Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 877-447-4999 fax: 818-500-1855

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction) or quarterly (every three months)

Step 3

SEND THE COMPLETED APPLICATION TO:

First Eagle Insurance Services

333 S. Central Ave., Ste. 101

Glendale, CA 91204

Please make your check payable to: Celtic Insurance Company

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 877-447-4999

Thank you for choosing...

CELTIC

FOR OFFICE USE ONLY

CALIFORNIA

CELTIC

Celtic Health Plans

UNDERWRITTEN BY CELTIC INSURANCE COMPANY, CHICAGO, IL

Please print in ink

Requested Effective Date: Requesting an effective date DOES NOT GUARANTEE underwriting to be completed before the date requested. _____ _____ _____
NOTE: the 29, 30 and 31 of the month are not eligible as effective dates. Application is valid within 60 days from the signature date. MO. DAY YR.

Please check if this application is for: ☐ New Applicant ☐ Add Dependent ☐ Plan Change ☐ Reapply

Initial Payment Method:
One month/quarter premium: (Complete Section 4)
☐ Credit card (including Check/Debit cards)
☐ Check
☐ Bill me later - online application only

Subsequent Payment Schedule:
☐ Monthly Automatic Pay - One month premium required (Complete Section 4)
☐ Monthly Billing* - One month premium required (Not available for Celtic Basic)
☐ Quarterly Billing* - Three months premium required
*Billing fee applies

Total Payment Submitted: (Application fee waived for online application, www.celtic-net.com)
$ _____ /Monthly + $25.00 One-time, non refundable Application Fee = $ _____ Total Payment submitted
$ _____ /Quarterly + $25.00 One-time, non refundable Application Fee = $ _____ Total Payment submitted

Have you previously applied for insurance with Celtic Insurance Company? ☐ Yes ☐ No

SECTION 1: GENERAL INFORMATION

If child-only coverage is being requested, the child is the primary applicant and a separate application must be completed for each child.

Primary Applicant's Name: **Sex:** ☐ Male ☐ Female
FIRST MIDDLE LAST

Birth Date:	**Age:**	**Social Security Number:**	**Height:** ft. in.	**Weight:** lbs.

Email Address: **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone Number:	**Best Time To Call:** a.m. p.m.	**Phone Number during regular business hours:**	**Best Time To Call:** a.m. p.m.

Primary Applicant's Current Residential Address:
STREET CITY STATE ZIP

Is the Primary Applicant to be insured a U.S. citizen or a permanent legal resident of the U.S.? ☐ Yes ☐ No
(If "No," coverage cannot be granted.)

GUARDIAN INFORMATION: (For Applicants under 18 years of age)

Guardian's Name: (with whom the child resides)
FIRST MIDDLE LAST

☐ Parent ☐ Legal Guardian ☐ Grandparent ☐ Other _____

BILLING INFORMATION: If different from Primary Applicant's Residential Address (Please send bills to)

Name and Billing Address:
NAME STREET CITY STATE ZIP

Relationship to Applicant: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other _____

Does the payor want to include other family members on one billing statement? ☐ Yes ☐ No
If "Yes," the Family Billing Statement Form needs to be completed, dated, signed and submitted with the application.

SECTION 1: GENERAL INFORMATION (continued)

PRODUCT OPTIONS: (Choose one of the three plans):

☐ **Celtic Basic:**	
Coinsurance:	**80/20 of the next $10,000**
Deductible Options:	☐ $1,500 ☐ $2,500 ☐ $5,000
Benefit Options:	☐ Prescription Drug Card
☐ **CeltiCare Preferred Options:** (Select one)	☐ Select PPO ☐ "AnyDoc" PPO ☐ Managed Indemnity
Coinsurance/Deductible Options: (Select one)	**80/20 of the next $10,000** ☐ $500 ☐ $1,500 ☐ $5,000 ☐ $1,000 ☐ $2,500 **100%** ☐ $2,500 ☐ $5,000
Benefit Options:	☐ Prescription Drug ☐ Supplemental Accident ☐ Term Life Insurance Term Life Beneficiary Name: Relationship to You:
☐ **CelticSaver HSA Options:** (Select one)	☐ PPO ☐ Managed Indemnity
Coinsurance/Deductible Options: (Select one)	**Individual (Applicant Only)** ☐ 80/20 of the next $18,000- $1,500 deductible ☐ 80/20 of the next $12,000- $2,600 deductible ☐ 100%- $1,500 deductible ☐ 100%- $2,600 deductible ☐ 100%- $5,000 deductible

