

FILED

DEC 17 2008

**INSURANCE COMMISSIONER
OKLAHOMA**

**BEFORE THE INSURANCE COMMISSIONER OF THE
STATE OF OKLAHOMA**

**STATE OF OKLAHOMA, ex rel. KIM
HOLLAND, Insurance Commissioner,**)

Petitioner,)

v.)

**RONALD SIPES, a licensed Oklahoma
Insurance Producer,**)

Respondent.)

Case No. 08-1414-DIS

CONSENT ORDER

The State of Oklahoma, ex rel. Kim Holland, Insurance Commissioner, and Respondent Ronald Sipes, stipulate to the following facts and applicable laws. The parties consent to the entry of this Order.

JURISDICTION AND AUTHORITY

1. Kim Holland is the Insurance Commissioner of the State of Oklahoma and is charged with the duty of administering and enforcing all provisions of the Oklahoma Insurance Code, 36 O.S. §§ 101 et seq., including the Oklahoma Producer Licensing Act Licensing Act, 36 O.S. §§ 1435.1 et. seq.

2. Respondent is licensed by the State of Oklahoma as a resident insurance producer holding license number 170662. His address of record is 7421 S. 77th E. Avenue, Tulsa, Oklahoma 74133.

3. The Insurance Commissioner may place on probation, censure, suspend, revoke or refuse to issue or renew a license issued pursuant to the Oklahoma Producer

Licensing Act and/or may levy a fine up to \$1,000.00 for each occurrence of a violation of the Oklahoma Insurance Code, 36 O.S. § 1435.13(A) and (D).

4. Informal disposition of this matter may be made by consent order 75 O.S. § 309(E).

STIPULATION OF FACTS

1. Sheila Peterson filed a complaint with the Consumer Assistance/Claims Division of the Oklahoma Insurance Department stating that Respondent incorrectly completed a health insurance application to Coventry Health Care covering her adult disabled daughter Shelly Peterson. The health insurance application was dated September 11, 2007 with an effective date of October 1, 2007 (Exhibit A).

2. Respondent telephoned Sheila Peterson at work to complete the application. The application completed by Respondent mirrored Shelly Peterson's previous application with American Medical Security (Exhibit B). It did not include new health information given to Respondent by Sheila Peterson in the telephone conversation.

3. Neither Sheila Peterson nor Shelly Peterson reviewed the application prior to submission to Coventry. Neither Sheila Peterson signed the application as the accountholder on page 2 of the application nor did Shelly Peterson sign the application as the applicant on page 4.

4. Coventry sent a letter dated June 25, 2008 to Shelly Peterson rescinding the policy for material misrepresentations. Coventry found the application replete with incorrect health and medical information (Exhibit C).

5. Coventry was notified of Sheila Peterson's complaint and found Respondent in violation of their Broker Compensation Agreement. (Exhibit D).

Respondent provided a written statement to Coventry that “we at Sipes Insurance Agency have ceased doing any applications without the insured filling out the application and/or signing it” and that “a Peterson incident will never happen again” (Exhibit E).

6. The end result was the loss of Shelly Peterson’s primary health insurance. Sheila Peterson is now unable to obtain primary health insurance on her daughter because of her health.

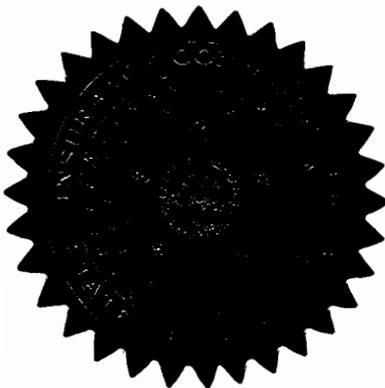
AGREED CONCLUSIONS OF LAW

Respondent has violated 36 O.S. § 1435.13(A)(8) by using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state.

ORDER

IT IS THEREFORE ORDERED by the Insurance Commissioner and agreed to by Respondent that a **FIVE HUNDRED DOLLAR (\$500.00) fine** is imposed against Respondent and shall be paid to the Oklahoma Insurance Department. The payment shall reference Respondent’s case number 08-1414-DIS, and shall be sent to the attention of Julie Delluomo, Assistant General Counsel, at the same time as Respondent returns this Consent Order. The Insurance Commissioner agrees not to submit Notice of Regulatory Activity (RIRS) to the National Association of Insurance Commissioners (NAIC) regarding this action.

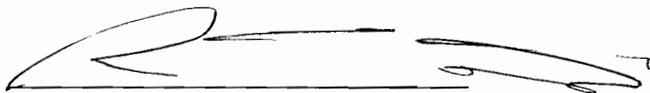
WITNESS My Hand and Official Seal on this 12th day of ~~November~~ December, 2008.




