



Agent Reference Guide

The Basics of Underwriting for Individual Plans



AVAHEALTH, INC. 3030 N ROCKY POINT DR W, SUITE 800, TAMPA, FL 33607

Agent Reference Guide 9/1/2008 AVAiarg-18 (9-08)

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The Basics of Underwriting for Individual Plans

Introduction

Welcome to AVAHEALTH, INC.! Focused exclusively on Consumer Directed Health Plans (CDHP) and HSA eligible health plans, AVAHEALTH offers two unique products from which to choose. Avalon Healthcare, offering health benefit plans in all 67 Florida counties, and Sawgrass Plans, an affordable suite of health benefit plans centered around a specific group of best in class hospitals and doctors. AVAHEALTH's leading edge plans provide flexible, affordable quality healthcare combined with industry leading customer service, allowing Members to get the most out of their healthcare benefits.

Please take the time to read through this guide. It was created as a resource for frequently asked questions and to allow you a point of reference on some of the underwriting processes of AVAHEALTH, Inc. Contained in this document you will find helpful, practical information outlining the process of submitting new business, effective dates, medical & paramedical exam requirements, medical condition guidelines and copies of useful forms.

The listed process turnaround times are averages and do not include every possible scenario. Each application is unique and as a result the outcome may vary from the guidelines shown. AVAHEALTH reserves the right to maintain flexibility in our underwriting practices.

If you have any questions, comments, or concerns please contact your General Agent for assistance.



Contact Information

Member Services

Benefit Information	
Claims Information	1-866-469-2347
Replacement of ID Card(s)	
Precertification of Services	

Online – for Member

Benefit Information	
Network information/directory	www.avalonhealthcare.com
Forms and other materials	
Helpful information	

Online – for Agent

Quotes	
Forms and other materials	www.avalonhealthcare.com
Marketing Materials	
Online Case Tracking	

Sales

To speak to an Sales Representative	1-877-280-0010
Producer Relations Fax Line	1-877-280-8881
Sales Representative Email	sales@avalonhealthcare.com

Underwriting

Application Status Line	1-877-280-0010
Prescreen Fax Line	1-813-549-0747
Underwriting Department Fax	1-800-572-9384
Underwriter of the Day	1-877-280-0010

Prescreen Guidelines

If your prospective client has a medical condition and is concerned on how it will affect his/her rate, AVAHEALTH has provided three avenues for you to use as guides to the probable underwriting outcomes. Please be aware that pre-screens and agent guidelines are reference tools only and the actual underwriting outcome may vary.

1. Agent Medical Condition Guidelines - AVAHEALTH has created an Agent Guideline reference with the most commonly seen conditions and the possible rate effects. This guide may be used in collaboration with the Quote Disk “uprate” feature to estimate possible premium amounts.

2. Pre-screen - If your prospective client’s conditions are not listed in the Agent Guidelines or if you would like to provide your prospect with a more detailed quote, our Pre-screen Process is available. A pre-screen is a form that provides an overview on a potential applicant’s current health status, including medical conditions, current treatments and medications. Based on the information provided on the pre-screen form, our underwriting department will propose the possible underwriting outcome. Please be as **specific as possible** when listing conditions, treatments and medications! The more detailed the information is, the more specific the underwriter can be when estimating the rate effects.

Our underwriters will estimate the underwriting outcome to one of seven tiers.

To submit a pre-screen, please fill out the **Underwriting Pre-screen Form** (AVAiup-30) and fax to: **813-549-0747**.

Level 1 1-15%;	Level 4 46-60%;	Level 7 101% +
Level 2 16-30%;	Level 5 61-75%;	
Level 3 31-45%;	Level 6 76-100%;	

The pre-screen is an estimate based on the information provided. The pre-screen is not a guarantee of coverage and does not replace the medical underwriting process. Additionally, any change in personal or medical information not disclosed on the pre-screen, but later disclosed on the application may affect the final rate. The guaranteed turnaround time for a pre-screen is 48 hours. Average turnaround time is approximately 24 hours.

3. Underwriter of the Day

The Underwriter of the Day is an option provided by AVAHEALTH for agents to obtain probable underwriting outcomes. This avenue is available for agents that are on the way to or at an appointment, do not have access to a prescreen form and need a response immediately. The Underwriter of the Day can provide general guidance on the probable underwriting outcome. However, for a more detailed prescreen opinion, you will need to complete the prescreen form. To speak to our Underwriter of the Day, call: 1-877-280-0010.

Remember, the prescreen form is available on our website and the average turn-around time is 24 hours!

When calling the Underwriter of the day, please have the following information ready before placing your call.

- Proposed Insured’s Age
- Proposed Insured’s Gender
- Proposed Insured’s Home Zip Code
- Plan Choice (Medical and/or Rx)
- Proposed Insured’s Conditions and/or Medications

New Business Submission for Individual Plans

All new business should be submitted through your General Agent or online. Your General Agent is a valuable resource for you. He/she can assist you in creating quotes, answer general questions and guide you through our processes and forms. Additionally, your General Agent reviews all applications to ensure their completeness so that the underwriting process is expedited.

Your General Agent will complete the final delivery of the application in one of two ways, Mail or Fax.

Faxed applications can give you a jumpstart on the processing of your client's application rather than waiting for traditional mail to deliver the package to AVAHEALTH. We will underwrite from a faxed application; there is no need to send the original unless the underwriter requests it. If your General Agent will be faxing the application, an initial premium payment as credit card or bank debit is preferred. If your client wishes to submit his/her application with a check, a faxed application may still be used. Simply enclose a copy of the check with the faxed application and mail the original to:

AVAHEALTH, Inc.
3030 Rocky Point Dr. W.
Suite 800
Tampa, FL 33607

Completing the Application

Please be thorough when reviewing the application with your client as incomplete or vague applications slow down the underwriting process. We always appreciate an agent's attention to detail as applications with complete information allow us to provide a more timely and accurate underwriting decision.