OTHER HEALTH COVERAGE

Do you have any major medical health insurance coverage currently in force? ☐ Yes* ☐ No

***If "Yes," will the insurance coverage applied for be used to replace this existing coverage?** ☐ Yes ☐ No

(If "Yes," a replacement form may be required in your state. Consult your agent. If "No," coverage cannot be issued.)

Were you covered under any other Health Insurance plan in the last 18 months? ☐ Yes* ☐ No

***If "Yes," what type of coverage was your or your dependents last plan?**

☐ Employer Based Group ☐ Individual ☐ COBRA ☐ Other

If you currently have a major medical plan in force or had coverage in the last 18 months complete the following:

Carrier Name:

IMPORTANT: DO NOT cancel any existing health coverage until written notification of your acceptance by Celtic.

SECTION 2: HEALTH AND OCCUPATION QUESTIONS

HEALTH QUESTIONS

For this insurance to be issued, the answers to the following health questions must be true, complete, and accurately recorded. All health information must be provided in Section 3 of this application, and Celtic Insurance Company must approve this application. No one may change this requirement in any way. If any information on any form is misstated or omitted, coverage may later be rescinded. Rescission voids coverage from the effective date, and any premiums already paid will be refunded, minus any claims already paid. No payments will be made for any claims submitted, whether or not the treatment was related to the condition that was omitted or misstated. **PLEASE DO NOT MARK OVER OR STRIKE OUT ANY SIGNATURE, DATE OR HEALTH QUESTION INFORMATION.** (Any changes, corrections or alterations must be initialed and dated by the primary applicant.) Medical conditions that occur after the signature date and before the effective date of the coverage, if approved, will be considered in the final underwriting decision. You need to communicate any medical condition occurring during such period to the Underwriting Department at (877) 865-5478.

☐ YES ☐ NO ☐ NOT SURE **1. PREGNANCY**

Are you, your spouse or any dependent, whether to be covered or not, now pregnant or an expectant parent or have an adoption pending? (If "YES," this coverage cannot be provided.)

If "Yes," check all who apply: ☐ Applicant ☐ Spouse ☐ Dependent(s)

2. GENERAL HEALTH

☐ YES ☐ NO ☐ NOT SURE **a.** Within the last 10 years, have you been counseled or advised that you have or may have had any disease, disorder, impairment, deformity, familial or congenital abnormality, injury or any chronic or untreatable condition whether active or in remission?

☐ YES ☐ NO ☐ NOT SURE **b.** Do you have a prosthetic device or implant (including breast implants)?

☐ YES ☐ NO ☐ NOT SURE **c.** Have you been prescribed any medications in the last 12 months?

List all medications taken by you within the last 12 months.

If more space is needed attach a separate sheet which must be signed and dated by the Primary applicant.

Name of Medication	Date Started	Date Ended	Dosage and Frequency	Reason/Condition

3A. SPECIFIC HEALTH CONDITIONS

Within the last 10 years, have you ever been treated for or diagnosed with:
(Y=Yes, N=No and NS=Not Sure)

	Y	N	NS			Y	N	NS	
a.	☐	☐	☐	Stroke	**n.**	☐	☐	☐	Seizures or Epilepsy
b.	☐	☐	☐	High Blood Pressure	**o.**	☐	☐	☐	Arthritis
c.	☐	☐	☐	Mitral Valve Prolapse	**p.**	☐	☐	☐	Fibromyalgia
d.	☐	☐	☐	Diabetes	**q.**	☐	☐	☐	Gout
e.	☐	☐	☐	Cancer	**r.**	☐	☐	☐	Chronic Fatigue Syndrome
f.	☐	☐	☐	Tumor	**s.**	☐	☐	☐	Asthma
g.	☐	☐	☐	Cyst	**t.**	☐	☐	☐	Alcohol, substance or drug abuse or dependence
h.	☐	☐	☐	Infertility					
i.	☐	☐	☐	Complications of pregnancy	**u.**	☐	☐	☐	MS/ALS/Parkinson's/Alzheimer's
j.	☐	☐	☐	Sexual dysfunction	**v.**	☐	☐	☐	Attention Deficit Disorder
k.	☐	☐	☐	Sexually transmitted disease(s)					
l.	☐	☐	☐	Elevated Cholesterol					
m.	☐	☐	☐	Migraines					

