listed in this application satisfies the requirements of this application. • PreferredOne will act in reliance upon the information I have provided herein. • I understand that, if I select a plan under Section V, part 4, such contract does not provide the essential health benefits for pediatric dental services as defined by the Affordable Care Act and that PreferredOne has made me aware that pediatric dental coverage may be purchased as a stand-alone product through MNsure to meet the minimum essential benefit requirements for pediatric dental as required under the Affordable Care Act.

I must update the information that I have provided on this application and resubmit it if any changes to the information take place between submission of the application and the effective date of coverage; and, failing to notify PreferredOne of any change, providing false information or the omission of relevant information on this application which materially affects either the acceptance of risk or hazard assumed by PreferredOne may result in denial of claims, rescission of coverage, or an increase in premiums, and may be considered insurance fraud.

If PreferredOne issues coverage to me, I consent to receiving, through my secure member home page at www.preferredone.com, electronic delivery (in lieu of paper delivery) of the following information to the extent that PreferredOne makes them available electronically: coverage documents, explanations of benefits, adverse determination notices, and summaries of benefits and coverage. I understand that PreferredOne will notify me by email when such information is newly available, of the document's significance, and how to access the document at www.preferredone.com. I understand that I may request a paper copy of these documents and/or to opt out of electronic delivery by contacting PreferredOne's Customer Service Department at 1 (800) 379-7727 or (763) 847-4488, 1 (855) 717-5267 or (763) 847-3020 or accessing www.preferredone.com.

IX. SIGNATURE(S)

By signing below, I certify under penalty of perjury that: (i) I have completely read and fully understand the terms and conditions of this application; (ii) all the representations in this application are made by me, or by the applicant on my behalf, and are true and complete; and (iii) I agree to the statements, authorizations, acknowledgements and terms of this application. I understand that any misrepresentation may result in the forfeiture of insurance coverage and that I will be personally responsible for all claims affected by such misrepresentation. I understand that I may be subject to penalties under law if I provide false or untrue information.

Applicant signature	Date	Print full name
Spouse (if applying for coverage)	Date	Print full name
Dependent signature (age 18 and older applying for coverage)	Date	Print full name
Dependent/guardian signature (if minor(s), with legal guardian)	Date	Print full name
Agent signature (if applicable)	Date	Print full name

PreferredOne®
INSURANCE COMPANY

PreferredOne Insurance Company
6105 Golden Hills Drive
Golden Valley, MN 55416
763.847.4477   1.855.997.1750

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway Suite 101
White Bear Lake, MN 55110
Phone Number: 651.407.3149 Fax Number: 651.407.3150

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan.

If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

PreferredOne Insurance Company Nondiscrimination Notice

PreferredOne Insurance Company ("PIC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PIC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Insurance Company
PO Box 59212
Minneapolis, MN 55459-0212
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013)·

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.800.940.5049 (TTY: 763.847.4013)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.940.5049 (телетайп: 763.847.4013).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (መስማት ለተሳናቸው: 763.847.4013).

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၢ နီတမံၤဘဉ်သ့န့ဉ်လီၤ. ကိး 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1.800.940.5049 (TTY: 763.847.4013).។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013). 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).