SummaCare℠
Health Insurance

Individual & Family Application Form

This plan is underwritten by the Summa Insurance Company and administered by SummaCare. Failure to complete all sections may delay coverage date.
Please complete in blue or black ink only.

Requested plan: _____

Requested effective date of coverage: _____

Requesting an effective date does not guarantee that date. Coverage is not effective until it is approved by Summa Insurance Company and you are notified in writing.

INTERNAL USE ONLY: Actual effective date of coverage: _____

Contract Number: _____

Name: _____

Social Security Number: _____ **Date of Birth (MM/DD/YY):** _____

Gender: _____ **Smoker:** ◯ Yes ◯ No **U.S. Citizen:** ◯ Yes ◯ No

Marital Status: ◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Legally Separated

Physical Address (Number/Street): _____

City: _____ **State:** _____ **ZIP:** _____ **County:** _____

Mailing Address (Number/Street, leave blank if same): _____

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Cell Phone: _____ **Alternate Phone:** _____

Email Address: _____

◯ I understand that by providing an email address I am consenting to receive communications (including policy information) by electronic mail.

Are you of Hispanic, Latino or Spanish origin?: ◯ Yes ◯ No

Please list your race/ethnicity: _____

Broker Name: _____ **NPN #:** _____

Primary Care Provider (PCP) is: _____

Type of Coverage Selected (check one):

◯ For you only ◯ For you and your spouse ◯ For you and your children
◯ For you, your spouse and your children ◯ Child(ren) only

SummaCare Coverage History (check one):

◯ I am applying for new coverage
◯ I am an existing policyholder applying for a different policy. My policy # is: _____
◯ I am an existing policyholder applying to add dependent(s) to my current policy.
My policy # is: _____
◯ I am a former member of Summa Insurance Company/SummaCare

Dependent Information

Complete the following information for any dependents you would like covered. If the addresses of any of the following individuals are different from the address above, please list the names and addresses on a separate sheet and attach them to the application form.

Last Name	First Name	MI	Relationship (Child/Step/Other)	Social Security Number	Date of Birth (MM/DD/YY)	Gender	Smoker (Y/N)	Citizen (Y/N)

Billing Information

Complete the following information for billing purposes. Select your payment method by completing the appropriate section below.

Monthly Premium Payment Amount: $_____

◯ **Monthly Billing by Check:** Initial premium will not be billed and must be paid at time of approval. **Please attach/enclose check.**

◯ **Direct Debit from Checking or Savings Account:** If possible, include a voided check to eliminate discrepancies in account information. Payment will be drawn on the due date listed on the invoice for the current monthly premium and any past due premiums.

Check one: ◯ One time (If making a one-time payment, payment is taken upon receipt of the form.) ◯ Recurring

Check one: ◯ Checking account ◯ Savings account

For new policy holders, your one-time initial payment must be received before you can set up recurring payments.

Routing Number (nine digits):_____ Account Number:_____
Bank Account Holder's Name:_____
Financial Institution's Name and Branch:_____
Financial Institution's Address:_____
City: _____ State: _____ Zip: _____ County: _____

Account Holder's Signature:_____ **Date:** _____

◯ **Direct Debit from Credit or Debit Card:**

Check one: ◯ One time ◯ Recurring **Check one:** ◯ Visa ◯ Mastercard ◯ Discover

Card Number:_____ Expiration Date:_____CVV:_____
Cardholder's Name:_____

Cardholder's Signature:_____ **Date:** _____

Company Name: SummaCare, Inc. / Company ID Number: 34-1726655

I hereby authorize SummaCare, Inc., called SummaCare, and the financial institution issuing the account, credit or debit card named above, to initiate electronic draw, debit or credit transactions to my account. I acknowledge that the origination of automatic withdrawal, credit or debit card transactions to my account must comply with the provision of U.S. Law.

- If the individual cannot sign, a court-appointed Legal Guardian or person with Durable Power of Attorney (DPA), if authorized by state law, must sign this document. Attach a copy of proof of Legal Guardian, DPA or proof of authorization by state law.
- My signature also indicates my acknowledgement that it is my responsibility to update SummaCare, Inc. of such changes to my credit or debit card expiration date or any other changes which would result in nonpayment or a delay in payment to SummaCare, Inc. by my credit or debit card provider.
- **Payment will be drawn on the due date listed on the invoice for the current monthly premium and any past due premiums**. This authority will remain in full force and effect until SummaCare has received written notification from me of its termination in such time and manner as to afford SummaCare and the financial institution issuing the account a reasonable opportunity to act upon it. Submit an updated auto debit form one-month prior to credit or debit card expiration to avoid an interruption in service.

Terms and Conditions

1. You, or your legal representative, authorize your information to be provided to SummaCare and its underwriters for the purpose of developing a rate for insurance coverage. You agree that this authorization will remain valid for 30 days from the date of the application. An individual or person authorized to act on your behalf, you or your authorized representative, is entitled to receive a copy of the authorization form.
2. Personal health information may be released without your consent by order of a court with appropriate jurisdiction. SummaCare warrants that any other person and/or entity that receives information from SummaCare sign a confidentiality agreement which requires them to abide by and release information in accordance with SummaCare's confidentiality policies and procedures.
3. You understand and agree that SummaCare will rely upon the information provided in this application as the basis for establishing premium rates for health care coverage. You acknowledge that you may be required to complete and sign an additional authorization form.
4. You agree that benefits payable on your account or your dependent's account under your medical benefit plan will be paid directly to the provider of care.
5. You understand that no benefits shall take effect until this application is approved for SummaCare participation. Upon acceptance, as soon as possible, a SummaCare identification card(s) will be issued to you as evidence of coverage hereunder. Upon termination, all identification card(s) received must be destroyed.
6. If there is a payroll, disability or pension deduction for your enrollment in SummaCare, you authorize it to be made.

You have the right to cancel this policy until midnight of the 10th day after the date on which you received the policy, by returning the policy to SummaCare or our agent. No reason needs to be stated for the cancellation. The policy is deemed returned if, by the 10th day, you mail the policy to SummaCare or our agent delivers or causes the delivery of the policy to SummaCare or our agent. The coverage under the policy shall be in force for any period prior to its return. You will be refunded any paid premium, less a prorated share while the policy was in effect.

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

By signing this application, you are attesting that you have reviewed the Summary of Benefits and Coverage Document (SBC) applicable to your plan. If you need a copy of the SBC for the plan in which you are applying, please contact SummaCare Member Services at **800.996.8701 (TTY: 711)** or visit **summacare.com**.

Applicant Signature:_____ Date: _____

Spouse Signature:_____ Date: _____

Dependents over 18 years of age must sign below.

Dependent Signature:_____ Date: _____

Dependent Signature:_____ Date: _____

Dependent Signature:_____ Date: _____

Dependent Signature:_____ Date: _____

SummaCare
ATTN: Eligibility
P.O. Box 3620
Akron, OH 44309
330.996.8671 or 833.443.1808 (TTY 711)
summacare.com