3B. SPECIFIC HEALTH CONDITIONS

Within the last 5 years, have you ever been treated for or diagnosed with: (Y=Yes, N=No and NS=Not Sure)

	Y	N	NS		Y	N	NS	
a.	☐	☐	☐	Heart Condition, including chest pain	☐	☐	☐	**m.** Joint disorder
b.	☐	☐	☐	Heart Murmur	☐	☐	☐	**n.** Musculoskeletal system disorder
c.	☐	☐	☐	Circulatory Disorder	☐	☐	☐	**o.** Digestive system disorder
d.	☐	☐	☐	Blood disorder	☐	☐	☐	**p.** Respiratory disorder, other than for cold or flu
e.	☐	☐	☐	Liver	☐	☐	☐	**q.** Eye Disorder, other than for cold or flu
f.	☐	☐	☐	Kidney	☐	☐	☐	**r.** Ear Disorder, other than for cold or flu
g.	☐	☐	☐	Genital Disorder	☐	☐	☐	**s.** Skin Disorder, other than for cold or flu
h.	☐	☐	☐	Urinary Tract Disorder	☐	☐	☐	**t.** Emotional, psychological, psychiatric or nervous condition or disorder
i.	☐	☐	☐	Any disease or disorder of the reproductive system	☐	☐	☐	**u.** Thyroid disorder
j.	☐	☐	☐	Neurological disorders or condition	☐	☐	☐	**v.** Allergies
k.	☐	☐	☐	Nervous system disorder				
l.	☐	☐	☐	Back, Neck or Spine disorder				

4. RECENT MEDICAL TREATMENT

Within the past 24 months, have you undergone or been advised or recommended for: (Y=Yes, N=No and NS=Not Sure)

	Y	N	NS		Y	N	NS	
a.	☐	☐	☐	Lab work or tests	☐	☐	☐	**e.** Psychological or marital counseling
b.	☐	☐	☐	Hospitalization	☐	☐	☐	**f.** Physical, occupational, or disability therapy
c.	☐	☐	☐	Surgery or surgical consultation	☐	☐	☐	**g.** Second opinion from another physician
d.	☐	☐	☐	Treatment for any condition(s)				

☐ YES ☐ NO ☐ NOT SURE **h.** Are you scheduled for or awaiting the results of any tests, biopsies, procedures or lab work?

☐ YES ☐ NO ☐ NOT SURE **i.** Have you consulted with or received treatment from any doctor or other healthcare provider for any other condition or symptom(s) not listed on this application?

☐ YES ☐ NO ☐ NOT SURE **j.** Have you seen any healthcare provider for any other condition, signs or symptom(s) which have not yet been diagnosed?

☐ YES ☐ NO ☐ NOT SURE **5. IMMUNE SYSTEM DISORDER**

WARNING: California law prohibits an HIV Test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Have you ever been treated for or diagnosed as having Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS or any immune system disorders other than HIV infection?

☐ YES ☐ NO ☐ NOT SURE **6. OCCUPATION/AVOCATION QUESTION**

Do you participate in or work in any of the following occupations/avocations?

Bartending
Crop dusting
Hazardous materials
Inter-state trucking
Mining
Modeling
Motorized vehicle racing
Musician
Off-shore drilling
Police
Professional fire fighting
Professional sports or athletics
Roofing

If "Yes," please provide the name(s) of each occupation/avocation.

Occupation/Avocation: _____

Occupation/Avocation: _____

Occupation/Avocation: _____

☐ YES ☐ NO ☐ NOT SURE **7. TOBACCO QUESTION**

Have you used any type of tobacco product in the last 12 months?

