Preferred *Provider Plan*

National Financial Professionals of America

Please Print in Black Ink

☐ **I am a new enrollee**
☐ **I am changing my existing coverage**

Applicant Data			
Last Name	**First Name**	**M.I.**	**Social Security Number**

Street Address (Residence)	**City**	**State**	**Zip Code**	**Phone #:** **Business #:** **Fax #:** **Email:**

Date of Birth (MM/DD/YYYY): ____ /____ /_____ **_____Height** **_____Weight** ☐**Male** ☐**Female**

Company

Code: TRG-

TYPE OF COVERAGE: (CIRCLE ONE) M M&SP M&CHILD FAMILY **REQUESTED EFFECT**

PLAN: 80/60 or 90/70 **DATE: ____ / 1 / 200__**

Deductible: $250 $500 $1000

Optional Dental:

☐Gold Plan ☐Silver Plan

Dependent Information (Only if Dependants Are to be Covered)

Dependents from age 19 to 24 are covered only if you submit current proof of full-time student status.

Dependents	Name(Last First, MI)	Social Security #	Sex: (M,F)	Date of Birth: MM/DD/YYYY	Full-time Student
Spouse					Y ☐or N ☐
Child #1					Y ☐or N ☐
Child #2					Y ☐or N ☐
Child #3					Y ☐or N ☐
Child #4					Y ☐or N ☐
Child #5					Y ☐or N ☐

Other Coverage Information

Have you or any of your dependents been covered through any other health plan within the past 60 days? ☐Yes ☐No

If "Yes", please complete: Name of Coverage
Company:_____
Effective Date: _____ Termination Date: _____ Policy or Certificate Number:_____

Type of Coverage: ☐ Employer-Sponsored ☐Individual Coverage was for: ☐ Self ☐ Spouse ☐ Child(ren)

Please attach a copy of your certificate of coverage

Preferred Provider Network: Plan comes with Health Smart/Beech Street Network unless other selection made.

Health Smart/Beech Street **NPPN** **Other: _____**

FOR OFFICE USE ONLY: STATUS_____ EFF _____

PRE EX _____ DATE_____

All Information MUST be completed or a delay in processing will occur

Enroller Name Robert Petralia Enroller Phone Number 888-880-7314 Enroller Writing # TRG-2682

Medical History

Section 1

Please Ch eck box if, in the past 10 years, you and/or any of your dependents been diagnosed with any of the following conditions:

- ☐ Immune System Disease
- ☐ Cancer or Tumors
- ☐ Asthma or Respiratory/Lung Disorders
- ☐ Arthritis/Rheumatism
- ☐ Diabetes
- ☐ Liver Disorder
- ☐ Thyroid / Goiter
- ☐ Alcoholism/Addiction/Drug Abuse
- ☐ Disorder of Eyes, Ears, nose or Throat
- ☐ Epilepsy
- ☐ Transplant
- ☐ Disorders of Digestive System
- ☐ Nervous/Mental/Emotional Disorders
- ☐ Ulcers/Stomach Disorders
- ☐ Spine/Discs/Joints/Back
- ☐ Gall Bladder/Gallstones
- ☐ Kidney Disease/Stones
- ☐ Heart/Blood/Vascular disorders
- ☐ Heart Attack/Stroke/Paralysis
- ☐ Pregnancy

Section 2

Please Circle "Yes" or "No" to all of the following Questions

1. Has any applicant Incurred claims in excess of $2500 in the past 2 years? ☐YES ☐NO
2. Is any applicant receiving treatment, taking medication, or being advised of a condition that will require attention in the next 24 months? ☐YES ☐NO
3. Has any applicant been examined or treated by a physician or been advised by a physician that hospitalization or a surgical procedure is necessary in the future? ☐YES ☐NO
4. Has any applicant been absent from work or school for seven days or more due to illness or injury? ☐YES ☐ NO
5. Has any applicant, in the past 12 months, been prescribed or currently taking any prescription medications? ☐ YES ☐ NO

Please Provide Complete Details of All Checked boxes in Section 1 as well as all YES answers from Section 2.

Name of Individual	**Occurrence/Diagnosis**	**Date Last Treated**	**Prognosis/Treatment**	Recommended/Medications

I HEREBY AGREE that all statements in the Application Form are true to the best of my knowledge and belief and they shall form a part of my Certificate of coverage, which is issued. The Coverage requested in this Application will not be effective until approved by **TRG Administration.** Any misstatements or omission of information made on this Application Form may be the basis for later rescission of my health coverage. Rescission voids my coverage. No payments will be nude for any claims submitted, whether or not the treatment was related to the condition for which the information was omitted or misstated. Premiums already paid will be refunded. I acknowledge that along with the Major Medical Expense Plan, them is a Hospital Certification Program This Program requires pre-certification for all hospital confinements. **I AUTHORIZE release** of medical information pertaining to myself and all eligible dependents to **TRG Administration,** or their representatives for compliance with the Hospital Certification Program requirements. I UNDERSTAND that failure to participate and comply with the Hospital Certification Program may result in a penalty reducing my plan benefits. **THIS AGREEMENT** (or a photographic copy) authorizes any licensed doctor, medical practitioner, hospital, clinic, or other medical or medically related facility, coverage company, consumer reporting agency, or other organization, institution or person that has any records or knowledge or me (us) or my (our) health, to give any such information. This authorization is valid for one year and six months from the date shown below.

I UNDERSTAND that the coverage applied for may not pay benefits for any loss incurred during the first year after the Effective Date on account of a disease or physical condition which I/we have or have had in the past. The employer health plan being administered by TRG Administration is a fully self-funded plan formed and operated in accordance with the Federal Employee Retirement Income Security Act of 1974 (ERISA).

__ /__ / ____ Date Signed _____Signature of Applicant

Only original applications will be processed

First months Contribution must be attached and made payable to- TRG Administration,

Mail to: Health Care Quotes.com® 1039 Isabella Ave. Coronado, CA 92118