Some questions are commonly overlooked and this causes delays in the underwriting process. To help prevent this possible delay, we have created a tip sheet listing the most common omissions/errors and a checklist that guides you through the individual application. Both forms can be found in the Agent's Toolkit on the website. (www.avalonhealthcare.com) Examples of these forms can be found in the forms section of this document.

General Tips When Completing an Application

- Answer all questions. If any part of any section is incomplete, it may result in processing delays.
- Fill in the applicant's name and social security number on every page.
- Make sure the applicant lists all health conditions. Please provide full details as AVAHEALTH will review the medical history information of each applicant to determine if they are eligible for coverage.
- All persons named on the application who are age 18 or older must sign and date the signature page.
- Have your client print his/her answers in ink. If there are any corrections, please have them initial at the spot of the correction.
- White-out should not be used.

Most Frequent Omissions or Errors that Cause Delays in Underwriting

- Answers to Health Questionnaire missing or incomplete
- No details (readings, results, severity of condition etc.) provided for Health Questionnaires with "yes" answers
- Address information incomplete
- Omitted height, weight, date of birth or age of applicant and /or dependents
- Missing signature of spouse and/or dependent over age 18
- Missing name and address of physician or providers in health history sections.
- Application not dated
- Changes made to answers without accompanying explanation or initials
- Broker information incomplete or agent number missing

Situations which may result in the application being closed without underwriting include but are not limited to:

- Applications which have been completed in pencil
- Submission of an outdated or expired application form
- Multiple omitted items on the application
- Application not dated
- Missing signatures of applicant, spouse, over-age dependents
- Missing signature of parent or guardian for "child only" policies

When are separate applications needed?

We ask that you complete a separate application for each person when Members of the same family choose a different plan type or live in different locations. (Excluding students away from home but attending school in Florida.)

Students that are away from home but attending school in Florida may apply on the same application with the other family members.

Florida Residency

We provide Florida-based insurance policies. We require that applicants reside in Florida for at least 10 months a year.

Legal US Resident Applicants (Non-citizens)

If the applicant(s) is a legal US resident, please attach to the application a copy of a valid visa or permanent resident card.

Non-US Resident Applicants

Following are general guidelines for applicants without a social security number, visa or resident card.

You must advise underwriting that the application is to be processed as a non-US resident. In place of the social security number on the applicant information section, fill in the applicant's passport or driver license number.

Additionally, Applicants unable to speak, read &/or write English must have their agent or a designated person that will translate the application & other documentation for them sign a "Statement of Accountability".

We have a Spanish translator on staff for phone interviews.

Effective Dates & Signatures

AVAHEALTH issues policies with first of the month effective dates.

Applications must be submitted to AVAHEALTH by the last day of the month prior to the requested effective date. If you have submitted your client's application prior to the 1st of the requested effective month, we can hold your client's requested effective date until the 10th of that month.

For example, AVAHEALTH receives Mr. Smith's application on January 25th and Mr. Smith requests a February 1st effective date. Our Underwriting Department finishes its review of the application on February 8th. If Mr. Smith would like to keep his requested effective date as February 1st, we can issue an approval of the application for a February 1st effective date.

However, if our Underwriting Department finished its review on February 15th, Mr. Smith will not receive his requested date of February 1st and will be issued for the next possible effective date of March 1st.

Applicants with Current Insurance Coverage

After the 15th of the month, before an underwriter can approve an application, the underwriter will call the agent to confirm the chosen effective date and if the applicant has paid their current insurance provider for the effective month. It is the agent's responsibility to confirm with their client the effective date and if a payment has been made to the current insurance carrier.

Approval Letter Signatures and Payment Processing

1. Standard Approvals

If an applicant(s) is approved standard, no signature is necessary. The first month's payment is processed on the approval letter date and the approved application is sent to enrollment.

2. Approvals with rates increases less than \$25.00

If an applicant(s) is rated up less than \$25.00, a signature is requested. However in order to avoid any delay in sending the Member welcome kits & cards, the underwriter will not hold the application for a signed approval letter. On the approval letter date, an approved application is sent to enrollment and the first month's payment is processed.

3. Approvals with rates increases more than \$25.00

If an applicant(s) is rated up more than or equal to \$25.00, a signature is required. The underwriter will hold the application while waiting for the signed approval letter. On receipt of the signed approval letter, the application will be sent to enrollment and the first month's payment is processed.

4. Approvals with an exclusionary rider

If an applicant is approved with an exclusionary rider, a signature is required. The underwriter will hold the application while waiting for the signed rider/approval letter. On receipt of the signed exclusionary rider/approval letter, the application will be sent to enrollment and the first month's payment is processed.

Attending Physician Statements (APS)

Occasionally, an attending physician statement (APS) will be required to process an application.

General Guidelines for when an APS will be ordered:

- For applicants under the age of 2 or age 55 and older.
- For applicants age 2 to 54, an APS may be ordered if a condition warrants.
- For applicants who have undergone a gastric bypass or lap band surgery.*
- For applicants with non-insulin Type II Diabetes.**

*Gastric bypass/lap band surgery within past 2 years is a decline.

**Type II Diabetes must be diagnosed more than 6 months prior & be well-controlled by oral rx/diet only with no complications

Based on application answers and/or interview results, the Underwriter may request an APS outside of the above guidelines.

The average turnaround time for an APS is two weeks. You will be notified via email if an APS has been ordered for your client. The applicant can help to speed up the process by contacting his/her medical facility and requesting that they respond promptly to our request.

The first attending physician statement ordered will be at the expense of AVAHEALTH. If the records are incomplete or inconclusive and additional information is required, it will be the applicant's responsibility to provide the additional records.