SECTION 3: ADDITIONAL HEALTH QUESTION INFORMATION

To be completed if the applicant answered "Yes" to any questions in Section 2. If more space is needed attach a separate sheet, each separate sheet must be signed and dated by the primary applicant.

Please give month and year when providing dates. Also, please give specifics when listing conditions, (Ex. Broken left leg.)

Ques. No.:

Diagnosis/Condition:

Onset Date: Date Last Treated:

Length of Treatment:

Medication(s), including over the counter (please list med/dosage):

Details of Treatment:

Is Treatment Pending or Scheduled? If so, please provide details:

Name of Test(s)/Surgery:

Date of Test(s)/Surgery:

Results of Test(s)/Surgery:

Is the condition still present? If not, date of recovery:

Doctor's name, Address and Phone Number:

Ques. No.:

Diagnosis/Condition:

Onset Date: Date Last Treated:

Length of Treatment:

Medication(s), including over the counter (please list med/dosage):

Details of Treatment:

Is Treatment Pending or Scheduled? If so, please provide details:

Name of Test(s)/Surgery:

Date of Test(s)/Surgery:

Results of Test(s)/Surgery:

Is the condition still present? If not, date of recovery:

Doctor's name, Address and Phone Number:

Ques. No.:

Diagnosis/Condition:

Onset Date: Date Last Treated:

Length of Treatment:

Medication(s), including over the counter (please list med/dosage):

Details of Treatment:

Is Treatment Pending or Scheduled? If so, please provide details:

Name of Test(s)/Surgery:

Date of Test(s)/Surgery:

Results of Test(s)/Surgery:

Is the condition still present? If not, date of recovery:

Doctor's name, Address and Phone Number:

SECTION 4: PREMIUM PAYMENT METHOD AND AUTHORIZATION AGREEMENT

INITIAL PAYMENT: CREDIT CARD OR CHECK, **PRODUCER PAYMENTS ARE NOT ACCEPTED**

THE PLAN APPLIED FOR IS NOT AN EMPLOYER SPONSORED GROUP HEALTH PLAN.

1. For Initial Payment Only: I authorize Celtic Insurance Company to bill my account for the initial payment and I agree to pay the initial payment billed in accordance to my payment selection on this application by checking the following credit card box:

☐ VISA® (including Check/Debit cards*) ☐ Mastercard® (including Check/Debit cards*) ☐ Discover®

* Debit cards must have a Visa or Mastercard logo on the front of the Debit Card.

Card No.: Expiration Date (MO/YR):

Cardholder's Name: _____

2. Or, attach your check below for total payment submitted.

MONTHLY AUTOMATIC PAY PLAN

Note: If your withdrawal is not honored by your bank, you will be removed from the Monthly Automatic Pay Plan and sent a paper bill.

Payor Name or Depositor if different: (Please print)

FIRST MIDDLE LAST

Relationship to Applicant: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other _____

Signature of Primary Payor: **Date:**

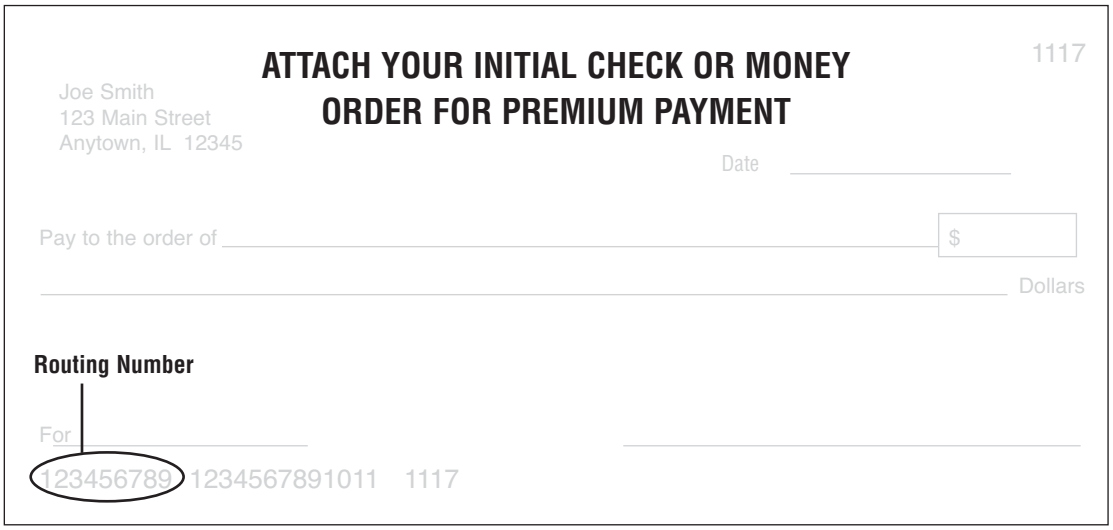
Name of Financial Institution:

