

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly.

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: LifeWise of Arizona

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...



Arizona Individual Enrollment Application

M.S. 295
P.O. Box 91120
Seattle, WA 98111-9220



Please read all accompanying materials before completing this application. **All questions must have complete and accurate answers.** Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage. Please **PRINT**, sign and date in ink. You must be a resident of the state of Arizona and not eligible for Medicare to apply.

SECTION 1 – TYPE OF APPLICATION

- New Enrollment Application: Requested effective date: _____ (month) 1st 15th
For new enrollments, applications postmarked by the 14th day of the month, and approved, will be effective on the 15th of the same month.
Applications postmarked by the last day of the month, and approved, will be effective on the first day of the following month.
- Plan Change (from and to a current LifeWise plan): Subscriber ID# _____
- Adding Spouse: Subscriber ID# _____ Date of Marriage: ____/____/____
- Adding Child: Subscriber ID# _____ Newborn Adoption Date of birth / placement ____/____/____
- Adding Child: Legal Ward/Guardianship/Medical Child Support Order Date of Order ____/____/____ (attach copy of court order)

SECTION 2 – PRIMARY APPLICANT, SPOUSE & DEPENDENT INFORMATION

Name (26 character max.) (Last, First, Middle Initial)	Social Security #	Gender (M/F)	Height (Ft. In.)	Weight	Date of Birth (MM/DD/YYYY)	Relationship to Subscriber
					/ /	SELF
					/ /	LEGAL SPOUSE
					/ /	DEPENDENT CHILD (under 25 only)
					/ /	DEPENDENT CHILD (under 25 only)
					/ /	DEPENDENT CHILD (under 25 only)
Home Address (not P.O. Box) <i>required</i>	City / State / ZIP				County	Home Telephone Number ()
Mailing Address (if different from Home Address)	City / State / ZIP				County	Work Telephone Number ()
Billing Address (if different from Mailing Address)	City / State / ZIP				County	Cell Telephone Number ()

SECTION 3 – BENEFIT PLAN SELECTION

1. Passport 500 / 20 / 2000 1000 / 20 / 2500 1500 / 20 / 2500 2500 / 30 / 3000 5000 / 30 / 3000
2. Essentials 20 2500 / 20 / 3000 5000 / 20 / 3000
- The following are Health Savings Account (HSA) Eligible Plans:**
3. HSA 20 (Individual) 1250 / 20 / 3750 1700 / 20 / 3300 2500 / 20 / 2500
4. HSA 20 (Family) 2500 / 20 / 7500 3400 / 20 / 6600 5000 / 20 / 5000
5. LifeWise HSA (Individual) 5000 / 0 / 0
6. LifeWise HSA (Family) 10,000 / 0 / 0

SECTION 4 – ELIGIBILITY

To be eligible for coverage, applicants:

- Must be a resident of Arizona and have your principal residence located in Arizona.
- Must not be entitled to Medicare (including entitlement due to disability):
 - If over 65 years of age and not eligible for Medicare, attach a “not eligible for Medicare document” from the Social Security Administration.

SECTION 5 – RATE/BILLING INFORMATION

PAYMENT OPTIONS: Select One

- Monthly Billing
- Monthly Automatic Funds Transfer (Complete Section 6.)

SECTION 6 – AUTOMATIC FUNDS TRANSFER AUTHORIZATION

I have selected the Automatic Funds Transfer (AFT), and I hereby authorize LifeWise Health Plan of Arizona (LifeWise) to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

Financial Institution or Bank Name:	Bank Routing Number:
Account Holder’s Name (print):	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
City, State, ZIP:	Account Number:
9-digit number at bottom of check (for checking account) or deposit slip (for savings account)	
Additional Terms and Conditions:	
<ul style="list-style-type: none"> ➤ Funds are to be transferred on the 1st business day of each month or as soon thereafter as practical, paying for that month’s coverage. (For example: The deduction on January 1st pays for coverage in January.) ➤ I understand that if I have chosen an effective date of the 15th of the month, the initial transfer will be for the initial pro-rated month PLUS the first full month’s subscription charge. Subsequent transfers will be for single months. ➤ I understand that this Automatic Funds Transfer Authorization will remain in effect until LifeWise has received notice from me that it should be cancelled. To ensure prompt cancellation of my Automatic Funds Transfer, this notice must be submitted at least 20 days prior to my next scheduled transfer. I have the right to stop payment of a specific transfer from my depository financial institution at least 3 days before the next scheduled withdrawal date. ➤ It may take as long as 45 days to set up an AFT. You may receive an invoice to cover initial month(s). 	
<i>Please enclose a voided check (for checking account) or deposit slip (for savings account) from the account TO BE DEDUCTED.</i>	
Signature of Account Holder: X _____ Date (MM/DD/YYYY): ____ / ____ / ____	