Medical and Paramedical Exam Requirements

- There are no automatic exam requirements for those under the age of 40.
- All Applicants ages 40-49 who have not completed a general health physical within the past 3 years must complete a paramedical exam.
- All Applicants age 50 (+) who have not completed a general health physical within the past 15 months must complete a paramedical exam, which includes an EKG.
- Female Applicants age 40 (+) who have not completed a Pap test with pelvic exam within 18 months will have the option of having an exclusionary rider placed on them until they have the Pap with pelvic exam completed and submitted with normal results to AVAHEALTH. If they become a member they can have the test done under our preventive care benefits.
- Female Applicants age 45 (+) and who have not completed a mammogram within 18 months will have the option of having an exclusionary rider placed on them until they have the mammogram completed and submitted with normal results to AVAHEALTH. If they become a member they can have the test done under our preventive care benefits.

* Paramedical exams with blood work and EKG (if necessary) will be arranged through our exam vendor and paid for by AVAHEALTH, Inc. We reserve the right to change this policy at any time.

** Based on application answers and interview results, the Underwriter may request a paramedical exam outside of the above guidelines.

*** Female Applicants who had a total hysterectomy (removal of the uterus and cervix) are not subject to the Pap test guideline (a pelvic exam would still be required), unless the surgery was done as a treatment for cervical cancer or pre-cancer.

Paramedical Exams

A paramedical examination is a personal interview with the applicant at his/her home, workplace or local medical facility by a trained professional to collect information about his/her medical history. This information allows underwriting to perform a comprehensive evaluation of the applicant's current health. The exam usually includes recording of height, weight, blood pressure and pulse. The exam may also include the collection of blood, urine, oral fluid, and an EKG, depending on the applicant's age, application answers and interview results.

If a paramedical exam is required for your client, the underwriter will contact you to ensure your client is available and willing to complete the exam. The turnaround time for a paramedical exam rests with the applicant. The applicant will be contacted by our paramedical exam provider within 72 hours of our Underwriting Department placing the request. Please advise your client to schedule the exam as soon as possible to ensure uninterrupted processing of his/her individual health insurance application.

Can the applicant have a copy of their medical records? (APS or paramedical exam results)

Upon request, the underwriter can forward a form to the agent for their applicant to request a copy of their paramedical exam results. A signed form is required to release of copy of the exam results to the applicant or a physician of their choice. The average turnaround time for the release of paramedical exam results is 5 to 7 business days.

Copies of medical records (APS) obtained by AVAHEALTH will not be released to applicants or agents. The underwriter cannot discuss the contents of the medical records with the applicant or agent.

If the applicant would like to know the underwriting involved with their application, a letter can be sent to a physician of the applicant's choice detailing the conditions that led to the underwriting decision. A signed form is required and a copy of the form can be provided by the underwriter upon request. The average turnaround time for the release of medical underwriting to a physician is 5 to 7 business days.

Tracking Underwriting/Case Status

Once an individual health insurance application is received by AVAHEALTH (online, mail or fax), a confirmation of receipt email will be sent to the agent and his/her General Agent within 24 hours.

On the day the application is acknowledged, the applicant will receive a courtesy call or email to notify him/her that the application is in review and an underwriter my call within the next 3 business days for a phone interview.

Within 3 business days an underwriter will contact the applicant for a phone interview, if needed.

While the application is under review, underwriters will notify agents of any updates to the application status by email.

Common updates include:

- Underwriter is unable to reach your client for the phone interview
- Phone Interview has been completed
- Paramedical Exam Required
- Attending Physician Statement Ordered
- Additional Exams Required
- Status updates on pending information
- Final Underwriting Decision (Underwriter also notifies General Agent & MGA)

Processing Times for an Individual Health Insurance Application

Turnaround times for applications depend upon the completeness of the application, health of the applicant(s), and if any additional information/exam is required.

If the application is complete and no additional information, APS or paramedical exam is required, the average turnaround time for application processing is 5 business days.

As noted earlier, if an attending physician statement is required, it can add an average of 2 weeks to the application processing time. The additional processing time for a paramedical exam depends on how promptly the applicant can schedule his/her exam.

Timing Outline for Changes to Individual Health Insurance Plans

Base Plan Changes

- Requesting a lower deductible than original choice:
 - Client may request only at renewal. New Plan choice will be underwritten.
- Requesting a higher deductible than original choice:
 - Can be submitted at any time with 45 days notice.

Rx Plan Changes

- If applicant has current coverage
 - Delete coverage:
 - Can delete at any time with 45 days notice
 - Requesting a higher deductible than original choice:
 - Can change at any time with 45 days notice.
 - Requesting a lower deductible than original choice:
 - Client may request only at renewal. New Plan choice will be underwritten.
- If client does not currently have Rx coverage:
 - Can request only at renewal. New Plan choice will be underwritten.

Maternity Rider Changes

- If client has current coverage:
 - Can request to delete at any time with 45 days notice.
- If client does not have current coverage:
 - Can request only at renewal. Maternity Rider will be underwritten.

Dental Plan Changes

- If client has current dental coverage:
 - Can delete coverage at any time with 45 days.
- If client does not have current dental coverage:
 - Can add at any time with 45 days notice.

In order to request any changes to a member's policy, please complete the individual member change form available on our website.

The completed form can be sent to ATTN: Member Services, Fax # 1-800-693-7875.

Useful Forms on our Website

Examples of these forms can also be found in the forms section of this document.

- Individual Applicant Prescreen Form
- Individual Application Withdrawal Form
- Replacement of Coverage Form

Miscellaneous

Agent of Record Change Request

If an applicant chooses to change agents, the applicant must submit a formal communication to AVAHEALTH requesting the agent of record change. The agent of record change will take effect upon the renewal date of the policy. The agent who first submitted the application and received acknowledgement will retain the case for the 1st year of the policy.

If the applicant chooses to change agents prior to the completion of underwriting and wants the new agent to receive the commission during the 1st policy year, the applicant must first formally withdraw the application submitted by the previous agent. A change of "Agent of Record" supplement form must be completed, signed and submitted to the underwriter.

