10.	**Prescriptions / Medications –** List any medications, prescriptions, or injections taken in the last 12 months				
	Family Member Name	**Medication / Rx / Injection**	**Dosage**	**Medical Condition**	**Currently Taking?**
					Yes **No**
					Yes **No**
					Yes **No**
					Yes **No**
					Yes **No**
					Yes **No**
					Yes **No**

(As Necessary, Please Attach Additional Sheets, Signed and Dated by the Employee Subscriber.)

SECTION 7: AGREEMENTS, AUTHORIZATION & ATTESTATION

Agreements

The answers and statements on this Employee Health Application are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its home office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract. I agree to disclose any updates to the answers and statements on this Employee Health Application that may arise prior to the effective date of my coverage.

Fraud Warning

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Medical Authorization

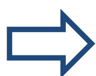
I hereby authorize my health plan, healthcare provider, and their applicable business associates to disclose my Protected Health Information (“PHI”) to Medova Healthcare Financial Group, LLC and Medova’s respective carriers. I authorize Medova Healthcare and Medova’s respective carriers to assist me in obtaining health care services, payment information, or account resolution. Medova Healthcare and Medova’s respective carriers will not use this information for any purposes other than underwriting, eligibility, precertification and authorization, utilization management, case management, disease management, and patient advocacy services. PHI includes the following: enrollment, claims, payment, or managed-care information.

Unless otherwise revoked in writing, this authorization will commence on the date indicated below and will expire twenty-four months from the date below. I understand that:

- Information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 C.F.R. Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 C.F.R. Part 164), and the Privacy Act of 1974 (5 U.S.C. § 552a).
- I may revoke the authorization at any time by giving written notice of the revocation to Medova Healthcare Financial Group, LLC at 8300 E. Thorn Drive, Suite 300, Wichita, KS 67226. Revocation of this authorization will not affect any action that Medova Healthcare, Medova’s respective carriers, or any duly authorized representatives, have taken reliance on this authorization before my written notice of revocation was received.
- Medova Healthcare Financial Group LLC provides administrative and informational services for our respective carriers only and does not provide health insurance or medical services, nor does either recommend or endorse any treatment.

Acknowledgement & Attestation

In the event that I enroll in the Plan under Medova’s Lifestyle Health Plan product, I understand that the aforementioned authorization will remain in force as it relates to the normal functions and duties of Medova in conducting its administrative, care coordination, member services, and population health duties and responsibilities. I also hereby agree to abide by the terms and conditions of the summary plan documents which consist of the employee benefit booklet and schedule of benefits and contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. I hereby acknowledge that I may obtain a copy of these documents from my employer directly. Upon request, a customer service representative can explain my benefit coverage options.



Employee Signature: ______________________________ **Date:** ____________________

SECTION 8: CONSENT TO ELECTRONIC DISCLOSURE OF PLAN MATERIALS

Under the Employee Retirement Income Security Act of 1974 (ERISA) and related regulations, employee consent must be given in order to receive electronic copies of employee benefits materials in certain situations. Unless I "OPT OUT," as described below, I hereby consent to receive:

(i) an electronic version of the Summary Plan Documents, Summary of Benefits and Coverage, HIPAA Portability Notice, HIPAA Privacy Notice, and other DOL, HHS, or IRS required participant notices and summaries; and

(ii) an electronic version of my claims information, including explanation of benefits (EOBs).

I understand and acknowledge that the Plan materials listed above will be available to me (and any dependents enrolled in the Plan) on the online web portal to which I will need to establish electronic access and, further, that I will receive electronic notice at the email address provided by me (or any enrolled dependent, as applicable) whenever such Plan materials become available via the online web portal.

I acknowledge, further, that I have access to email at the address provided by me, as well as access to the Internet and the ability and the necessary equipment and software to view, read, and print documents in the Adobe Portable Document Format (.pdf).

I understand that I can request a paper copy of these documents, update my contact information, and/or withdraw this authorization at any time (all without charge) by contacting Medova (with respect to EOBs and other claims information) or my employer directly (with respect to all other disclosures listed above).

I understand that I will have the opportunity to "OPT OUT" of receiving the communications described above in electronic form. (*Note, if you do not have access to email, do not have access to the Internet, or do not have the programs necessary to view .pdf files, you should "opt out" of electronic disclosure when given the opportunity to do so.*)

I have read and understand all of the above conditions, acknowledgements, and declarations and attest to the above statements.

Employee Signature: ____________________________________ **Date:** __________________

SECTION 9: EMPLOYEE AUTHORIZATION FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize the above-referenced Plan and any entities that provide services to such Plan to disclose certain protected health information about me to Medova Healthcare Financial Group, LLC ("***Medova***").

The Plan or any entities providing services to it are hereby authorized to disclose to Medova any protected health information from my medical records as is requested by Medova solely for the purpose of cost analysis, pricing, and/or underwriting.

I understand that this request does not apply to: (1) certain health information that is not held in the records of the Plan or any entities providing services to it; (2) psychotherapy notes (i.e., notes documenting or analyzing the contents of a conversation during a counseling session that are maintained separate from the rest of my medical record); (3) information compiled in reasonable anticipation of or for litigation; and (4) other health information not subject to the right of access under HIPAA.

The information may be disclosed to Medova to assist me in obtaining health care services. Medova will not use this information for any purposes other than cost analysis, pricing and/or underwriting.

This authorization will expire two (2) years after the date of its execution, unless expressly revoked by me at an earlier time.

- I understand that the Plan or any entities providing services to it may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
- I understand that if my protected health information is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.
- I understand that I may revoke this authorization at any time by delivering a revocation in writing to Medova Healthcare Financial Group, LLC at 8300 E. Thorn Drive, Suite 300, Wichita, KS 67226. If I revoke this authorization, it will have no effect on actions already taken by the Plan or Medova in reliance on this authorization.

I authorize the disclosure described herein. I have read and understand this authorization. I am the employee listed on this authorization.

Employee Signature: ________________________________ **Date:** _______________

Employee Printed Name: ____

EMPLOYEE OR EMPLOYEE'S REPRESENTATIVE ENTITLED TO RECEIVE A SIGNED COPY OF THIS AUTHORIZATION UPON REQUEST