SECTION 7 – ELIGIBILITY FOR INDIVIDUAL PORTABILITY COVERAGE

If your employer provided group health coverage or your COBRA continuation coverage terminated within the past 63 days, you may be eligible for Individual Portability Coverage. This coverage does not require medical underwriting and there is no pre-existing condition waiting period. In order to qualify for this coverage, you must meet specific criteria. To determine if you qualify for this coverage, you must also complete the “Eligibility for Individual Portability Coverage Questionnaire.”

Are you applying for Portability Coverage? Yes No

If you answered “Yes,” an “Eligibility for Individual Portability Coverage” questionnaire must be completed.

SECTION 8 – PRIOR or CURRENT COVERAGE

Do you have health insurance coverage currently? Yes No

If you answered “yes,” what is the name of your insurance carrier? _____

What type of coverage is it? Group Individual Other (explain) _____

SECTION 9 – HEALTH QUESTIONNAIRE

In the past 10 years, have you or any family member listed on this application experienced symptoms, been advised of, diagnosed with, received treatment or had treatment recommended for any of the following conditions?

Please check each item either Yes or No	Yes <input type="checkbox"/>	No <input type="checkbox"/>
1. Alcohol or Drug Abuse / Dependence		
a. Alcohol / Chemical / Drug / DUI	<input type="checkbox"/>	<input type="checkbox"/>
2. Autoimmune Disorders		
a. Lupus / Scleroderma / Mixed	<input type="checkbox"/>	<input type="checkbox"/>
3. Bleeding / Blood / Circulatory Disorders		
a. Anemia / Bleeding / Hypercoagulation	<input type="checkbox"/>	<input type="checkbox"/>
b. Blood Disorder (TCP, etc.) / Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
c. Aneurysm / Impaired Circulation	<input type="checkbox"/>	<input type="checkbox"/>
d. High Cholesterol, Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
e. Hypertension (Last: ____/____)	<input type="checkbox"/>	<input type="checkbox"/>
f. Phlebitis / Clots / Raynaud's / PVD	<input type="checkbox"/>	<input type="checkbox"/>
4. Congenital Conditions		
a. Congenital Disorder / Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>
5. Ear / Nose / Throat / Eye		
a. Ear Infections (# ____ past yr.) / Tubes	<input type="checkbox"/>	<input type="checkbox"/>
b. Nasal Malformation / Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>
c. Nasal Polyps / Sinusitis / Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
d. Crossed Eyes / Strabismus	<input type="checkbox"/>	<input type="checkbox"/>
e. Retina / Macular: Detach, Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
f. Cataract(s) / Lens Implants / Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
6. Gastrointestinal Conditions		
a. Swallowing Problems / GERD / Reflux	<input type="checkbox"/>	<input type="checkbox"/>
b. Ulcers / Chronic Abd. Pain / Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>
c. Diverticulitis / Hemorrhoids / IBS	<input type="checkbox"/>	<input type="checkbox"/>
d. Ulcerative Colitis / Crohn's / Colitis	<input type="checkbox"/>	<input type="checkbox"/>
e. Hernia (Specify type) / Polyps	<input type="checkbox"/>	<input type="checkbox"/>
f. Weight gain or loss > 10 lbs. within 1 yr.	<input type="checkbox"/>	<input type="checkbox"/>
7. Glandular or Hormonal Disorders		
a. Diabetes / Elevated Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>
b. Goiter / Nodule / Thyroid: Hyper / Hypo	<input type="checkbox"/>	<input type="checkbox"/>
c. Adrenal / Pituitary Condition	<input type="checkbox"/>	<input type="checkbox"/>
8. Heart Conditions		
a. Angina / Chest Pain / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
b. Arterio-Atherosclerosis / Coronary Artery Disease / Congestive Failure	<input type="checkbox"/>	<input type="checkbox"/>
c. Heart Murmur / Arrhythmia / Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
d. Valve Disorder (Specify type, cause)	<input type="checkbox"/>	<input type="checkbox"/>
9. Immune Disorders		
a. AIDS / AIDS Related Complex / HIV	<input type="checkbox"/>	<input type="checkbox"/>
10. Kidney/Bladder Conditions		
a. Bladder: Infections / Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
b. Kidney Infections / Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
c. Kidney Failure / Nephritis	<input type="checkbox"/>	<input type="checkbox"/>
11. Liver Conditions		
a. Hepatitis A / B / C / Other	<input type="checkbox"/>	<input type="checkbox"/>
b. Cirrhosis / Liver Failure	<input type="checkbox"/>	<input type="checkbox"/>