Individual Agent Medical Condition Guidelines

Overview

The following agent guidelines should be used as a reference tool only to the probable underwriting outcome for the enclosed listed conditions. The listed conditions are the most commonly seen conditions and do not include every condition. Also, each application is considered based on its own medical risk characteristics. As a result, the underwriting outcome may vary from the guidelines shown.

No coverage is in force, or rating final, until written approval for the product sold with rates from an AVAHEALTH Underwriter is given.

The Agent guidelines are intended for use only by agents appointed with AVAHEALTH, Inc.

Key to Understanding the Meaning of Possible Underwriting Actions Noted in this Agent Guide

IC: The application will be given Individual Consideration by the Underwriter and/or Medical Director.

STD: This indicates that the applicant can be approved for coverage using Avalon Healthcare's standard premium tables without any exclusionary riders or premium surcharges.

Rate-Up (numerical value): This indicates the possible medical (and/or Optional Rider) premium rating range that may be required for the medical condition. This numerical value is the percentage of the required premium increase over and above the standard premium.

Rider: This indicates that an exclusionary rider is required to exclude coverage from the policy for the specific medical condition indicated or for the part of the anatomy affected by the medical condition.

Decline: This indicates that due to the severity of the medical condition indicated, no offer of coverage can be extended and the applicant will be declined.

Tobacco Usage (used in the last 5 years)

- Rate-up 10%

Ineligible Behavior or History

Alcohol dependence, abuse or addiction	<i>any time over the past 5 years</i>
Drug Dependence	<i>any time over the past 7 years</i>
Felony Convictions	<i>the longer of 5 years since conviction or 3 years since confinement</i>
DUI with either a permanently suspended license or permanently revoked license	<i>any time over the past 5 years</i>
Participation in Clinical Drug Trials	<i>any time over the past 5 years</i>
Children without immunizations	<i>decline until immunizations are current for age group</i>

Individual Agent Medical Condition Guidelines

Adult Male Build Chart

(average rate-up will vary by age)

Height		Normal Std	Overweight Percentage Rate Up			
Ft.	In.		30%	40%	60%	Decline
5	0	106-165	166	196	211	226
5	1	106-165	166	196	211	226
5	2	106-180	181	196	226	241
5	3	106-180	181	211	226	241
5	4	121-180	181	211	226	241
5	5	121-195	196	211	241	256
5	6	121-195	196	226	241	256
5	7	121-195	196	226	241	256
5	8	136-210	211	241	256	271
5	9	136-210	211	241	256	271
5	10	136-225	226	241	271	286
5	11	136-225	226	256	271	286
6	0	151-225	226	256	286	301
6	1	151-240	241	271	286	301
6	2	151-240	241	271	301	316
6	3	151-255	256	286	301	316
6	4	166-255	256	286	316	331
6	5	166-270	271	301	316	331
6	6	166-270	271	301	331	346
6	7	181-285	286	316	331	346
6	8	181-285	286	316	346	361

Individual Agent Medical Condition Guidelines

Adult Female Build Chart

(average rate-up will vary by age)

Height		Normal Std	Overweight Percentage Rate Up			
Ft.	In.		30%	40%	60%	Decline
4	8	91-150	151	166	181	196
4	9	91-150	151	181	196	211
4	10	91-165	166	181	196	211
4	11	91-165	166	181	196	211
5	0	91-165	166	196	211	226
5	1	91-165	166	196	211	226
5	2	106-180	181	196	211	226
5	3	106-180	181	211	226	241
5	4	106-180	181	211	226	241
5	5	106-180	181	211	226	241
5	6	106-195	196	226	241	256
5	7	121-195	196	226	241	256
5	8	121-195	196	226	241	256
5	9	121-210	211	241	256	271
5	10	121-210	211	241	256	271
5	11	121-225	226	256	271	286
6	0	136-225	226	256	271	286
6	1	136-240	241	271	286	301
6	2	136-240	241	286	301	316

Individual Agent Medical Condition Guidelines

Ratings & Ineligible Conditions Chart (average rate-up will vary by age)

Conditions	Rider	Decline	Rate Up
Addison's Disease		Decline	
AIDS, ARC OR HIV		Decline	
Allergy			
Testing in Progress			20 to 120%
Weekly Shots			30% to Decline
Bi-Weekly Shots			15% to 75%
Monthly Shots			7% to 35%
Seasonal Shots			5% to 25%
Anaphylaxis reaction requiring epinephrine		Decline	
Non-prescription medications			STD
ALS		Decline	
Alzheimer's Disease		Decline	
Anemia, Aplastic		Decline	
Aneurysm		Decline	
Angina Pectoris		Decline	
Angioplasty		Decline	
Anorexia Nervosa		Decline	
Arrhythmia		Decline	
Arteriosclerosis		Decline	
Asthma			
Mild to Moderate; one inhaler			12% to 60%
Moderate or multiple medications	Rider		
Attention Deficit Hyperactivity Disorder			
Mild to Moderate			8% to 40%
Severe			16% to 80%
Autism/Asperger's Syndrome		Decline	

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Individual Agent Medical Condition Guidelines

Ratings & Ineligible Conditions Chart (average rate-up will vary by age)

Conditions	Rider	Decline	Rate Up
Baker's Cyst			
Present			50% to Decline
Bartholin's Cyst			
Present		Decline	
Basal Cell Carcinoma			
Present	Rider		50% to Decline
Single incident & recovered	Rider		10% to 50%
Bell's Palsy		Decline	
Benign Prostatic Hypertrophy			
PSA Normal			30% to Decline
PSA Abnormal		Decline	
Bipolar Disorder		Decline	
Blepharitis/Blepharospasm			40% to Decline
Bone Marrow Transplant		Decline	
Bone Spur			
Unoperated			15% to Decline
Breast Implants			
Silicone Implants	Rider		
Bronchitis			
Less than 2 weeks/yearly			15% to 25%
Bruit			
Ultrasound or CT Negative			STD
Stenosis or No Studies Completed		Decline	
Buerger's Disease		Decline	
Bulimia		Decline	
Bunions or Hammer Toes			10% to 75%

