

Application for Individual Coverage

Please fax completed application to:
Arkansas Superior Select, Inc.
Fax Number: 1-866-912-1869

PLEASE TYPE OR PRINT IN BLACK INK
BE SURE APPLICATION IS COMPLETED IN FULL
Customer Service: Toll Free Number 1-866-423-0415
completebenefitplans.com

This application is for a product provided by Arkansas Superior Select, Inc. ("ASSI" "we," "our" or "us") in which Policyholders enroll in Complete Personal and Direct Care, authorizing providers to perform various covered services.

Section 1 Policyholder Information		
Desired Effective Month/Year ____/____		
Policyholder Last Name	First Name	Middle Initial
Date of Birth	Social Security Number	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Section 2 Benefit Options		
Please select the benefit plan option(s) for enrollment: <input type="checkbox"/> Dental \$111/mo <input type="checkbox"/> Vision \$37/mo <input type="checkbox"/> Hearing \$98/mo <input type="checkbox"/> Podiatry \$65/mo <input type="checkbox"/> Behavioral Health \$47/mo		
Section 3 Payment Options		
Please select a premium payment option: <input type="checkbox"/> Coordinate Payment Through My Facility <input type="checkbox"/> Get a Bill		
Section 4 Facility Information		
Name of Nursing/Residential Care/Assisted Living Facility	City	
Section 5 Application Signature		
<i>By signing the line below, you are agreeing to the Acknowledgement section listed on the back of this application.</i>		
_____	_____	
Policyholder/Representative Signature	Date	
If you are the authorized representative , you must sign above and provide the following information:		
Name: _____		
Address: _____		
Phone Number: (____) _____ - _____		
Relationship to Enrollee: _____		
Name of Agent (if assisted by a licensed insurance agent): _____		

Section 6 | Acknowledgement

In submitting this application to ASSI for coverage, I understand that if my application is accepted, my contract will consist of the Policy issued to me, along with a Policy Schedule containing information about my coverage, such as my premium and effective date. I understand that I am required to pay premium for the duration of the contract. I further agree that the coverage requested is subject to the approval of ASSI, that no coverage shall become effective until ASSI receives my initial premium and that no representative has authority to make changes or modify this application.

I certify that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that misrepresentation of submitted data may cause this application and subsequent Policy to be null and void. I understand that the Policy will become effective on the first day of the month following approval of this application and ASSI's receipt of the initial premium.

By my submission of this application, I attest that I am a resident of a nursing, residential care or assisted living facility in Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit to an insurer or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.