Please check each item either Yes or No	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Musculoskeletal Conditions		
a. Chronic Back or Neck Pain / Strain	<input type="checkbox"/>	<input type="checkbox"/>
b. Disc Problems / Bone spurs	<input type="checkbox"/>	<input type="checkbox"/>
c. Arthritis / Rheumatoid / Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
d. Fibromyalgia / Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
e. Muscular Dystrophy / Polio Residuals	<input type="checkbox"/>	<input type="checkbox"/>
f. Tendon / Joint: Inflammation / Gout / Carpal Tunnel / Replacement (Specify site)	<input type="checkbox"/>	<input type="checkbox"/>
g. Foot Disorder / Bunions / Hammertoe	<input type="checkbox"/>	<input type="checkbox"/>
h. Fractures (Specify site, hardware present)	<input type="checkbox"/>	<input type="checkbox"/>
i. Gait Abnormality / Loss of Limb(s)	<input type="checkbox"/>	<input type="checkbox"/>
j. Chronic Pain / Decreased Motion	<input type="checkbox"/>	<input type="checkbox"/>
13. Mental Health Disorders		
a. Schizophrenia / Bipolar / Psychosis	<input type="checkbox"/>	<input type="checkbox"/>
b. Depression / Anxiety / Suicide Attempt	<input type="checkbox"/>	<input type="checkbox"/>
c. Anorexia / Bulimia	<input type="checkbox"/>	<input type="checkbox"/>
d. Attention Deficit Hyperactivity Disorder	<input type="checkbox"/>	<input type="checkbox"/>
14. Neurological Conditions		
a. Brain Injury / Seizures / Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
b. Stroke / TIA / Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
c. Headaches (Recurrent or Migraine)	<input type="checkbox"/>	<input type="checkbox"/>
d. MS / Alzheimer's / Huntington's / ALS / Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
e. Meningitis / Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>
f. Developmental delay (Specify type, cause)	<input type="checkbox"/>	<input type="checkbox"/>
15. Organ		
a. Transplant (Previous or pending)	<input type="checkbox"/>	<input type="checkbox"/>
b. Critical Organ Cyst / Tumor (i.e., brain)	<input type="checkbox"/>	<input type="checkbox"/>
c. Cancer (Specify type, location, extent)	<input type="checkbox"/>	<input type="checkbox"/>
16. Reproductive System Conditions		
a. Menstrual Irregularity / Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
b. Breast Disorder / Fibrocystic / Implant	<input type="checkbox"/>	<input type="checkbox"/>
c. Abnormal Pap Smear / Dysplasia	<input type="checkbox"/>	<input type="checkbox"/>
d. Endometrial / Uterine / Cervix Disorders	<input type="checkbox"/>	<input type="checkbox"/>
e. Ovarian / Testicular: Cyst / Torsion	<input type="checkbox"/>	<input type="checkbox"/>
f. Prostate Problems / Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
17. Respiratory Conditions		
a. Allergies / Asthma / Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
b. Chronic Bronchitis / Pneumonia / TB	<input type="checkbox"/>	<input type="checkbox"/>
c. Lung Clot / Collapsed Lung	<input type="checkbox"/>	<input type="checkbox"/>
d. Chronic Obstructive Lung Diseases	<input type="checkbox"/>	<input type="checkbox"/>
18. Sexually Transmitted Diseases		
a. Genital Herpes / HPV / Other	<input type="checkbox"/>	<input type="checkbox"/>
19. Skin Conditions		
a. Burns / Scars / Acne / Ulcers (Specify site)	<input type="checkbox"/>	<input type="checkbox"/>
20. Specify other condition(s) not listed above:		
a.		
b.		

21. If you have answered "yes" to ANY of the previous questions or have experienced any other health issues, complete this question.

Instructions: Include complete details including site, cause, and extent of condition. Attach additional sheet if needed. You may wish to submit copies of relevant medical records to expedite the process (at your own expense).