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Individual Agent Medical Condition Guidelines

Ratings & Ineligible Conditions Chart (average rate-up will vary by age)

Conditions	Rider	Decline	Rate Up
Bursitis or Tendonitis			
Resolved for more than 3 years			Standard
Cancer			
Within past 5 years		Decline	
Cardiac Pacemaker		Decline	
Cardiomyopathy		Decline	
Carpal Tunnel Surgery			
Mild or resolved with no future surgery			15% to 75%
Cataracts	Rider		
Cerebral Palsy		Decline	
Cholecystitis			
No surgery	Rider		30% to Decline
Cholecystolithiasis (gallstones)			
Present	Rider		30% to Decline
Chronic Fatigue			
Present		Decline	
Cirrhosis of the Liver		Decline	
Colitis, Ulcerative		Decline	
Colon Polyps			
Present		Decline	
Removed			15% to Decline
Combined System Disease		Decline	
Condyloma Acuminatum			
Multiple Episodes			5% to 25%
Congestive Heart Failure		Decline	
COPD (Chronic Obstructive Pulmonary Disease)		Decline	

Individual Agent Medical Condition Guidelines

Ratings & Ineligible Conditions Chart (average rate-up will vary by age)

Conditions	Rider	Decline	Rate Up
Coronary Artery Disease		Decline	
Coronary Bypass Surgery		Decline	
Crohn's Disease		Decline	
Cyst- Pilonidal, Sebaceous or Sublingual			
Present			5% to 25%
Cystic Fibrosis		Decline	
Degenerative Osteoarthritis	Rider		
Dementia		Decline	
Dermatomyositis		Decline	
Depression or Mental/Nervous Disorder			
In Current Counseling		Decline	
Detached Retina	Rider		
Deviated Nasal Septum	Rider		
Diabetes			
Type 1		Decline	
Insulin Dependent		Decline	
Using injectable medications		Decline	
Type 2 with normal readings & no complications			IC
Dislocation of Joint			
Within past year	Rider		
Down's Syndrome		Decline	
Drug Abuse/Addiction			
Within the past 7 years		Decline	
Edema		Decline	
Emphysema		Decline	

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Individual Agent Medical Condition Guidelines

Ratings & Ineligible Conditions Chart (average rate-up will vary by age)

Conditions	Rider	Decline	Rate Up
Endocarditis			
Within the past 3 years		Decline	
Endometriosis	Rider		
Epilepsy			
With Seizure within past 2 years		Decline	
Otherwise			IC
Fatty Liver			
With Abnormal Liver Function		Decline	
Fibromyalgia			20% to Decline
Functional Heart Murmurs			STD
Gastric Bypass/Lap Band Surgery			
Within past 2 years		Decline	
More than 2 years since surgery and no complications			IC
Gastritis			
Multiple or chronic attacks		Decline	
Gaucher's Disease		Decline	
GERD (Reflux Disease)			
Mild or infrequent, stable symptoms and no prescription medications			STD
Mild to Moderate, stable symptoms, controlled with prescription medications and no recommended or anticipated surgery	Rider		IC
Severe, frequent symptoms, uncontrolled or pending further workup		Decline	
Glaucoma	Rider		
Gout			
Mild			STD to 30%

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Individual Agent Medical Condition Guidelines

Ratings & Ineligible Conditions Chart (average rate-up will vary by age)

Conditions	Rider	Decline	Rate Up
Heart Attack/Disease		Decline	
Heart Stent		Decline	
Hemophilia		Decline	
Hepatitis		Decline	
Hernia			
Asymptomatic, incidental finding only, with no recommendation of surgery	Rider		STD to 30%
Herniated Disc Disease/Back Disorders	Rider		IC
HIV Disease		Decline	
Hodgkin's Disease		Decline	
Huntington's Chorea		Decline	
Hydrocephalus		Decline	
Hypercholesterolemia			
Controlled			STD to 15%
Hypertension (High Blood Pressure)			
Uncontrolled		Decline	
Infertility Testing or Treatment			
Within the last year		Decline	
Irritable Bowel Syndrome			8% to 40%
Juvenile Arthritis		Decline	
Kidney Stones/Renal Calculi			
Present	Rider		
Passed spontaneously, single incident			STD-30%
Kidney Transplant		Decline	
Leukemia		Decline	

Agent Reference Guide | 9/1/2008 AVAiar-g-18 (9-08)

Individual Agent Medical Condition Guidelines

Ratings & Ineligible Conditions Chart (average rate-up will vary by age)

Conditions	Rider	Decline	Rate Up
Lipoma (Benign growth)			
Small (<5cm) and asymptomatic	Rider		STD to 40%
Liver Transplant		Decline	
Lupus Erythematosus		Decline	
Lymphoma		Decline	
Marfan's Syndrome		Decline	
Medications (currently taking)			
Geodon, Human Growth Hormone, Lamictal, Lithium, or Seroquel		Decline	
Melanoma			
Local and Treated	Rider		
Present		Decline	
Menopausal Syndrome			
Mild			STD
Menstrual Disorders	Rider		
Mental Retardation		Decline	
Mitral Valve Prolapse			
Asymptomatic, incidental finding with no other cardiac findings			IC
Multiple Sclerosis		Decline	
Muscular Dystrophy		Decline	
Myelofibrosis		Decline	
Narcolepsy			40% to Decline
Nephrosclerosis		Decline	
Organic Brain Syndrome		Decline	
Osteoarthritis	Rider		

Agent Reference Guide 9/1/2008 AVAiarq-18 (9-08)

Individual Agent Medical Condition Guidelines

Ratings & Ineligible Conditions Chart (average rate-up will vary by age)

