



## TERMS AND CONDITIONS

1. By signing this Application, I understand and agree that: (a) all statements and answers I have given are complete and true to the best of my knowledge and belief; (b) the insurance I hereby apply for will be effective only when Dean Health Plan, Inc./Dean Health Insurance, Inc. approves this Application. Evidence of such approval will be the issuance of ID Card(s), which will be delivered to the group or employee. The effective date will be the date shown on the I.D. card issued; (c) the Social Security numbers I have provided may be used for I.D. purposes; and (d) if me or my dependents health has changed from what is indicated on the Application prior to the effective date of coverage, I will notify Dean of the change immediately. Changes in medical history prior to the effective date of coverage, but not reported to Dean, will be considered misstatements. Any person who knowingly presents a false or fraudulent claim within the contestable period 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/or imprisonment under *Wis. Stat. 943.395*. I further understand that, in the event of fraud or misrepresentation, this information may be used to reduce or deny a claim, void coverage, or void the group contracts within the contestable period, if such misrepresentation affects Dean's acceptance of risk.
2. By my signature on this application, I authorize: (a) Any physician, medical practitioner, hospital, clinic, medically related facility or other institution who provided treatment or service to me, my spouse or my minor child(ren) at any time, or their agent(s) (including billing service), having medical information which includes, but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and/or services, test results (excluding genetic tests and FDA-licensed blood tests for the presence of HIV, but including X-rays), summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness (including pregnancy and treatment or service, if any, for mental or nervous conditions, alcohol abuse or drug abuse), and (b) Any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associates having non-medical information about me, my spouse, or my minor child(ren), concerning eligibility and claim administration to disclose to Dean, or their representatives (including the claims department) all such information. I understand that when used for obtaining information in connection with an insurance policy application, this Authorization is valid for 30 months. I understand that when used for the purposes of obtaining information in connection with claims for benefits, utilization review, quality improvement, health care operations or other activities as permitted by law, this Authorization is valid during the Policy term or pendency of the claims for benefits, which ever is longer. I understand that I may request and receive a copy of this authorization.
3. I understand that any approved coverage is not effective for me or my dependents if I am not actively at work at my full-time employment with my employer on the assigned effective date, but that such coverage will first become effective on the first day thereafter that I am actively working at such employment.
4. This Application, when approved, and any endorsement, amendment, or rider thereto, will be made part of the contract(s) applied for.
5. No person, except an officer of Dean, is authorized to vary or modify a contract. I further understand and agree that Dean, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorney's fees) that I or any of my dependents suffer as a result of any improper advice, action, or omission on the part of any health care provider.
6. Subject to the acceptance of the Application by Dean, I authorize the group, as my remitting agent and until this authorization is revoked in writing, to deduct from my wages or salary a sufficient amount to provide for the regular and timely prepayment of the prevailing subscription fees that are not otherwise contributed by my employer for the contract(s) applied for and to remit the same on my behalf to Dean.
7. The contract(s) applied for will become void if and when I cease to be employed or affiliated with the group. Should I wish to retain my membership after such termination, it shall be my responsibility to secure a new application form from Dean and to apply for the programs then being offered to such individuals.