ALTERNATE APPLICATION AUTHORIZATION

INSTRUCTIONS:

IF YOU ARE SUBMITTING AN APPLICATION FROM ANOTHER CARRIER
AS A SUBSTITUTE FOR THE **QUALCHOICE EMPLOYEE APPLICATION**
THIS FORM MUST BE COMPLETED, SIGNED, AND ATTACHED TO THE ALTERNATE APPLICATION.

I, hereby, authorize QualChoice to use the attached application as a substitute for the QualChoice Employee Application including all questions and answers relating to medical conditions, treatment and use of prescription drugs. The undersigned understands submission of attached application containing a materially false statement; misrepresentation or omission may constitute insurance fraud and may result in termination or rescission of coverage. The undersigned also understands the statement included below replaces any statement of understanding in the attached application:

"In signing below, I: (a) represent that the statements and answers given in this application (or any attachment hereto) are true, complete and correctly recorded to the best of my knowledge and belief; (b) authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company having Protected Health Information with respect to any physical or mental condition or treatment on me or any member of my family (if applicable), to give QualChoice, its respective agents, affiliates, reinsurers, appropriate reporting agencies or legal representatives any and all such information to use for underwriting or claims purposes; (c) understand that QualChoice may deny coverage if you do not authorize us to obtain any additional Protected Health Information; (d) understand that if QualChoice approves coverage, the Protected Health Information received will become a part of my record with QualChoice and, further, if QualChoice denies coverage, QualChoice will not use, disclose or retain the Protected Health Information except as required or authorized by law; (e) agree that a photocopy of this authorization shall be as valid as the original, and I understand that a copy is available to me upon request. I understand that any fraudulent statement, omission, or material misrepresentation may result in QualChoice terminating or rescinding (voiding) any coverage, including dependent coverage, issued in reliance thereon, and that QualChoice may recover any monies and damages incidental and consequential that result."

I acknowledge my understanding that consistent with the requirements of the **Genetic Information Nondiscrimination Act of 2008**, QualChoice does not use genetic information for underwriting purposes or any other purpose prohibited by applicable law. I also acknowledge that QualChoice has requested that in answering the questions in the attached application I do not include any family medical history or information related to genetic testing, genetic services or genetic counseling. Also, QualChoice has requested that I do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information. I further acknowledge that QualChoice has directed me to omit or remove from the attached application any genetic information.

Print Name of Applicant	Signature of Applicant	Date

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