Conditions	Rider	Decline	Rate Up
Osteopenia/Osteoporosis			
Severe		Decline	
Otitis Media			
Multiple Episodes or Chronic	Rider		
Ovarian Cysts	Rider		
Pancreatitis		Decline	
Paralysis		Decline	
Parkinson's Disease		Decline	
Pelvic Inflammatory Disease	Rider		
Peptic Ulcer Disease	Rider		
Phlebitis/Embolism		Decline	
Polycystic Kidney Disease		Decline	
Polycystic Ovarian Disease			
Unoperated		Decline	
Pulmonic Stenosis		Decline	
Rheumatoid Arthritis			
Severe, chronic or surgery anticipated		Decline	
Otherwise	Rider		
Schizophrenia		Decline	
Shunt, Cerebral		Decline	
Sickle Cell Anemia		Decline	
Simmond's Disease		Decline	
Spondylitis	Rider		
Spondylolisthesis or Spondylosis	Rider		
Stroke (CVA or TIA)		Decline	
St. Vitus' Dance		Decline	

Agent Reference Guide | 9/1/2008 AVAiar-g-18 (9-08)

Individual Agent Medical Condition Guidelines

Prescriptions not covered by plan design

Below is an abbreviated listing of categories of drugs that are excluded by plan design. Please remember that this is not an all inclusive list. The policy will be administered according to the certificate of coverage and it should be referred to for specific detail on coverage.

- Acne products for members over age 25
- ADD drugs for members over age 18
- Alcohol & substance Abuse Deterrents
- Anti-Obesity, Appetite suppressants
- Contraceptives (injectables, oral, patch, diaphragms/cervical caps, IUD, norplant, plan B)
- Cosmetic Preps (Renova, Vaniqua)
- Fertility Drugs
- Growth Hormones
- Hair Growth Stimulants (Rogain, Propecia)
- Injectables
- Isotretinoin Accutane
- Mental, Nervous Drugs
- Nutritional Diet Supplements
- OTC
- Sexual Dysfunction (Caverject, Edex, Muse, Viagra, Yocon)
- Smoking Deterrent



Useful Forms

How to Apply for AVAHEALTH Individual Plans

Please read the following directions carefully to ensure your application is processed as quickly as possible.

- Answer all questions. If any part of any section is incomplete, it may result in processing delays.
- Fill in applicant name and social security number on every page.
- Make sure you list all your health conditions. Please provide full details as Avalon Healthcare will review the medical history information of each applicant to determine if they are eligible for coverage.
- All persons named on this application who are age 18 or older must sign and date the signature page located on page 7.
- Print your answers in ink. If you make any corrections, please initial at the spot of the correction
- Do not use white-out.

APPLICATION SUBMISSION CHECKLIST

Please verify all information to ensure your application is processed as quickly as possible.

Personal Information for all applicants

- Name
- Social Security Number
- Gender
- Date of Birth
- Height and Weight
- Address
- HIPAA Section
- Prior Coverage
- U.S. Citizenship

Plan for which you are applying

- Plan Selected
- Prescription Drug Plan (optional)
- Dental Plan (optional)
- Maternity Rider (optional)
- Effective Date

MEDICAL HISTORY

- Please make sure all questions are answered completely; do not leave any items blank.
- If you answer "yes" to any medical history questions, please be sure to fill out the details sections provided. If necessary, use extra paper in order to provide complete details. Please be sure to note the question number and name of person that the answer relates to when filling out extra sheets.

SIGNATURES

- Please make sure that all required signatures are completed.

AGENTS

**PLEASE INCLUDE A QUOTE FOR THE PLAN REQUESTED.
WITHOUT A QUOTE AN APPLICATION CANNOT BE PROCESSED BY AVAHEALTH, INC.**

Tips on How You Can Streamline the Underwriting Process

An application cannot be reviewed by underwriting until all information has been provided by the applicant(s) and agent. Listed below are the most frequent omissions or errors that cause delays in underwriting:

- Answers to Health Questionnaire missing or incomplete
- No details (readings, results, severity of condition etc.) provided for Health Questionnaires with "yes" answers
- Address information incomplete
- Omitted height, weight, date of birth or age on applicant and /or dependents
- Missing signature of spouse and/or dependent over age 18
- Missing name and address of physician or providers in health history
- Application not dated
- Changes made to answers without accompanying explanation or initials
- Broker information incomplete or agent number missing

Situations which may result in the application being closed without underwriting include, but are not limited to:

- Applications which have been completed in pencil
- Submission of an outdated or expired application form
- Multiple omitted items on the application
- Application not dated
- Signature date is over 60 days old or is post-dated
- Missing signatures of applicant, spouse, over-age dependents
- Missing signature of parent or guardian for "child only" policies



Without a Plan Selection,
a Pre-Screen Evaluation Cannot be Completed.

Individual Underwriting Prescreen

Use one form per person. If multiple applicants need a pre-screen, check here and submit together.

Agent Name _____ Phone Number _____
 Email _____ Fax Number _____
 GA Name _____ GA Fax Number _____

General Information

Proposed Insured's Name _____ Occupation _____
 Age _____ Gender _____ Height _____ Weight _____ Tobacco User Yes No
 Replacing Prior Coverage Yes No Replacing COBRA Yes No HIPAA Eligible Yes No

Plan Selection

Plan Selection _____ Rx _____
 Effective Date _____ Zip Code _____

Medical Conditions/Diagnosis

Common Conditions Hypertension – provide last reading _____
 Diabetes – provide hbA1c results _____
 Hypercholesterolemia LDL _____ HDL _____ Total _____
 Other Conditions _____

Treatments/Medication (include how often medication is refilled and dosage)

Disclaimer

- Please be advised, this is an estimate based on the information supplied.
- This pre-screen is not a guarantee of coverage.
- This quote is not intended to replace the medical underwriting process.
- Any change in personal or medical information not disclosed may alter this pre-screen.
- No commission is paid on HIPAA cases.
- Avalon plan choices for HIPAA individuals are limited.

Please fax this request to AVAHEALTH's Underwriting Office at # 813-549-0742.

