



Administered by BMI P.O. Box 1090 Great Bend, Kansas 67530 Toll-Free number 1-877-888-NHHP(6447)

SUPPLEMENTAL FAMILY COVERAGE FOR MANAGED CARE OPTION H

| | | | | | | |
|---|-------|--------|--------------------------|---|--|--------------|
| Reason for completing form: <input type="checkbox"/> Add new family member <input type="checkbox"/> Remove family member (Note: any person who is removed from coverage cannot be reinstated for one year) | | | | | | |
| Effective date: _____ (must be 1 st of month following the date of this application) | | | | | | |
| Primary Policyholder Information: | | | | | | |
| NAME: _____ | | | HOME PHONE: _____ | | | |
| Last | First | Middle | | | | |
| ADDRESS: _____ | | | City | State | Zip | |
| Street / P.O. Box | | | | | | |
| Last | First | Middle | Birth Date | Sex | Non-Smoker | Relationship |
| Primary Policyholder | | | Month, Day, Year | M <input type="checkbox"/> F <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Spouse or Partner to a Civil Union | | | | M <input type="checkbox"/> F <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Dependent | | | | M <input type="checkbox"/> F <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Dependent | | | | M <input type="checkbox"/> F <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Dependent | | | | M <input type="checkbox"/> F <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| Dependent | | | | M <input type="checkbox"/> F <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> | |

Non-Tobacco User Discount: If Yes, you must complete the Non-Tobacco User Affidavit

The deductible and out-of-pocket maximums are limited to 2 times the individual amounts for the family.

- Each family member must separately meet the \$5,600 individual deductible (until the family reaches \$11,200 as stated below)
- After any given family member satisfies the \$5,600 individual deductible, benefits are paid at 100% for that individual
- After the family has satisfied an aggregate of \$11,200 family deductible limit, then benefits are payable at 100% for all members of the family insured

(See Policy Plan for complete details.)

The premium for the additional family dependent is calculated as follows:

- For a family with 2 adults, a factor of 0.91 is applied to the adult rates
- For a family with one or more children insured:
 - The applicable child rate of \$63 per child (ages 0 – 18) insured is added to the adult rate
 - For children age greater than 18, a factor of 0.91 is applied to the adult rates
 - Dependent children under the age of 26 may also be covered under this policy. For the purposes hereof, “dependent” means your child by blood or by law, who: (1) is less than 26 years of age; (2) is unmarried; (3) is a resident of New Hampshire or is enrolled as a student at a public or private institution of higher education; and (4) is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, or entitled to benefits under Title XVIII of the Federal Social Security Act, Public Law 89-97, 42 U.S.C. 1395 et seq.

I represent that my answers and statements on this application are true and complete to the best of my knowledge. I understand that if they are not, my policy may not be valid and I may be subject to prosecution for insurance fraud. I understand that all hospitalizations and certain other procedures as specified in my policy must be precertified (except on an emergency basis) or benefits will be reduced. I authorize providers of health care to furnish the Administrator with medical information to the extent necessary for processing this application or claims.

Policyholder's Signature _____ Date _____



Non-Tobacco User Affidavit

Under penalty of perjury, I declare that I neither (i) presently smoke or use tobacco products, nor (ii) have smoked or used tobacco products at any time during the 12 months immediately preceding the date of this affidavit. I understand that if I falsely claim the non-tobacco user discount on my application for insurance, I am subject to prosecution under applicable laws (the penalties for a false claim may include criminal charges and/or fines), an obligation to pay the additional premium required of tobacco users and the denial of any claim under the insurance policy for which I am applying.

“Smoke or use tobacco products” for purposes of this affidavit means any use of cigarettes, pipes, cigars or any other tobacco products regardless of the number of times, frequency or method of use.

I, the applicant, have read the above and understand the penalties that may apply if my statements are false.

Date: _____ Printed Name: _____ Signature: _____

For applicants under the age of 18: I am the custodial parent / legal guardian of the applicant. Under penalties of perjury, I declare that the above statements of or on behalf of the applicant are true.

Date: _____ Printed Name: _____ Signature: _____