LEAMON FREEMAN
HEARING EXAMINER

VERIFICATION AND CONSENT

I, Ronald Sipes, state that I have read this Consent Order. The contents and facts set forth in the order are true to the best of my knowledge. I consent to the entry of the Order by the Insurance Commissioner and I waive my right to appeal this Order.

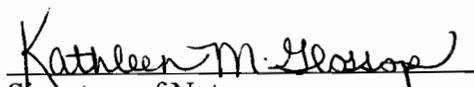


RONALD SIPES

STATE OF OKLAHOMA
COUNTY OF TULSA

This instrument was acknowledged before me on 12/04/2008

by RONALD SIPES.


Signature of Notary

Seal

My Commissions expires:
04/21/2009

My Commission number:
05003841

APPROVED:



Julie Delluomo, OBA #14410
Assistant General Counsel
Oklahoma Insurance Department

CERTIFICATE OF MAILING

I, Julie Delluomo, hereby certify that a true and correct copy of the above and foregoing Consent Order was mailed by certified mail with postage prepaid and return receipt requested on this 17 day of December, 2008, to:

Ronald Sipes
7421 S. 77th E. Avenue
Tulsa, Oklahoma 74133

CERTIFIED MAIL NO.

and that a copy was mailed to:

All Appointing Insurers

and that a copy was delivered to:

Agents Licensing Division
Consumer Assistance/Claims Division


Julie Delluomo



Check One
 New Enrollment Change Form

Fax To: 800-899-6228
 If all The Coventry Care
 Allow Individual Policy Department
 8880 Ward Parkway
 Kansas City, MO 64114

APPLICATION AGREEMENT FOR
 INDIVIDUAL HEALTH INSURANCE

INDIVIDUAL INFORMATION (To Be Completed By Applicant)

LAST NAME Johnson	FIRST NAME Shelly	SEX F	AGE 36	BIRTH DATE 02-26-67	SOCIAL SECURITY NO.	REGISTRATION EFFECTIVE DATE 02-26-07
ADDRESS 2805 Concord		EMPLOYER Student	COMPANION/TYPE Student	BUSINESS PHONE	E-MAIL ADDRESS	
CITY Graham Kansas	STATE KS	ZIP CODE 67412	COUNTY Tulsa	HOME PHONE 8163511003	HEIGHT 56	WEIGHT 165
TOBACCO USE Yes						

Small Selection - Please select the benefit plan for which you are requesting coverage.

One of the following benefit plans:

- CI C0000 20 (\$200 Ded., 80%/90%)
- CI C1000 20 (\$1,000 Ded., 80%/90%) **A-26-120-**
- CI C2000 20 (\$2,000 Ded., 80%/90%)
- CI C2500 20 (\$2,500 Ded., 80%/90%)
- CI C3000 30 (\$3,000 Ded., 80%/90%)
- CI C3500 30 (\$3,500 Ded., 80%/90%)
- CI C4000 30 (\$4,000 Ded., 80%/90%)
- CI C4500 30 (\$4,500 Ded., 80%/90%)
- CI F3000 30 (\$2,000 Ded., 80%/90%)
- CI C4500 30 (\$4,500 Ded., 100%/90%)
- CI C4500 30 (\$4,500 Ded., 100%/90%)

OTHER HEALTH INSURANCE Do you have other health coverage? No (skip to section C) Yes (Complete this Section)

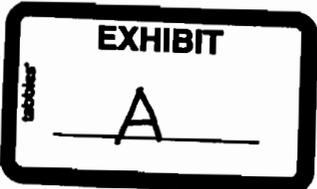
Policyholder Name Shelly Johnson	Policyholder Address 2805 Concord	Name of Insurance Company A.M.S.	Contract # / Group # 1700-077957	Policy Eff. Date 01/1/00	Policy Term Date 01/1/07
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Do you have or are you eligible for coverage under Medicare? No Yes

PREMIUM PAYMENT
 Premiums due for coverage under this policy will be paid from funds deducted from either your checking or saving account. This collection is done with your authorization and approval, pending first medical underwriting, on approved premium and your acceptance of coverage. To facilitate the monthly premium withdrawal we need your banking information. Providing this information does not guarantee coverage and no funds will be drawn prior to notification and acceptance by applicant.