Proposed Underwriting Action (best case, worst case)

Level 1: 1-15% Level 2: 16-30% Level 3: 31-45% Level 4: 46-60% Level 5: 61-75% Level 6: 76-100% Level 7: 101%+

Underwriter _____ Date _____

Supplement to Underwriting

Name of Applicant:

Applicant's Social Security Number:

Name of Group (if applicable):

Use this space to amplify and extend answers to questions in your application dated _____

Please answer ALL questions in ink, sign and date.

RE: Statement of Accountability

I, _____, personally read and completed this Individual Enrollment Application for the Applicant because:

Applicant does not read English Applicant does not speak English Applicant does not write English

Other (explain) _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the Fraud Statement below and the "Agent Information" found in the application.

x _____
Signature Translator (required) Date signed (required)

I represent that the answers as amplified and extended above are true and complete to the best of my knowledge and belief. I further acknowledge that any person who knowingly and with the intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

Signature of Proposed Insured

Date Signed



3030 North Rocky Point Drive West, Suite 800
 Tampa, FL 33607
 Phone: (813) 549-0742 Fax: 1-800-572-9384

Authorization for Release of Paramedical Exam Results

All of the information is to be completed by the applicant. Please print using ink. If you make any corrections, please initial at the spot of the correction. Return completed form to the Underwriting Department at Fax: 1-800-572-9384 or Mail:

AVAHEALTH, Inc.
 Attn: Underwriting Department
 3030 N. Rocky Point Drive W.
 Suite #800
 Tampa, FL 33607

APPLICANT INFORMATION			
Last Name	First Name	Middle Initial	
Social Security Number		Date of Birth	
Home Address (Include Apt. #, Lot # or Rte. #)		City	State Zip

A. RELEASE OF RECORDS TO PHYSICIAN OR MEDICAL PRACTICE

I, the undersigned, hereby authorize AVAHEALTH, Inc. to provide the following physician or medical practice with copies of all medical records related to my examination taken during the medical underwriting process of my individual insurance application, including but not limited to the following: all reports and summaries of the paramedical exam, results of all laboratory tests, electrocardiogram, and all notes, correspondence, or other records of any nature concerning me, my conditions or my treatment.

PHYSICIAN OR MEDICAL PRACTICE INFORMATION			
Last Name, First Name OR Medical Practice Name			
Address (Include Apt. #, Lot # or Rte. #)	City	State	Zip

OR

B. RELEASE OF RECORDS FOR PERSONAL REVIEW

I, the undersigned, hereby authorize AVAHEALTH, Inc. to provide to me, for my personal inspection, copies of all medical records related to my examination taken during the medical underwriting process of my individual insurance application, including but not limited to the following: all reports and summaries of the paramedical exam, results of all laboratory tests, electrocardiogram, and all notes, correspondence, or other records of any nature concerning me, my conditions or my treatment. I, the undersigned, do hereby take full responsibility for reviewing and obtaining professional medical interpretation of my records.

CONFIRMATION OF REQUEST FOR PERSONAL REVIEW OF RECORDS	
Signature of Applicant (Parent or Guardian if applicant is under the age of 18)	Date

SIGNATURE

I understand that this authorization will expire 180 days from the date of this signed authorization. A photocopy of the signed original of this "Authorization for Release of Medical Information" shall have the same force and effect as the original and shall be sufficient for the same purposes. I further acknowledge that any person who knowingly and with the intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

 Applicant Signature
 (Parent or Guardian if primary applicant is under the age of 18)

 Date



Authorization for Release of Medical Information (Attending Physician Statement)

All of the information is to be completed by the applicant. Please print using ink. If you make any corrections, please initial at the spot of the correction. Return completed form to the Underwriting Department at Fax: 1-800-572-9384 or Mail:

AVAHEALTH, Inc.
 Attn: Underwriting Department
 3030 N. Rocky Point Drive W.
 Suite #800
 Tampa, FL 33607

APPLICANT INFORMATION			
Last Name	First Name	Middle Initial	
Social Security Number		Date of Birth	
Home Address (Include Apt. #, Lot # or Rte. #)		City	State Zip

RELEASE OF RECORDS TO PHYSICIAN OR MEDICAL PRACTICE		
I, the undersigned, hereby authorize AVAHEALTH, Inc. to provide the following physician or medical practice with a letter regarding the underwriting involved with my application and copies of all medical records related to the medical underwriting process of my individual insurance application, including but not limited to the following: all reports and summaries, results of all laboratory tests, electrocardiogram, and all notes, correspondence, or other records of any nature concerning me, my conditions or my treatment.		
PHYSICIAN OR MEDICAL PRACTICE INFORMATION		
Last Name, First Name OR Medical Practice Name		
Address (Include Apt. #, Lot # or Rte. #)		
City	State	Zipcode
Phone Number	Fax Number	

SIGNATURE

I understand that this authorization will expire 180 days from the date of this signed authorization. A photocopy of the signed original of this "Authorization for Release of Medical Information" shall have the same force and effect as the original and shall be sufficient for the same purposes.

I further acknowledge that any person who knowingly and with the intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

 Applicant Signature
 (Parent or Guardian if primary applicant is under the age of 18)

 Date



Request for Withdrawal of Application for Individual Health Insurance

All of the information is to be completed by the Primary applicant. Please print using ink. If you make any corrections, please initial at the spot of the correction. If more space is needed, attach another sheet. Withdrawal forms must be returned to AVAHEALTH, Inc. within 72 hours of receipt.

Return completed forms to the Underwriting Department at Fax: 1-800-572-9384 or Mail:

AVAHEALTH, Inc.
 Attn: Underwriting Department
 3030 N. Rocky Point Drive W.
 Suite #800
 Tampa, FL 33607

PRIMARY APPLICANT INFORMATION			
Last Name	First Name	Middle Initial	
Social Security Number		Date of Birth	
Home Address (include Apt. #, Lot # or Rte. #)		City	State Zip
Home Phone			

APPLICANT(S) TO WITHDRAW			
I chose to withdraw the application for the following person(s) and plan choice.			
Plan (IFocus or HSA)		Prescription Drug Plan	
Last Name	First Name	Middle Initial	Social Security Number
1			
2			
3			
4			
5			
6			

AUTHORIZATION

I wish to withdraw the application at this time for the aforementioned health insurance plan and person(s). I understand that if I want to resume the underwriting process of my application, I may do so at any time until 60 days from the date on which the original application was signed.

