THE IHC GROUP
Independence Holding Company

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Email Application

Eligibility

Please answer the following eligibility questions before you begin.

Current Plan Details

Applicants
Applicant (51 year old male)
Spouse (46 year old female)
Number of Children (3)

State/Zip
Ohio/45036

Payment
Monthly

Effective Dates
Short-Term Medical: 11/21/2018

Change Your Information
New Quote

* Required

Short-Term Medical

Eligibility

Please answer the following medical questions for all individuals, including dependents, applying for coverage:

Please be aware that any misstatements and omissions may be a material misrepresentation and a basis for rescission of your coverage. In the event of a rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) any claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

*** Will any person to be covered be eligible for a government sponsored health insurance plan (Medicare or Medicaid)?**

Yes / No

*** Are you or is any immediate family member (whether named or not named in this enrollment form) pregnant, an expectant parent, in the process of adopting a child, or undergoing fertility treatment?**

Yes / No

*** Are you or any person applying for coverage currently over 300 pounds if male or 250 pounds if female OR has anyone to be insured undergone weight loss or bariatric surgery?**

Yes / No

*** WITHIN THE LAST 5 YEARS, HAS ANY PERSON LISTED ON THIS APPLICATION RECEIVED ANY MEDICAL OR SURGICAL ADVICE, CONSULTATION OR TREATMENT, INCLUDING MEDICATION, FOR:**

- **Stem cell transplant**
- **Heart disorder, heart attack, coronary artery disease or circulatory system disorder (includes by-pass or stent surgery or carotid artery disease/surgery**
- **Stroke, seizures disorder or other neurological disorder**
- **Cancer or tumor OR taking medication to prevent recurrence of cancer or tumorous growth**
- **Paraplegia, quadriplegia or multiple sclerosis**
- **Emphysema, chronic bronchitis or COPD (chronic obstructive pulmonary disease)**
- **Insulin dependent diabetes**
- **Kidney disorder other than stones and/or liver disease**
- **Degenerative arthritis (degenerative disc disease, herniated disc, rheumatoid or psoriatic arthritis or degenerative joint disease)**
- **Alcohol or drug abuse or dependency OR chemical dependency**

Yes / No

*** Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, OR any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS.**

Yes / No

Information is saved each time you click continue

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