ONL-01APP-01.02 Underwritten by Coventry Health and Life Insurance Company
 Administered by Coventry Health Care of Kansas, Inc. CoventryCare Oklahoma Agent

Applicant Last Name: Johnson First Name: Shelly



LI CHECKING ACCOUNT

NAME	
ADDRESS	
CITY	
STATE	
ZIP	
ACCOUNT NUMBER	
ACCOUNT NUMBER	

Name of Bank or Saving Institution: Tulsa Teachers Credit Union
 Routing Number: 308996313 Account Number: 00601581
 Address of Bank: Tulsa, OR
 Name that appears on the Account: SHEILA PETERSON - Whymon Peterson
 Address on the Account: 1400 E. Concord, Broken Arrow, OK 74012

Frequency of Transactions: Monthly Transaction Date: 1st Day of each Month.
 Your policy coverage will go in effect when the premium rate has been received and accepted, provided underlying conditions are approved, and premium payments received and applied to your account. By signing below, I authorize County Health and Life Insurance Company in full and irrevocable assignment of applicable premium payments from the account listed above. I understand that if I am responsible for paying the Plan I change banks or insurance members.
 Account Holder Signature: Sheila Peterson Date: 9-11-07

HEALTH HISTORY Please check Yes or No and provide details for all Yes answers below.
 Within the past ten (10) years have you consulted or sought treatment, been diagnosed, had treatment recommended, received treatment or therapy, been surgically treated or been hospitalized for any of the following conditions? Incomplete applications may be imposed or returned to you for completion.

1. Heart attack, heart surgery, irregular heart rate, stroke, chest pain, high blood pressure, angina, abnormal ECG, congestive heart failure, heart or valve disorder?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	14. Have you been treated in the emergency room, been hospitalized, or had surgery in the past 5 years?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
2. Hypertension, high cholesterol, arteriosclerosis, circulatory or vascular problems, aneurysm, blood clots, aneurysm, blood vessels or bleeding disorder?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	16. Mental depression, bipolar, panic attacks, schizophrenia, obsessive-compulsive disorder (OCD), depression, or behavioral disorder?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. Stroke, seizure, coma, Crain's disease, hernia, hepatitis, liver disease or disorder of the stomach, intestines, pancreas, rectum, or gall bladder?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	18. Currently taking prescription medication or receiving injection therapy?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
4. Cancer, cyst, polyp, tumor or growth of any kind?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	20. Are you or any family member pregnant or have you recently been pregnant? If so, when?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
5. Disorder of the kidneys, prostate or urinary system, kidney failure, blood or abnormal in urine, or receiving dialysis?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	21. Been treated, convicted, or ordered to seek treatment regarding use of alcohol, illegal substances, narcotics or prescription drugs?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
6. Tuberculosis, emphysema, COPD, bronchitis, asthma, diabetes, deep vein thrombosis, phlebitis, or disorder of the large or respiratory system?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	22. Sought or been advised to seek psychiatric, psychological or mental health treatment, or counseling?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
7. Epilepsy, hearing aids, deafness, frequent infections, uterine fibroid, if applicable, child of past marriage?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	23. Anorexia, bulimia, gender dysphoria, or other eating disorder?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
8. Lupus, rheumatoid arthritis, osteoarthritis, back or spinal conditions, or disorder of the joints, muscles or bones?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
9. Any head injury, concussion, trauma, congenital problems or defects? Any chronic infections or infectious diseases?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
10. Diabetes or abnormal glucose test (fasting)? If diabetic, Type _____ Any complications?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		

Underwritten by County Health and Life Insurance Company
 Administered by County Health Care of Kansas, Inc.
 Applicant Last Name: Peterson First Name: Shelly
 CHL02LAPP-0108 County-Our Oklahoma Application

11. Doctor, recipient, or a substitute for a transplant?
 Yes No

12. Any medications, psychiatric devices or implants?
 Yes No

13. Any insurance deductible/deductible, HV, ADA, or ADA-related complaint?
 Yes No

17. List any diseases, condition, or hypertension not mentioned above.

24. Had an X-ray, electrocardiogram, cardiac catheterization, MRI, CT scan, ultrasound or other diagnostic test or procedure?
 Yes No

25. Have you used tobacco products in the past 12 months?
 If Yes, what kind? Frequency

26. Any pending or recommended surgery or procedure not yet performed, or have been advised to obtain approval or consent?

28. Please describe any habits, substances, natural treatment, or remedies in the past twelve (12) months.

29. Please list any injections you are currently taking, or have taken in the past 12 months, including injection therapy.
 Name of medication: Penicillin Phytol

30. Name of agent/doctor: Dr. Jeffrey A. F. Rao 9235 S. Niango Tulsa Okla 74136 918-457-9648 Pharm D
Seasonal Allergies Both Partners are Pharmacists

If you answered "Yes" to any of the previous medical questions, you must complete the requested information about those conditions. Please explain and provide FULL DETAILS for each "Yes" answer to any condition(s) checked in the preceding items. Please give details on the last date that medical attention was received regardless of date or reason. Insert additional sheets if necessary.

