

THREE EASY STEPS TO OBTAIN A CONVERSION APPLICATION

To obtain an application and to receive more information about Celtic Conversion Coverage, take the following steps:

1. Complete the "General Information" section in this brochure.
2. Have your administrator or organization fill out the "Administrator's or Organization's Statement" section of this brochure.

3. Send the completed forms to:

Celtic Conversion Coverage
P.O. Box 06469
Chicago, IL 60606

or fax us at (312) 441-0822

Remember that your organization or your group health plan is providing you with the option to obtain Celtic Conversion Coverage. It is now up to you to exercise your Conversion option by completing this form and returning it to Celtic within 31 days after the date your health coverage ends. *(Some states allow a longer period in which to exercise your option. Please contact Celtic directly for more information.)*

If you have any questions or require additional information, please call a Celtic Conversion Client Services Representative at (800) 365-2365.



Solid, Strong, Committed

these are the characteristics that have shaped Celtic Insurance Company. And they are representative of the way in which we conduct business. Celtic is a company known for financial stability. We have always protected our customers with a conservative investment strategy, and have earned an "A-" Excellent rating from A.M. Best Company. We also believe our quality products should be backed by superior service. So you can count on our well trained personnel to administer your policy efficiently and without delay.

CELTIC

Insured by Celtic Insurance Company,
a Celtic Group Company
2001 Celtic Insurance Company

***Your Rights
Your Options***



**CONVERSION
PROGRAM**

PRINCETON UNIVERSITY

CELTIC

Earning your trust, every day

Conversion coverage guaranteed

Celtic Conversion Coverage guarantees your right to medical coverage regardless of your health or past medical history.

Even though coverage through your organization health plan is about to expire, you will be relieved to know that you have been provided the option to obtain major medical insurance. Even after your health plan benefits expire, you will have the right to choose a plan that's right for you.

SELECT THE COVERAGE THAT BEST MEETS YOUR NEEDS.

In addition to Celtic Conversion Coverage, Celtic also offers a Short-Term Health plan to persons who only need medical insurance for a limited period of time and who can meet Celtic's underwriting requirements. To determine which plan may best fit your needs ask yourself the following questions.

CELTIC CONVERSION COVERAGE

- Do you need health insurance for a long period of time?
- Do you need health insurance for a serious or ongoing medical condition?
- Do you need immediate coverage for any pre-existing health conditions?
- If you answered "yes" to any of the above, then Conversion Coverage is probably the best plan for you.

CELTIC SHORT-TERM HEALTH PLAN*

- Do you need health insurance for only a short time? (*ie. A few months*)
- Are you in good health and free of any serious or ongoing medical conditions?
- Are you able to accept limited coverage for pre-existing conditions?
- If you answered "yes" to all of the above, then Short-Term coverage may be best plan for you.

For additional information regarding Short-Term, call (800) 365-2365.

HEALTH PLAN COMPARISON AT-A-GLANCE

	CONVERSION COVERAGE	SHORT-TERM HEALTH PLAN
Benefits	Choice of deductibles and plan maximums, subject to certain dollar limits	Choice of deductibles, plan maximums generally higher than conversion
Pre-Existing Conditions	Fully covered with no limitations	Not covered in most states
Length of Coverage Period	Continues in force as long as premiums are paid	3 to 12 months only
Underwriting Requirements	None. Coverage is guaranteed regardless of present health or past medical history	Must be in excellent health and able to answer "no" to all health questions on the application
Cost	Higher than Short-Term	Relatively inexpensive
To Apply	Complete the information requested in the brochure and send it to us.	For additional information regarding Short-Term, call (800) 365-2365.

* Not available in all states. For further information contact Celtic or refer to the brochure.



YOU ARE ELIGIBLE IF:

You were covered for three consecutive months under your group plan*. You may apply if you are in any of the following categories:

1. You and/or your dependents are no longer eligible under your group plan or any other medical plan.
2. The covered group plan participant has died, and you are a dependent spouse or child.
3. You are a covered dependent that has reached the maximum age under the group plan.