Specify type of account: ☐ Checking or ☐ Savings | **Checking/Savings Account Number:**

ABA 9 Digit Routing Number: (See below or please call your Financial Institution for assistance)

Celtic Insurance Company is hereby authorized to present checks drawn on my checking or savings account on the first business day of each month, until this authorization is terminated. I understand that premiums already paid will be refunded to me if my Health Plan is not issued.

I further authorize the bank named to pay and charge to my account those payments that are drawn on my account by Celtic Insurance Company, and I agree that the bank named shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorizations above remain in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Celtic Insurance Company in writing.



DO NOT STAPLE CHECKS TO FORM.

SECTION 5: AGREEMENT AND SIGNATURE

1. **TRUE AND COMPLETE:** To the best of my knowledge and belief my answers to the questions on this application and any additional information I have provided are true and complete and accurately recorded. I understand that under no circumstances is a producer or company representative allowed to permit me to answer any question inaccurately or untruthfully and I represent that such did not occur. The producer is not authorized to alter any terms of the Health Plan. I understand that I may not pay cash or make checks payable to the agent or broker, or leave the payee blank.
2. **PRE-EXISTING CONDITIONS:** I understand that eligible expenses for pre-existing conditions may be limited.
3. **EFFECTIVE DATE:** Except as provided in the Conditional Receipt, I understand that this insurance, if approved, will become effective the day after the confirmed receipt date the application and all required medical and other information is received by Celtic. Application is valid within 60 days from the signature date.
4. **HEALTH INFORMATION.** I understand any medical conditions that occur after the signature date and before the effective date of the coverage, if approved, will be considered in the final underwriting decision. I am responsible for communicating any medical condition occurring during such period to the Underwriting Department at (877) 865-5478.
5. **HEALTH CARE CERTIFICATION:** I understand that a Health Care Certification Program is a part of the Health Plan. This program requires me to have all hospital confinements, outpatient surgeries, and major diagnostic tests Certified. I understand that failure to do so will result in a reduction of my health plan benefits or no benefits paid at all. The Health Care Certification Program number is 1-800-477-7870.
6. **OTHER COVERAGE:** I understand that in order to be eligible for this coverage I cannot be covered under any other major medical plan. I hereby attest that no one applying for coverage under the Health Plan will be covered under any other coverage.
7. **PREFERRED PROVIDER ORGANIZATION:** I understand if I have selected one of the PPO plan options as part of my Health Plan, then I agree to participate and comply with all requirements of the PPO plan. I understand that I will maximize my benefits when treatment is received from a participating hospital (and physician, if the Select PPO plan is chosen) and that it is my responsibility to ensure that a PPO hospital (and physician, if the Select PPO plan is chosen) is near me.
8. **APPLICATION:** I understand that I am applying for membership in the Celtic 18 Plus Health Plan Trust and am responsible for ensuring that all premium payments are met. I understand that Celtic will individually underwrite my application and that if my application is accepted by Celtic, a Health Plan will be issued to me. I understand that the plan applied for is not an employer-sponsored group health plan, that it will in no way be related to any employer/employee relationship, and it is not offered pursuant to and does not comply with state or federal small employer laws. If premium will be paid from a business/employer account, I hereby certify that I will not receive favorable tax treatment under sections 162, 125 or 106 of the United States Revenue Code, unless such favorable tax treatment would not make the plan subject to any state or federal small employer laws.
9. **AUTHORIZATION TO RELEASE INFORMATION:** I authorize any physician, medical or health care practitioner, hospital, clinic, other medically related facility, insurance company, third party administrator, employer or consumer reporting agency having information regarding me, including information concerning advice, diagnosis, treatment or care of physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness or injury, and copies of all hospital records, medical records, pharmaceutical records or non-medical information, to give to Celtic Insurance Company, its reinsurers, or its legal representatives, and its affiliates, any and all such information. However, such information does not include psychotherapy notes (as defined by 45 C.F.R. §164.501). This information will be used by Celtic to determine eligibility for insurance and make benefit determinations. I understand that there is a possibility of redisclosure of any information pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. I understand failure to sign this authorization may result in the denial of my application for coverage or eligibility for benefits.