Question # 1 Condition of Diagnosis Seasonal Allergies Date of Onset/Treatment (Month/Year) 12/06 Date Ended 01/07 Under Treatment? Y/N

Treatment Received

Name of Hospital, Clinic or person providing care

Address Pharm D

Question # 2 Condition of Diagnosis Seasonal Allergies Date of Onset/Treatment (Month/Year) 12/06 Date Ended 01/07 Under Treatment? Y/N

Treatment Received

Name of Hospital, Clinic or person providing care

Address Pharm D

Question # 3 Condition of Diagnosis Seasonal Allergies Date of Onset/Treatment (Month/Year) 12/06 Date Ended 01/07 Under Treatment? Y/N

Treatment Received

Name of Hospital, Clinic or person providing care

Address Pharm D

OH-CR-APP-1-10

Applicant Last Name: Rao First Name: Shelly

Underwritten by Country Health and Life Insurance Company
 Administered by Country Health Care of Kansas, Inc.

Country One Oklahoma Application

CONDITIONS OF ENROLLMENT

I agree to read and consent that Coventry Health and Life Insurance Company or their authorized representatives (collectively referred to as "Health Plan") may use or disclose to third parties the information contained on this enrollment form and individually identifiable health information relating to me for purposes of administering my health insurance benefit, including for treatment, payment or health care operations, as those terms are explained in detail in Health Plan's Notice of Privacy Practices and to the extent permitted by law.

I also agree that, to the extent permitted by law, health care providers, insurers, claims administrators, employers and others may disclose my personal information including individually identifiable health information that may include diagnosis, prognosis, treatment, and payment information related to physical and/or mental illness, including substance abuse, substance dependency symptoms, AIDS related complex, human immunodeficiency virus or genetic conditions to Health Plan for Health Plan's administration of health insurance benefits, including for treatment, payment or health care operations and other purposes permitted by law.

I represent that all information on this application form is complete and accurate to the best of my knowledge. I understand that my answers to the questions on this form will be used to determine eligibility for coverage and in the event of a claim, my premium rate may be determined. I further understand that if my information is omitted or misrepresented, it could result in the denial or reduction of coverage and to reduce my premium rate as though coverage had never been in force. After coverage has been in force for two years, no statement except fraudulent conduct will void my coverage or reduce my benefits.

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

If applicant is under the age of 18, his application must be signed by the applicant's parent or legal guardian.

Applicant's Signature Shelly Peterson Date 9-11-07 Relationship _____ *If signed by someone other than the applicant.*

ACKNOWLEDGEMENT OF EXCLUSION WAIVER

I agree that I have reviewed and understand the CoventryCare Exclusion Waiver. I also agree to have this Waiver attached to my CoventryCare Policy.

Applicant's Signature Shelly Peterson Date 9-11-07

BROKER INFORMATION

Name of Broker Ronald L. Sipes Signature of Broker [Signature]
Phone Number (918) 294-2580 Email Address rsipes@rcb.com
Broker ID Number -5136
Name of General Agent _____ Signature of General Agent _____
Phone Number _____ Email Address _____

Office Use Only

CHLOR-APP-0108

Applicant Last Name:

Underwritten by Coventry Health and Life Insurance Company
Administered by Coventry Health Care of Kansas, Inc.

Peterson

First Name:

Shelly

CoventryCare Oklahoma Application

Underwritten by
**UNITED WISCONSIN
 LIFE INSURANCE COMPANY**

**OKLAHOMA
 Member Application
 for Group Insurance**

Designed, Administered, and Marketed by:

**AMERICAN
 MEDICAL SECURITY**
 for Good Health

P.O. Box 14332, Green Bay, WI 54307-0332
 (920) 861-8130

P.O. Box 19822, Green Bay, WI 54307-0822
 (920) 866-1111 • (800) 230-0428

- New application Change in Benefits (specify requested date below in Coverage Information)
 Change Coverage Type: Marriage Divorce Birth Adoption - Give date of event: _____

Applicant Social Security Number - - Group No. -

Applicant

Last Name PETERSON				First Name SHELLEY				Initial SP	
<input checked="" type="checkbox"/> Single	Address 1400 E Concord St Broken Arrow OK Tulsa 74112							City Broken Arrow State OK ZIP 74112 County Tulsa	
Home Phone No. 918 855-1863	Personal Fax No. _____	Gender <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Date of Birth _____	Height 5'6"	Weight 105	Primary Care Physician's Name Dr. Janis Finer			
Applicant Occupation: Student									
Beneficiary Name (for EarlyCare, Payer is automatic beneficiary)		Last Peterson		First Shelley		Initial _____		Relationship ROTH	
For EarlyCare, give address of child (if different than Applicant)		Home Address _____		City _____		State _____		ZIP _____ County _____	
Premium Payer Name (for EarlyCare if not Applicant)		Last _____		First _____		Initial _____		Home Phone No. _____	
Premium Payer Billing Address		City _____		State _____		ZIP _____		County _____	

Family Information (If more space is needed, attach an additional sheet of paper, sign and date it.)