* Note: In the states of AZ, NM, and OK you may be eligible regardless of how long you were covered under your group plan. However, to be eligible you must still meet the other requirements listed above.

YOU ARE NOT ELIGIBLE IF:

1. Your group health plan was discontinued.
2. Your organization's group plan ended and there is a succeeding medical expense plan.
3. You or your organization failed to pay the required premium and/or fees.
4. You are age 65 or older.

5. You are covered or eligible for Medicare or other medical expense benefits offered by any group plan, individual policy, pre-payment plan, government program or any other plan which, according to our rules, results in excessive coverage or over-insurance.
6. You fail to apply for Conversion within 31 days after your group coverage terminates. (Note: Some states allow a longer period of time to convert. Please contact Celtic at (800) 365-2365 for more information.)

**CELTIC CONVERSION
COVERAGE & BENEFITS**

Celtic offers a variety of Conversion health plans to meet your needs. Specific benefits may vary from state to state.

Further information concerning rates and benefits can only be provided to you upon our receipt of this completed form within the 31 day period referred to above.

Details concerning Celtic Short-Term health coverage can be obtained by calling Celtic directly at (800) 365-2365.

GENERAL INFORMATION (TO BE COMPLETED BY APPLICANT)

Please fill out the following information completely or this form will be returned to you. **PLEASE PRINT.**

My participation in my present medical plan is provided by: *(Name of Organization)*

My organization's plan terminated effective:

THIS IS NOT AN APPLICATION FOR COVERAGE!

I hereby request Celtic Insurance Company to provide me with information regarding Conversion Coverage. The Conversion Coverage if applied for, and if issued, will be effective on the day following the date that participation in the group medical plan terminates.

Are any dependents to be covered? YES NO If yes, please fill in below:

NAME	RELATIONSHIP	BIRTH DATE	AGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Were these dependents covered under the prior group plan? YES NO If NO, please explain: _____

Are you, or any other person for whom coverage is being applied, currently employed, or expect to be employed in the near future? YES NO If YES, please explain: _____

If yes, was medical insurance offered? YES NO

Will a medical insurance plan be offered at a later date? Yes No

Was the medical insurance declined? YES NO

If yes, please indicate the date coverage will be effective: _____

Are you, or any other person for whom coverage is being applied, eligible for or covered by any other medical expense insurance policy (either individual or group), medical service subscriber contract or prepayment plan, or any other plan or program (insured or uninsured) offered privately or through a government program? YES NO If YES, please include a copy of your policy.

ORGANIZATION'S OR ADMINISTRATOR'S STATEMENT (TO BE COMPLETED BY ORGANIZATION OR ADMINISTRATOR)

Name of Organization _____

Parent Organization Name _____

Address: _____ City: _____ State: _____

Zip Code: _____ Telephone Number: (_____) _____

Date applicant first became covered under: THE GROUP PLAN: _____

Date applicant's coverage terminated under: THE GROUP PLAN: _____

Reason for termination: _____

If applicant is a former student, last day enrolled: _____

To be eligible for Conversion Coverage, mail this completed form within 31 days of termination of coverage to:

CELTIC CONVERSION COVERAGE
P.O. BOX 06469
CHICAGO, IL 60606
(800) 365-2365

Name: *(person whose benefits are terminating)* _____

Social Security Number: _____

Birth Date: _____ Age: _____ Sex: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Telephone Number: (_____) _____

How were you covered under the organization's group plan? Student Spouse Dependent

Reason for termination of group plan coverage: _____

Is the applicant covered under any other extension of benefits provision? YES NO

If YES, please explain: _____

Are benefits limited by a pre-existing condition for this applicant? YES NO

If YES, please explain: _____

Is the applicant eligible for, or covered by, any other medical expense benefit plan? YES NO

If YES, name & details of benefit plan: _____

Name of person completing Organization Statement: _____

Title: _____ Telephone Number: (_____) _____

I hereby certify that the above information is correct to the best of my knowledge. I have enclosed a copy of the student's enrollment form.

Organization's or Administrator's signature: _____ Date: _____