I further acknowledge that any person who knowingly and with the intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

 Primary Applicant Signature
 (Parent or Guardian if primary applicant is under the age of 18)

 Date



AVAHEALTH USE ONLY
Return to _____
Account Name _____

**REQUEST FOR REEVALUATION
CLOSED/WITHDRAWN/DECLINED APPLICATION**

Date _____

Agent Name _____ GA Name _____

Phone Number _____

Primary Applicant Name _____

Reason for request _____

Please fax completed form and other required material to 1-800-572-9384

Application Closed

Within 60 days of original signature

- **An extension of application form may be required.**
- If the application was closed due to outstanding information, the missing information must be provided with this request to renew the individual insurance application.

Past 60 days of original signature

- **A new application will be required.**
- If the application was closed due to outstanding information, the missing information must be provided with this request to renew the individual insurance application.

Application Withdrawn

- **A new application will be required.**
- If the application was withdrawn with outstanding information, the missing information must be provided with this request to renew the individual insurance application.

Application Declined

- **12 months must have passed since the declination of the previous application.**
- **A new application will be required.**
- **Applicant must submit copies of medical records since time of declination**
- If the application was declined with outstanding information, the missing information must be provided with this request to renew the individual insurance application.

Member Policy terminated due to non-payment

- **12 months must have passed since the termination of policy.**
- **A new application will be required.**

Member Policy cancellation (other than non-payment)

- **6 months must have passed since the cancellation of policy.**
- **A new application will be required.**



Return to _____
Account Name _____

Note to Requestor
There may be a charge for copies of the designated record set.

Member Services
P.O. Box 1167
Eatontown, NJ 07724
(866) 469-2347
Fax: (732) 676-2654

Authorization to Release Medical Information

Member Name _____ Date of Birth (mm/dd/yyyy): _____

Former Name (If any): _____ Social Security Number: _____

Daytime telephone number: _____

Information to be released from _____
Member Name

I hereby authorize Avalon Healthcare, Inc. to release the following medical information:

RELATIVE, GUARDIAN or MEDICAL FACILITY

- ELIGIBILITY CLAIMS STATUS/HISTORY PLAN COVERAGE
- BILLING ADDRESS HISTORY MEDICAL HISTORY/RECORDS

AGENT

- ELIGIBILITY CLAIMS STATUS/HISTORY PLAN COVERAGE
- BILLING ADDRESS HISTORY

The purpose for this release of medical information is for:

Information to be released to:

Name of Organization or Person	Street Address	City/State/Zip	Relationship to Member
--------------------------------	----------------	----------------	------------------------

This authorization expires upon 6 months after the execution of this authorization.

If release of medical records is indicated above, I, the undersigned, hereby authorize Avalon Healthcare, Inc. to provide copies of all medical records, including but not limited to the following: all reports and summaries of the paramedical exam, results of all laboratory tests, electrocardiogram, and all notes, correspondence, or other records of any nature concerning me, my conditions or my treatment. I, the undersigned, do hereby take full responsibility for reviewing and obtaining professional medical interpretation of my records.

I understand that if my medical information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information might be re-disclosed and might no longer be protected.

I understand that I have a right to revoke this authorization at any time in writing.

However, a revocation will not be effective to the extent that the health plan or its business associates may already have used or disclosed my protected health information in reliance on the authorization.

I understand that my refusal to sign this authorization will not affect my ability to receive health care through the Health Plan.

Signature of Member or Legally Responsible Party Date

Print Name

If Personal Representative, then provide a description of representative's authority to act for Patient



Note to Requestor
There may be a charge for copies of the designated record set.

Return to _____
Account Name _____

Member Services
P.O. Box 1167
Eatontown, NJ 07724
(866) 469-2347
Fax: (732) 676-2654

Authorization to Release Medical Information

Member Name _____ Date of Birth (mm/dd/yyyy): _____

Former Name (If any): _____ Social Security Number: _____

Daytime telephone number: _____

Information to be released from _____
Member Name

I hereby authorize Sawgrass Plans to release the following medical information:

RELATIVE, GUARDIAN or MEDICAL FACILITY

- ELIGIBILITY CLAIMS STATUS/HISTORY PLAN COVERAGE
- BILLING ADDRESS HISTORY MEDICAL HISTORY/RECORDS

AGENT

- ELIGIBILITY CLAIMS STATUS/HISTORY PLAN COVERAGE
- BILLING ADDRESS HISTORY

The purpose for this release of medical information is for:

Information to be released to:

Name of Organization or Person	Street Address	City/State/Zip	Relationship to Member

This authorization expires upon 6 months after the execution of this authorization.

If release of medical records is indicated above, I, the undersigned, hereby authorize Sawgrass Plans to provide copies of all medical records, including but not limited to the following: all reports and summaries of the paramedical exam, results of all laboratory tests, electrocardiogram, and all notes, correspondence, or other records of any nature concerning me, my conditions or my treatment. I, the undersigned, do hereby take full responsibility for reviewing and obtaining professional medical interpretation of my records.

I understand that if my medical information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information might be re-disclosed and might no longer be protected.

I understand that I have a right to revoke this authorization at any time in writing.

However, a revocation will not be effective to the extent that the health plan or its business associates may already have used or disclosed my protected health information in reliance on the authorization.

I understand that my refusal to sign this authorization will not affect my ability to receive health care through the Health Plan.

Signature of Member or Legally Responsible Party _____ Date _____

Print Name _____

If Personal Representative, then provide a description of representative's authority to act for Patient