First Name & M.I. (last name if different)	Gender	Date of Birth	Height/Weight	Social Security No.	Primary Care Physician's Name
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/	/ /	
Spouse's Occupation: _____					
Child:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/	/ /	
Child:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/	/ /	
Child:	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	/	/ /	
Dependents (age 19 and older) attending school full-time, include name of dependent, name/address of school, and number of credits: _____					

Eligibility

Yes No Are you or any family members covered by Medicare/Medicaid? If yes, list family members and their effective date: _____

Yes No Are you or any eligible dependent disabled, hospital confined, or pregnant? If yes, explain: _____

Yes No Do any family members intend to keep other insurance coverage in addition to this policy? If yes, list family members: _____

List insurance company name(s) and the policy number(s): _____

Yes No Are you or any family members currently eligible for or receiving COBRA or State Continuation benefits? If yes, list names, eligibility dates, and date benefits end: _____

Yes No Is your employer paying the premiums for this policy, in whole or in part?

Yes No Are you and all family members to be insured U.S. citizens? If no, list names and how long in the U.S.: _____

(Attach copy of U.S. permit or VISA)

Coverage Information

Benefit Options: (Only available with medical coverage)

Medical: Applicant Applicant/Family Applicant/Spouse Applicant/Child(ren) Child only

Requested effective date **10-1-01** (Effective date may not be guaranteed)

Network Name **PEF**

Deductible/Copay **PEFD 30/1000** Coinsurance _____

I certify that I am a HIPAA Eligible Individual under Public Law 104-191 as defined in the Prior Coverage section on page 2 of this application and I choose to apply for a Non-HIPAA Eligible medical plan (this is not guarantee issue and a pre-existing condition limitation(s) may apply)

The HIPAA Eligible guarantee issue plan is (the Oklahoma Health Insurance Association (high risk pool) plan)

Yes No Supplemental Accident Benefit

NO Rx

EXHIBIT

tabbies

B

Home Office Use Only

Depending upon state law, this information may be submitted as evidence of insurability.

MEDICAL HISTORY

- A. Yes No Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, explain _____
- B. Yes No In the past 24 months, have you or any person to be insured received treatment, received therapy, taken medication, or consulted a health care provider for symptoms? If yes, explain Seasonal Allergies
- C. Yes No In the past 24 months, have you or any person to be insured been advised to have a test or been advised of a condition that may require attention? If yes, explain: _____
- D. Yes No Has any person to be insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or tested positive for HIV? If yes, list names: _____
- E. Yes No Has anyone to be insured used tobacco products during the previous 12 months? If yes, list names: _____
- F. Within the past five years, has any person to be insured ever had any symptoms, diagnosis, consultation, treatment, therapy, taken any medication, or received counseling for any of the diseases, conditions, disorders listed... (Provide details to "Yes" answers below.)
- | | | |
|--|--|---|
| 1. Abnormal Test Results <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 20. Emphysema/Lung/COPD <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 39. Neurological Signs, Symptoms, Disease <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 2. Alcoholism/Alcohol Abuse <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 21. Epilepsy/Seizure <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 40. Pap Smear, abnormal <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 3. Allergies <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | 22. Eye <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 41. Paralysis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 4. Arthritis/Rheumatism/Arthritic Disorder <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 23. Fracture/Dislocation/Internal Fixation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 42. Prostate/Rectal <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 5. Asthma/Respiratory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24. Gallbladder <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 43. Reproductive Organs Disorder <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 6. Back/Muscle/Joints <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 25. Headaches/Migraines <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 44. Sexually Transmitted Diseases <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 7. Bladder <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 26. Heart Disease/Murmur <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 45. Sinus <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 8. Blood Abnormality <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 27. Heart Valve/Mitral Valve Prolapse <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 46. Skin/Growth/Lesion/Abnormality <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 9. Bone Disease/Deformity <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28. Hepatitis/Liver <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 47. Spinal Disorder <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10. Breast/Implants <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 29. Hernia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 48. Stroke <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 11. Cancer/Leukemia/Hodgkin's/Lymphoma <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 30. High Blood Pressure/Hypertension <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 49. Thyroid or Goiter <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 12. Colitis/Spastic Colon/Polyps <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 31. Infertility Testing/Treatment <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 50. Transplants <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 13. Congenital Abnormality <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 32. Kidney <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 51. Tuberculosis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 14. Cystic Fibrosis/Multiple Sclerosis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 33. Lupus/Systemic or Discoid <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 52. Tumors/Growths/Cysts/Fibroids/Lesions <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 15. Diabetes/Pancreas <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 34. Lymphadenopathy/Immune System <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 53. Ulcerative Colitis, Crohn's or Regional Ileitis <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 16. Digestive System <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 35. Menstruation <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 54. Ulcers-Digestive, Skin, Other <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 17. Drug Addiction/Abuse <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 36. Mental, Nervous, Psychological <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 55. Urinary Tract Disorder <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 18. Ear/Throat <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 37. Mental Retardation/Down's Syndrome <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 56. Vascular Abnormality <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 19. Eating Disorder, Anorexia, or Bulimia <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 38. Muscular Dystrophy/Cerebral Palsy <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | |

Provide details to "YES" answers (if more space is needed, attach an additional sheet of paper, sign and date it.)

Question Letter/No.	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Physician's Name & Address
		Seasonal Allergies	(Christmas)	is needed.
		Both her mother & father are pharmanic.		

Prior Coverage

Prior Coverage Information for HIPAA Guaranteed Issue Plans

- Do you meet the requirements of a Federally Eligible Individual under HIPAA legislation (P.L. 104-191)? Please indicate yes or no to the following:
- Yes No Have you had a total of 18 or more consecutive months of prior health coverage, the most recent being an employer sponsored group plan?
- Yes No Are you ineligible for coverage under a group plan, Medicare Part A or B, or Medicaid, and do not have any health coverage now in force?
- Yes No Was your most recent group health insurance plan coverage terminated for reasons other than your fraud or your nonpayment of premiums?
- Yes No If offered to you, did you elect to continue your prior group insurance plan coverage under COBRA or a similar state continuation law?
- Yes No If you elected COBRA or state continuation, has that coverage, or will it soon be, exhausted?
- Yes No Have you had less than a 63-day break in coverage from the most recent group plan?
- If you answered No to ANY of the above questions, the pre-existing condition limitation WILL apply to you and any dependents. If you answered Yes to ALL of the above requirements you qualify as a HIPAA eligible person; as a result: 1) we MAY waive the pre-existing condition limitation for you and your dependents as allowed by state law, and we will advise you accordingly; or 2) you may qualify for a state-sponsored plan. If (2) applies in your state, we will advise you on how to enroll in the state plan. IF YOU ANSWERED YES TO ALL OF THE ABOVE REQUIREMENTS PLEASE ATTACH A CERTIFICATE OF CREDITABLE COVERAGE FROM THE PRIOR GROUP PLAN, OR ANY OTHER DOCUMENTS TO PROVE THAT YOU HAD PRIOR COVERAGE.
- Yes No Are you buying this insurance to replace prior group health coverage? If no, the pre-existing condition limitation will apply. If yes, according to state law: 1) we may waive the pre-existing condition limitation for you and any dependents; or 2) you may qualify for a state-sponsored plan. If 2) applies in your state, we will advise you on how to enroll in the state plan. If yes, you must also attach a Certificate of Creditable Coverage from the prior plan and complete all of the following:
- Prior group coverage effective date: _____ Prior group coverage termination date: _____ Reason for prior coverage termination: _____
- Who was covered? _____ Prior coverage was provided by: your employer group plan spouse's employer group plan
- Give name of prior insurance company, group policy/certificate number, address, and phone number: _____
- _____
- Yes No If prior group coverage was in effect for less than 18 months, did you have any preceding health coverage? If yes, was the coverage provided by:
- your employer group plan spouse's employer group plan individual policy you purchased for yourself other: _____
- Give name of insurance company and group policy/certificate number: _____
- Who was covered? _____

Terms and Conditions of Insurance

The Applicant shall furnish to the Insurer any information required for the Insurer to administer the Insurance. The Applicant shall have records available for the Insurer to inspect at any time while insurance is in force, and for up to the earlier of three years after termination date, or final adjustment and settlement of claims is made. The Insurer reserves the right to waive or change any of the above requirements at any time.

INSURER UNDERWRITING REQUIREMENTS

The Applicant is required to submit an Application for Insurance for self and/or for all eligible Dependents to be insured. Insurance for any person is not effective until the date specified by the Insurer. Depending upon state law, the Insurer may have the right to decline the Application for any person for whom information has been submitted in the Application.