#	Name	Dates	Describe Condition	Provider	Current Status	Follow Up
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? <input type="checkbox"/> No, resolved OR <input type="checkbox"/> Yes, persists	Future Care? <input type="checkbox"/> No, completed OR <input type="checkbox"/> Yes, future surgery or treatment
		End Mo ___ Yr ___	Treatment	Hospital	(Describe):	(Describe type, reason):
				___ Days		
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? <input type="checkbox"/> No, resolved OR <input type="checkbox"/> Yes, persists	Future Care? <input type="checkbox"/> No, completed OR <input type="checkbox"/> Yes, future surgery or treatment
		End Mo ___ Yr ___	Treatment	Hospital	(Describe):	(Describe type, reason):
				___ Days		
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? <input type="checkbox"/> No, resolved OR <input type="checkbox"/> Yes, persists	Future Care? <input type="checkbox"/> No, completed OR <input type="checkbox"/> Yes, future surgery or treatment
		End Mo ___ Yr ___	Treatment	Hospital	(Describe):	(Describe type, reason):
				___ Days		
		Start Mo ___ Yr ___	Diagnosis	Practitioner	Condition Present? <input type="checkbox"/> No, resolved OR <input type="checkbox"/> Yes, persists	Future Care? <input type="checkbox"/> No, completed OR <input type="checkbox"/> Yes, future surgery or treatment
		End Mo ___ Yr ___	Treatment	Hospital	(Describe):	(Describe type, reason):
				___ Days		

22. No Yes Has anyone listed on this application taken medications within the past year? If yes:

Name	Medication (name, dose, duration)	Prescriber	Diagnosis

23. No Yes Has any insurance company refused or restricted any insurance coverage for you or any person listed on this application? If yes, explain:

24. No Yes Has any other future surgery, diagnostic testing or medical treatment been recommended or discussed for any person listed on this application? If yes, explain:

25. No Yes Has anyone listed on this application ever used tobacco products? If yes:

Name	Tobacco Type	Packs a day/Frequency	# Years	Last Used

26. No Yes Is any member of the applicant's immediate family currently pregnant? Please include family members not listed on this application. If yes, explain:

SECTION 10 – NOTICE OF INFORMATION USE AND DISCLOSURE

When you apply for or are enrolled on this health plan, we may collect, use, share or disclose Protected Personal Information (PPI). PPI includes information about your health, including medical records, information on prior or current health-care coverage; and personal information such as your address, telephone number and Social Security Number. This information may come from health-care providers, hospitals, insurance companies (including members of our corporate family), the Medical Information Bureau, Inc. (MIB) or other sources.

We may collect, use, or disclose your PPI to conduct routine business functions, such as:

- Determining your eligibility for enrollment, credit for waiting periods, benefits
- Paying claims and coordinating benefits with other insurers
- Conducting case and care management, and quality reviews
- Fulfilling other legal obligations specified in our contract with you; and,
- We may also collect or disclose PPI as required or permitted by law.

If a disclosure of PPI is not related to a routine business function, we remove anything that can be used to easily identify you, or we obtain your prior signed authorization. This authorization will describe the PPI to be released, who it is released to, reasons for the release, and the time period in which the authorization is valid. You may revoke this authorization.