   I understand that I can revoke this authorization, as described in Celtic's HIPAA Notice of Privacy Practices for Protected Health Information (PHI), at any time by giving written notice to Celtic and my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. I know that I may request to receive a copy of this authorization. This authorization shall remain valid for two years from the date shown below. A photocopy of this authorization shall be considered as valid as the original.
10. **HSA INFORMATION:** I understand that the health insurance plan is separate from the Health Savings Account (HSA) and the HSA is administered by someone other than Celtic. I understand the HSA has a separate maintenance fee.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false, incomplete or deceptive statement may be guilty of insurance fraud.

I understand the policy form for which I am applying contains an arbitration provision and that any disputes arising under this policy may be resolved through the arbitration process as indicated in the applicable policy provision.

Signature of PRIMARY APPLICANT: (Parent or Guardian if under 18 years of age) _____

Date: _____

SECTION 6: PRODUCER INFORMATION

You must be currently licensed and appointed with Celtic in the state where the application was completed.

NOTE: If you have written business with Celtic *in this state* during this calendar year, just complete your name, Social Security number and sign below. There is no need to submit a copy of your license with every case.

Writing Producer's Name:	**Producer Number:**

Address:

Glendale, CA 91204

CITY STATE ZIP

Telephone Number: (Including Area Code)	**Fax Number:** (Including Area Code)
877-447-4999	818-500-1855

Email:

AS AN AGENT OR REPRESENTATIVE WHO IS SUBMITTING THIS APPLICATION TO CELTIC INSURANCE COMPANY, YOU HAVE THE DUTY TO ASSIST THE APPLICANT IN PROVIDING ANSWERS TO HEALTH QUESTIONS ACCURATELY AND COMPLETELY.

Agent/Broker Attestation:

To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

Notice: If you state as an agent any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Insurance Code 10119.3(c).

Signature of Agent (required): Date:

Print Name: Agent Number:

Agent Telephone Number:

Mail this application to:

Celtic Insurance Co.
P.O. Box 26110
Little Rock, AR 72221

www.celtic-net.com

PLEASE KEEP THE FOLLOWING SECTIONS FOR YOUR RECORDS

NOTICE OF INFORMATION PRACTICES

In order to properly underwrite and administer your insurance coverage, we must collect personal information concerning your insurability. You are our most important source of information, but we may also contact other sources, including medical professionals and institutions, employers, and other insurance companies.

In some situations, and in compliance with applicable law, we may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see (and copy if you wish) items of personal information about you which appear in our files, including the nature and scope of information contained in investigative consumer reports. You also have the right to seek correction, amendment, or deletion of information you believe to be inaccurate.

If you have questions or desire additional information about the items disclosed above, please write to us at Celtic Insurance Company, Underwriting Department, 233 South Wacker Drive, Suite 700, Chicago, IL 60606.

Requests for medical information will only be disclosed to your attending physician.

CONDITIONAL RECEIPT FOR HEALTHPLAN

ALWAYS COLLECT THE INITIAL PREMIUM AND GIVE THE APPLICANT THIS CONDITIONAL RECEIPT.

