**APPLICATION FOR CANCER/ SPECIFIED DISEASE COVERAGE**
**Humana Insurance Company**
**1100 Employers Boulevard, Green Bay, Wisconsin 54344**

**ADMINISTERED BY:**
**Bay Bridge Administrators, LLC**
**P.O. Box 161690, Austin, TX 78716**
**800-845-7519**

| PROPOSED INSURED LAST | FIRST | MIDDLE | SEX | DATE OF BIRTH |
|---|---|---|---|---|
| | | | | |

| STATE OF BIRTH | HEIGHT | WEIGHT | AGE | SOCIAL SECURITY NO. | MAILING ADDRESS |
|---|---|---|---|---|---|
| | | | | | |

| CITY | STATE | ZIP | PHONE NO. | OCCUPATION |
|---|---|---|---|---|
| | | | | |
| | | | | BUILDING ASSIGNMENT |

Complete for Family Coverage: (If more space is needed, add information on back of application in Additional Information Section)

| FIRST | LAST | BIRTH DATE | SEX | SOCIAL SECURITY NO. | RELATIONSHIP TO EMPLOYEE |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Selection of Coverage and Monthly Premiums:**
**Health Insurance Coverages: Cancer & Specified Disease Expense Policy**

**BBAC-03**
**BASE PLAN WITH OPTIONS**

| | |
|---|---|
| **Room Rate** | $100 per day |
| **Wellness Benefit** | $100 per calendar year |
| **Surgical Schedule** | $3,000 per schedule |
| **Radiation, Chemotherapy, Immunotherapy Benefit** | Actual charges up to $1,000 per day |
| **First Diagnosis Benefit** | **$**2,500 Lifetime Maximum |
| **Colony Stimulating Factors Benefit** | Actual Charges up to $1,000 per month |

| Coverage | Age Bracket up to 29 | 30-44 | 45-59 | 60+ |
|---|---|---|---|---|
| **Base Plan BBAC-03** | | | | |
| ☐ Employee Only | $ 9.47 | $17.93 | $36.87 | $53.47 |
| ☐ One Parent Family | 18.06 | 26.51 | 45.64 | 60.48 |
| ☐ Two Parent Family | 20.65 | 37.12 | 74.24 | 105.83 |
| **Optional Intensive care Rider $325 Benefit** | | | | |
| ☐ Employee Only | $ 1.48 | $ 2.59 | $ 3.24 | $ 3.61 |
| ☐ One Parent Family | 3.02 | 4.13 | 4.80 | 5.18 |
| ☐ Two Parent Family | 3.70 | 5.78 | 6.89 | 6.53 |
| **Optional Intensive care Rider $625 Benefit** | | | | |
| ☐ Employee Only | $ 2.85 | $ 4.99 | $ 6.22 | $ 6.95 |
| ☐ One Parent Family | 5.80 | 7.94 | 9.23 | 9.96 |
| ☐ Two Parent Family | 7.12 | 11.12 | 13.25 | 12.56 |

**TOTAL DEDUCTION:**

I hereby authorize my Employer **Cypress-Fairbanks Independent School District** to reduce my salary by the TOTAL DEDUCTION and forward this amount to Humana Insurance Company. TOTAL DEDUCTION is calculated as to produce the premiums as shown herein.

**Employee Signature:**_____ **Date:**_____

## Health Questions:

**1. Cancer and Specified Disease/Extended Benefit Rider** – Has anyone proposed for coverage ever been diagnosed as having, been treated for or, had care for which diagnostic test(s) have been recommended for: cancer or any malignancy, Addison's Disease, Amyotrophic Lateral Sclerosis, Cystic Fibrosis, Diphtheria, Encephalitis, Epilepsy, Hansen's Disease, Legionnaire's Disease, Lupus Erythematosus, Lyme Disease, Malaria, Meningitis, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Niemann-Pick Disease, Osteomyelitis, Poliomyelitis, Rabies, Reye's Syndrome, Rheumatic Fever, Rocky Mountain Spotted Fever, Scarlet Fever, Sickle Cell Anemia, Tay-Sachs Disease, Tetanus, Toxic Epidermal Necrolysis, Tuberculosis, Tularemia, Typhoid Fever, Undulant Fever, Whipple's Disease? ☐ Yes ☐ No If "yes", name(s) and condition:

_____
(who is excluded from coverage)

**2. Intensive Care Benefit/Rider** – Has anyone proposed for coverage ever been diagnosed as having or been treated for a heart attack, heart disease, a heart condition, or any abnormality of the heart? ☐ Yes ☐ No If "yes," name(s) and condition: _____
(who is excluded from coverage)

**3. All Coverages** – Has anyone proposed for coverage ever been diagnosed as having or treated by a member of the medical profession for: Acquired Immune Deficiency Syndrome (AIDS), "AIDS" Related Complex (ARC), or a condition or sickness derived from such infection, or tested positive for the HIV infection? ☐ Yes ☐ No If "yes," name(s):

_____
(who is excluded from coverage under this policy/rider)

Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes," state company and policy number:

_____

Other Health insurance coverage in force: (List Company name and amount of insurance in force, if known)

_____

Medicaid: Residents of Arkansas, Utah, Virginia, South Carolina and Iowa only. Is any proposed insured also covered by any Title XIX program (e.g. Medicaid)? ☐ Yes ☐ No If "yes" list person(s) _____

I have received the required Outline of Coverage for each policy checked above: ☐ Yes ☐ No

I have read, or had read to me, the completed application and realize that any false statements or misrepresentation thereon which materially affects the insurance company's acceptance of any person for coverage under a policy or rider may result in loss of coverage for that person during first two policy years.

Agent's Signature _____ Applicant's Signature _____

Agent's Number _____ Date of Signature _____

Proposed Insured's Name_____ Soc. Sec. No._____
Last First MI

Additional Information:_____

_____

_____

_____

| **Agent Use Only** | |
|---|---|
| Case #:_____ | Agent Split:_____ |
| Date of First Deduction:_____ | Agent II:_____% |
| Requested Effective Date:_____ | Agent III:_____% |

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

According to your application or information your have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance policy number _____, you have with _____ Insurance Company, and replace it with a policy to be **issued by Humana Insurance Company.** For you information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) You may wish to secure the advise of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(2) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all questions on the application concerning your medical/health history are truthfully and completely answered. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed, it should be carefully reviewed before being signed to be certain that all information has been properly recorded.

(3) New policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.

(4) This "Notice to Applicant" was delivered to me on:

(date) _____

Signature of Applicant _____

Signature of Witness / Agent _____

**COMPLETE THIS FORM IN DUPLICATE, ONE COPY TO BE LEFT WITH APPLICANT AND ONE COPY RETURNED TO THE HOME OFFICE.**

This form contains Personal Health Information (PHI) as defined and protected by the Health Insurance Portability & Accountability Act (HIPAA)

DO NOT SEND THIS FORM TO YOUR EMPLOYER

MAIL COMPLETED FORM TO:

BAY BRIDGE ADMINISTRATORS, LLC
Attn: Underwriting
P.O. Box 161690
Austin, Texas 78716
1-800-845-7519