SECTION 11 – BASIC TERMS of ENROLLMENT

- 1) I understand and agree that coverage does not begin until:
 - a) This application is received, reviewed and accepted by LifeWise, and an effective date of coverage is assigned; and
 - b) My complete and correct payment is received.
- 2) I also understand and agree that:
 - a) This application becomes a part of my Contract.
 - b) This application summarizes certain key terms of the Contract; to the extent that the application is inconsistent with the Contract, the Contract will govern.
 - c) Terms and conditions of enrollment are described in the Contract.
 - d) **I UNDERSTAND THAT THIS PLAN HAS A TWELVE-MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS. NO BENEFITS ARE PROVIDED FOR ANY MEDICAL CONDITION FOR WHICH TREATMENT WAS RECEIVED (OR RECOMMENDED) WITHIN THE TWELVE MONTHS PRIOR TO THE EFFECTIVE DATE OF THIS PLAN. THIS WAITING PERIOD DOES NOT APPLY TO NEWBORN AND ADOPTIVE CHILDREN ENROLLED AFTER THE SUBSCRIBER'S EFFECTIVE DATE OF COVERAGE AS LONG AS ADDED WITHIN 60 DAYS OF THE BIRTH OR PLACEMENT OR PORTABILITY COVERAGE ISSUED TO A HIPAA-ELIGIBLE INDIVIDUAL.**
 - e) The benefits under this Contract will be subject to coordination of benefits with other individual plans.
- 3) I also understand that acceptance for coverage is dependent on the following:
 - a) Persons listed on this application must be residents of the state of Arizona in order to apply for coverage under this Contract. "Resident" means a person who lives in the state of Arizona and intends to live in the state permanently or indefinitely. **In no event will coverage be extended to an applicant who resides here for the primary purpose of obtaining health-care coverage.** The confinement of a person in a nursing home, hospital or other medical institution shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
 - b) No one listed on this application is 65 years of age or older and eligible for Medicare on the date coverage would begin.
- 4) I also understand that no benefits are available under this Contract for services or supplies related to an inpatient confinement that began prior to the effective date of coverage, unless the applicant is a "HIPAA-eligible individual."
- 5) I also understand and agree that only LifeWise may:
 - a) Make or modify the terms of the application or Contract; or
 - b) Waive any of the LifeWise rights or requirements.
- 6) I understand that the benefits under this plan may vary based on the contracting status of the provider, and that the number of contracted providers varies in different geographic locations. In some cases, I may have substantially higher out-of-pocket costs when treatment is not received from a contracted provider.
- 7) I understand that this application is not an offer of coverage, and that its submission does not guarantee that I will receive coverage. I also understand that LifeWise may accept this application, but exclude certain conditions by rider. A rider is a form which, when attached to the contract, becomes a part thereof, and lists medical conditions for which coverage is not available under the contract, for the person specified, based on his/her past medical history. If a rider is required for enrollment, I will be notified in writing. All riders will remain for the duration of the coverage, or will be reviewed, upon the subscriber's request, after a period of five years of continuous coverage.
- 8) I also understand that LifeWise may modify or cancel my contract retroactively to its effective date, deeming some or all entitlements or rights to benefits under the contract void, if on this application I make any misrepresentation, incorrect statement or omit or conceal a fact that:
 - is fraudulent
 - is material to LifeWise's acceptance of the application or to the risk it assumes for the medical conditions I and my family members had at the time of application, or
 - had LifeWise known the facts as required by this application, LifeWise in good faith, would either not have: i) issued the contract; ii) issued the contract at the same premium or iii) provided coverage for the loss hazard.

SECTION 12 – SIGNATURES

I hereby apply for enrollment with LifeWise for myself and family members listed on this application for coverage under the Individual Contract indicated on this form. I understand I will have the right to examine and return the Contract within 10 days of its delivery to me. I certify that:

- a) I have read this form, and I have supplied all of the required information on this form.
- b) I have received and read a product information packet containing an Overview of Coverage and understand that a complete list of exclusions and limitations is detailed in the Contract. If there is a conflict, the terms of the Contract prevail.
- c) I have read and agree to all the Basic Terms of Enrollment listed in Section 11.
- d) I have read the Notice of Information Use and Disclosure in Section 10.
- e) In applying for enrollment as indicated on this application, I declare that to the best of my knowledge, all of the information on all forms necessary for enrollment is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members, that all entitlements to benefits are void and this Contract may be cancelled or modified retroactively to its effective date.
- f) I agree to notify LifeWise in writing of any new health condition that occurs prior to my coverage taking effect.

If one or more family members is not accepted for coverage, I authorize LifeWise to enroll those who are eligible in the plan I have selected (not applicable to HSA plan). Yes No

X	/ /	X	/ /
Signature of Primary Applicant	Date of Signature	Signature of Spouse	Date of Signature
X	/ /	X	/ /
Print Parent/Legal Guardian's Name if Primary Applicant is under 18 years of age	Date of Signature	Signature of Parent/Legal Guardian	Date of Signature

Applications postmarked by the 14th of the month and approved will be effective on the 15th of the same month (for new enrollment only). A pro-rated subscription charge will apply for the partial month of coverage. Applications postmarked by the last day of the month and approved will be effective on the first day of the following month.

To select a later effective date, please indicate here (no more than 60 days after the receipt day and must be the 1st or 15th of the month): _____ / _____ / _____.

DO NOT SEND PAYMENT WITH THIS APPLICATION.

Completion of this section **BY THE GENERAL AGENCY AND/OR AGENT** is required if the agent wishes to be considered as agent of record for applicant. All agent information must be provided below to ensure credit/commission for the application.

GENERAL AGENCY INFORMATION (IF APPLICABLE)	
General Agency Name (General Agencies contracted with LifeWise Health Plan of Arizona only):	
General Agency Sales Representative Name (Please print):	General Agency Email Address:
General Agency Address:	General Agency Telephone Number:
General Agency Signature:	General Agency LifeWise Agent Number & Schedule Code:
SELLING AGENCY INFORMATION	
Selling Agency Name:	
Selling Agent Name (Please print):	Selling Agent Email Address:
Selling Agent Address:	Selling Agent Telephone Number:
Selling Agent Signature:	LifeWise Agent Number & Schedule Code:

Please Note: Agents who do not have a current contract with LifeWise are not authorized to offer LifeWise products.