No insurance will become effective prior to the approval of your application by Celtic. No producer or broker is authorized to alter or waive any of the following provisions of the receipt:

Applicant's Name: _____

Social Security Number: _____

Amount Received: _____

Date: _____

Coverage will become effective on the "Effective Date" (as defined below) if all of the following conditions are met: (1) On the Date of Application, the applicant must be a risk acceptable to Celtic. (2) If Celtic cannot determine the acceptability of the applicant as defined in (1) above, due to the nonreceipt (within 60 days of the date of application) of medical or other material information that Celtic has requested from the applicant or other sources; then this condition has not been fulfilled and no coverage will be provided under the terms of this Conditional Receipt. (3) The initial premium, equal to one month/quarter of the first yearly premium has been paid, and the check, credit card or bank draft is honored on the first presentation for payment.

"Effective Date" as used herein means 12:01 a.m. on the later of: (A) the Requested Effective Date; (B) the day following the postmarked date on the application envelope addressed to Celtic; the day following the fax date to Celtic; or the date after the electronic submission of the application to Celtic.

If no postmarked date, the effective date is the day after the confirmed receipt date of the application. **Note: Metered mail is not an acceptable postmark.**

HIPAA Notice OF Privacy Practices For Protected Health Information ("PHI") For CELTIC Insurance Company ("Celtic")

EFFECTIVE NOVEMBER 1, 2003

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information.
Please Review It Carefully.

Celtic is committed to protecting the confidentiality and security of information it collects about you and does not share information about you with any other companies for their use in marketing products to you. **If the practices described in this Notice are acceptable to you, there is nothing you need to do.** If after reading this notice you still have questions, feel free to send them to
Attn: HIPAA Privacy Officer, [233 South Wacker Drive, Suite 700, Chicago, IL 60606.]

You have received this notice because of your proposed or actual health insurance coverage with Celtic Insurance Company. Celtic is required by federal law to maintain the privacy of your Protected Health Information ("PHI"), and to provide you with this notice of its legal duties and privacy practices regarding your PHI. Celtic is required to abide by the terms of this notice as currently in effect, and reserves the right to change the terms of this notice and to make new notice provisions effective for all PHI that it maintains. Notice of any such changes will be provided to you.

1. Protected Health Information ("PHI"):

This notice describes how Celtic may use and disclose your PHI if needed, to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI, which is individually identifiable information that relates to your past, present or future health or condition and related health care services. Examples of PHI used by Celtic include, but are not limited to, your application for coverage and claims submitted by you or health care providers on your behalf.

2. Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations:

Your PHI may be used and disclosed by Celtic for purposes of payment or health care operations. Celtic may use or share your PHI with providers for payment purposes. Celtic may share your PHI with third party "business associates" that perform various functions for the Company. Celtic maintains written agreements with its business associates contractually binding them to protect the privacy of your PHI. Celtic may use or disclose, as needed, your PHI to support the Company's business activities related to providing health insurance benefits. These activities may include, but are not limited to, quality assessment, underwriting, premium rating, actuarial analysis, reinsurance, medical review, legal services, auditing, fraud and abuse detection, regulatory compliance, business planning and development, and general management and administration.

3. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object:

Celtic may use or disclose your PHI in certain circumstances without your consent or authorization. These situations may include, but are not limited to, the following:

Required by Law: Celtic may use or disclose your PHI to the extent state or federal law requires use or disclosure. Any use or disclosure will be compliant with applicable law, and will be limited to the requirements of such law. Celtic will notify you of the uses or disclosures if the law requires such notification.

Public Health: Celtic may disclose your PHI to a public health authority for public health activities and purposes if applicable law permits the authority to collect or receive the information. Celtic also may disclose your PHI, when directed by a public health authority, to a foreign government agency that is collaborating with such authority.

Health Oversight: Celtic may disclose PHI to a health oversight agency for activities authorized by state or federal law, such as audits and investigations.

Abuse or Neglect: Celtic may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. Furthermore, Celtic may disclose your PHI to the governmental entity authorized to receive such information, in accordance with state or federal law, if the Company reasonably believes that you have been a victim of abuse, neglect or domestic violence.

Legal Proceedings: Celtic may disclose PHI in the course of judicial or administrative proceedings, in response to a court order or administrative tribunal, to the extent such disclosure is expressly authorized, and in response to a subpoena, discovery request, or other lawful purpose.

Military Activity and National Security: Celtic may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to a foreign military authority if you are a member of that foreign military. Celtic also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities.