TERMINATION OF INSURANCE

The Applicant may terminate insurance at any time by providing the Insurer with written notice at least 31 days in advance of the requested termination date. The Insurer will terminate insurance if the Applicant fails to pay premium on the due date, except that coverage continues for a grace period of 31 days after the premium due date. The Applicant may be responsible to pay premium for the grace period coverage. If before any premium due date the Applicant provides 31 days advance written notice to the Insurer of request to cancel, then the grace period coverage does not apply. In addition to reasons for termination that are specified in the group insurance Policy, the Insurer may also cancel for fraud or material misrepresentation.

The Insurer will provide the Applicant with a minimum of 31 days advance written notice of cancellation date (unless due to nonpayment of premium). Cancellation will not prejudice a valid claim existing on the termination date.

Upon termination, Applicant may request reinstatement of coverage only once by paying all past due premium, plus a \$25 nonrefundable reinstatement fee when allowed by state law. Insurer will deposit payment during review of Applicant's request. Depositing Applicant's check does not mean acceptance and does not guarantee reinstatement. Insurer can approve or decline reinstatement request and will notify Applicant in writing.

To be a valid application, your signature and the date you sign it are required.
Signature Required-Applicant Agreement/Authorization to Release Medical Information

I understand that the above answers will be relied upon by United Wisconsin Life Insurance Company, ("the Insurer") in the issuance of a certificate of insurance. I declare all statements contained in this entire form about myself and my dependents to be insured are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand and agree that the Insurer is not bound by any statement made by or to any agent unless written herein. I agree that no insurance will be effective until the date specified by the Insurer in the certificate of insurance. The actual effective date may not be the requested effective date.

To assist American Medical Security, Inc. (AMS) with determining my creditable coverage, I authorize any insurance company, third party administrator, or other authorized carrier, to release to AMS, third party administrator for Insurer, certificates of creditable coverage and all such information.

State law may require a group health plan to follow rules for use of Medical History, rating, renewability and replacement of prior coverage, when the plan is issued to a self-employed individual, a sole proprietor, an independent contractor, a partner, or a sole employee of a Subchapter S or Chapter C Corporation. If such law applies to my state of residence, the agent has advised me about the law and I hereby certify that I do not qualify for such group health plan.

I hereby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, medical information service, urgent care facility, other medical or medically related facility or entity, insurance or reinsurance company, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me, my spouse or my dependents and other nonmedical information of me, my spouse or my dependents, to release to AMS and/or Insurer, or its designee any and all such information. I hereby authorize, on behalf of myself and my dependents, that information obtained may be used by the Insurer, AMS or its designee and may be released to reinsuring companies, physicians, medical practitioners, hospitals, clinics, veterans administration facilities, or medically related facilities or other persons or organizations performing business, medical or legal services in connection with the coverage for any claim, medical management purpose or pharmacy benefit management purpose (including the release of claims and medical information by Insurer, AMS or its designee to treating physicians regarding potential problematic drug use patterns) or as may be otherwise lawfully required or as I may further authorize. I agree that a photographic copy of these authorizations shall be as valid as the original, and that these authorizations shall be valid for the maximum length of time permitted by law. I understand the information obtained by use of these authorizations may also be used by the Insurer, AMS or its designees to determine eligibility for insurance, or health coverage, and eligibility for benefits under an existing policy/certificate of insurance, for myself and my dependents. I understand that I may request a copy of this authorization at any time.

Any person who, knowingly and with intent to defraud any insurance company, submits an application or files a claim containing any materially false information may be found guilty in a court of law of insurance fraud, which is a crime, and may be subject to fines and confinement in prison. Unless all pages are attached and completed, this will not be considered as a complete application.

I, the applicant, give permission/authorization to release any information regarding my insurance to _____ (Name & Relationship).

Yes No Do you understand that this policy will not pay benefits during the first 12 months after the issue date for a disease or physical condition which you now have or have had in the past.

Applicant Signature X Shelley Peterson Date 10-5-01

(for EarlyCare, signature must be child's parent or legal guardian, if applicant is not of legal age) City & State Tulsa OK

Spouse Signature X _____ (Required if spouse is to be insured)

Child's Signature X _____ (for EarlyCare only, if child is of legal age)

Regional Office _____

Agent Name RONALD L. SIPES

Address 7421 S. 77th E. Avenue

Tulsa, OK 74133-2824

Phone () _____ Fax () 918-294-9580 513-36-5136

Licensed Resident Agent Signature X R. Sipes



June 25, 2008

Via Certified Mail

Shelly Peterson
1400 E Concord
Broken Arrow, OK 74012

Re: Material Misrepresentation of Information on Application

Dear Ms. Peterson:

During a recent review of claims for services received while a member of Coventry Health and Life Insurance Company ("Coventry"), under an individual policy issued to you, questions were raised pertaining to prior health and medical information disclosed on the Application Agreement for Individual Health Insurance ("Application") completed on 09/11/07.