4. Other Permitted or Required Uses and Disclosures That May Be Made With Your Consent, Authorization, or Opportunity to Object:

Celtic may use or disclose your PHI in certain circumstances with your consent, authorization or if you have no objection. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of your PHI, then Celtic may determine, using professional judgment, whether such use or disclosure is in your best interest. If such circumstances arise, only the PHI that is necessary and relevant to the provision of your health insurance benefits will be disclosed.

EOBs Sent to Primary Insured: Unless you object and instruct otherwise, all explanations of benefits ("EOBs"), including for all covered family members and eligible dependents, will be sent to the primary insured person.

5. Uses and Disclosures of PHI Based Upon Your Written Authorization:

Celtic may engage in other uses and disclosures of your PHI upon receiving your written authorization. You may revoke an authorization, in writing, at any time, except to the extent that an action has been taken in reasonable reliance on the use or disclosure indicated in the authorization.

6. Your Rights:

The following is a description of your rights with respect to your PHI and a brief description of how you may exercise those rights.

Inspect and Copy Your PHI: You may obtain and inspect a copy of your PHI that is in a designated record set for as long as Celtic maintains it. However, federal law prohibits Celtic from allowing an inspection or copy of psychotherapy notes; privileged information compiled in reasonable anticipation of or use in a legal proceeding; or PHI that is subject to a law which prohibits its access. If you wish to receive a copy of your PHI, your request must be made using Celtic's "Medical Records Request" form. You may request this form by submitting a written request to Attn: HIPAA Records Request Department, Celtic Insurance Company, 233 S. Wacker Dr., Suite 700, Chicago, IL 60606. Note that there is a fee of $25 per provider that must be received by Celtic from you before records will be released. Since your health care providers are the original source of this information, and they may or may not charge a fee for copies, you may wish to request this information from your provider(s) before requesting it from Celtic.

Place a Restriction on Your PHI: You may request that Celtic not use or disclose your PHI. Your request should be in writing, it must state the specific restriction requested, and it must state to whom the restriction applies. Your request should be sent to: Attn: Policyowner Service Department, Celtic Insurance Company, P.O. Box 26110, Little Rock, AR 72221. Celtic is not required to agree to a request for such a restriction, but will deny such a request only for a reasonable reason and will provide a written explanation of the reason for the denial. If Celtic agrees to the restriction, it may still disclose your PHI as permitted by law, or if your restricted PHI is needed for emergency medical treatment.

Alternative Means of Receiving Confidential Communications: You have the right to request that Celtic send and/or receive confidential communications by alternative means or to an alternative location. Celtic will accommodate your reasonable requests. Your request should be sent to: Attn: Policyowner Service Department, Celtic Insurance Company, P.O. Box 26110, Little Rock, AR 72221.

Amend Your PHI: You may request an amendment to your PHI in a designated record set for as long as Celtic maintains this information. Your request must be in writing, provide a reason to support the requested amendment, and sent to Attn: HIPAA Records Request Department, Celtic Insurance Company, 233 S. Wacker Dr., Suite 700, Chicago, IL 60606. In certain circumstances, Celtic may deny your request for an amendment. If Celtic denies your request for an amendment, you have the right to submit a statement of disagreement and Celtic may prepare a rebuttal to your statement. Celtic will provide you with a copy of any rebuttal. Since your health care providers are the original source of this information, you may consider making a request to amend your PHI directly to the individual providers.

Receive an Accounting of Certain Disclosures: You have the right to request an accounting of disclosures Celtic has made of your PHI. However, this right does not include any disclosures Celtic has made for purposes of treatment, payment or healthcare operations as described in this notice, nor does it include disclosures made for notification purposes. Please note that at the current time Celtic does not disclose PHI for any reason other than treatment, payment or healthcare operations.

Complaints: You have the right to voice a complaint to the U.S. Secretary of Health and Human Services if you believe your privacy rights have been violated. You also may file a complaint with Celtic by sending it to Attn: HIPAA Privacy Officer, 233 South Wacker Drive, Suite 700, Chicago, IL 60606. Celtic will not retaliate against you for filing a complaint.

Insured by Celtic Insurance Company

Celtic Group Company