A review of the Application you submitted revealed that "No" was answered to the following questions despite prior medical records showing diagnosis and treatment related to these questions.

Within the past five (5) years have you consulted or sought treatment, been diagnosed, had treatment recommended, received treatment or therapy, been surgically treated or been hospitalized for any of the following conditions?

"Currently taking prescription medication or receiving injection therapy."

- Physician notes during services rendered on 05/18/07 and 08/28/07 that you are taking Risperdal.

"Any pending or recommended surgery or procedure not yet performed, or have been advised to obtain equipment or services?"

- During date of service 08/28/07 a referral was made to a dermatologist due to the hyperpigmentation related to Risperdal therapy.

"Please list any medication you are currently taking, or have taken in the past twelve months."

- Prescriptions for Risperdal and Doxycycline Powder are noted during office services 05/18/07 and 08/28/07.

The statements and responses to health questions on the Application omitted the medical and prescription information listed above. This omission of information is a material misrepresentation. The agreement on the Application, signed by you, includes the statement, "I further understand that if any material information is omitted, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force."

In accordance with the terms of the Application, Sections 3.7 and 3.7.5.3 of your Individual Policy, and as permitted under Oklahoma law, your coverage under this Coventry Individual Policy is rescinded. Premium payments shall be refunded back to the effective date of 10/01/07, as if coverage had never been in force.

If you wish to Coventry reconsider this action, you may do so by sending a written request within 30 days to Coventry Health Care of Kansas, Inc., Attention: Compliance Department, 8320 Ward Parkway,

8320 Ward Parkway • Kansas City, Missouri 64114
816-221-8400 • Toll Free: 1-866-795-3995 • Web Address: www.chckansas.com

EXHIBIT

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September 10, 2008

Mr. Ronald Sipes
7421 S. 77th E Ave
Tulsa, OK 74133

RE: Allegation of fraudulent activity

Dear Mr. Sipes;

Through a review of a recent consumer complaint, Coventry Health & Life Insurance Company ("Coventry") found that you are in violation of the Broker Compensation Agreement ("Agreement"). Specifically, allegations indicate that an Application Agreement for Individual Health Insurance ("Application") was completed by your office without the applicant's review of the information or signature.

Section 5, Application / Enrollment Forms and Materials of the Agreement states, "Broker agrees not to sign on behalf of enrollee, nor to make any changes to any enrollment forms, risk assessment questionnaires, statements of health or any other forms or documents provided by Consumers or enrollees in connection with enrollment in MCO."

Coventry takes these allegations very seriously and insists that any such activity cease immediately. In accordance with Section 10.4, Termination for Breach or Other Cause, of the Agreement, such default must be cured within thirty (30) days of this written notice. If such default is not fully corrected, this Agreement will terminate in accordance with this Section.

Please provide Coventry with a written statement of the actions taken by you to correct this issue.

Thank you for your cooperation.

Sincerely,

A handwritten signature in black ink, appearing to read 'SR', is written over a horizontal line.

Steven Robino
Director, Regulatory Compliance

SR/jes

Cc: Ann Stoeppelwerth, Executive Director (Oklahoma)
Martha Hall, Consumer Complaints, Oklahoma Department of Insurance



SIPES INSURANCE AGENCY

7421 So. 77th E. Ave.

Tulsa, OK 74133

Tele: 918 294-9580

Fax: 918 250-8233

RECEIVED
SEP 22 2008
CHC-KS COMPLIANCE

September 18, 2008

RECEIVED
OKLAHOMA INSURANCE DEPARTMENT

OCT 20 2008

LEGAL DIVISION

Coventry Health Care
8320 Ward Parkway
Kansas City, MO 64114

Attn: Steven Robino, Director
Regulatory Compliance

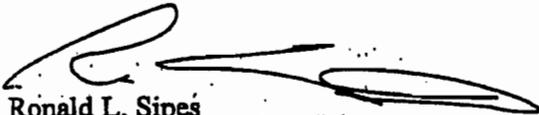
This letter is in response to your letter addressed to me, dated September 10, 2008.

I want to assure you that since July 10, 2008, when the Oklahoma Insurance Commission contacted me, we at Sipes Insurance Agency have ceased doing any applications without the insured filling out the application and/or signing it.

A Peterson incident will never happen again. We have new staff on board at the office and we hope to continue to write Coventry Insurance.

Thank you for your consideration in this matter.

Sincerely,


Ronald L. Sipes

EXHIBIT

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