MEMBERSHIP AGREEMENTS

I, the Named Primary Individual on the policy, agree to all the plan selections for myself and dependents. I agree and authorize to pay the monthly charges. I understand that I can cancel my subscription without penalty within the first 30 days, or following a qualifying event expressly noted by the federal government for health plans. After 30 days my subscription is in full force for the term of the contract (1-year), with automatic annual renewals on the anniversary of my effective enrollment month. To cancel my subscription during my renewal month I must inform InnovationsHR or its subsidiaries (Ovation Health, Kinetic Health, or Patient Physician Cooperatives) no less than 30 days before the next scheduled payment. Unless such notice is received, I agree to all authorized payments for my subscription.

SERVICES AGREEMENT

I agree to a one-year contract with my selected Providers for access to services related to the plan and any additional benefits I have chosen. I understand any requests to change providers prior to the end of my 12-month contract must be submitted in writing to be reviewed and approved by Member Services. I also understand that if I terminate this contract prior to 12 months that I may be legally responsible for the remaining subscription payments due.

TERMS AND AGREEMENT FOR BANK AUTHORIZATION

I authorize the financial institution named on the Payments Tab of this Application and pay these subscription charges. This authority is to remain in effect until revoked by me in writing, and until such notice is received. I agree that the plan provider shall be fully protected in honoring any such credit/debit card charge.

HIPAA AUTHORIZATION STATEMENT OF INTENT

It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act (HIPAA) that limits disclosure of my protected medical information. This authorization is being signed because it is crucial that my medical providers readily give my protected medical information to the plan provider designated in this authorization in order to allow me the advantage of being able to discuss and obtain advice from my family and/or friends. Therefore, pursuant to 45 CFR 164.501(a)(1)(iv) a covered entity (being a health care provider as defined by HIPAA) is permitted to disclose protected health information pursuant to and in compliance with this valid authorization under 45 CFR Sec. 164.508.

HIPAA AUTHORIZATION

I, The Named Primary Individual on the policy, hereby authorize all covered entities as defined in HIPAA, including but not limited to a doctor, (including but not limited to a physician, podiatrist, chiropractor, or osteopath,) psychiatrist, psychologist, dentist, therapist, nurse, hospitals, clinics, pharmacy, laboratory, ambulance service, assisted living facility, residential care facility, bed and board facility, nursing home, medical insurance company or any other health care provider or affiliate, to disclose the following information: All health care information, reports and/or records concerning my medical history, condition, diagnosis, testing, prognosis, treatment, billing information and identity of health care providers, whether past, present or future and any other information which is in any way related to my healthcare. Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information even if I am fully competent to ask questions and discuss this matter at the time. It is my intention to give a full authorization to ANY protected medical information to InnovationsHR or its subsidiaries (Including but not limited to: Ovation Health, Patient Physician Cooperatives, Kinetic Health).

TERMINATION OF HIPAA AUTHORIZATION

This authorization shall terminate on the first to occur of: (1) two years following my death or (2) upon my written revocation actually received by the covered entity. Proof of receipt of my written revocation may be by certified mail, registered mail, facsimile, or any other receipt evidencing actual receipt by the covered entity. This revocation shall be effective upon the actual receipt of the notice by the covered entity except to the extent that the covered entity has taken action in reliance on it. This authorization is not affected by my subsequent disability or incapacity.

HIPAA RE-DISCLOSURE

By signing this Authorization, I acknowledge that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the dependents, if any, also on this application, and the information once disclosed will no longer be protected by the rules created in HIPAA. No covered entity shall require my authorized persons to indemnify the covered entity or agree to perform any act in order for the covered entity to comply with this authorization. INSTRUCTIONS TO MY AUTHORIZED PERSONS My authorized persons shall have the right to bring a legal action in any applicable form against any covered entity that refuses to recognize and accept this authorization for the purposes I have expressed. Additionally, my authorized persons are authorized to sign any documents that the authorized persons deem appropriate to obtain the protected medical information.

VALID DOCUMENT

A copy or facsimile of this original authorization shall be accepted as though it were an original document.

WAIVER AND RELEASE

I hereby release any covered entity that acts in reliance on this authorization from any liability that may accrue from releasing my protected medical information and for any actions taken by my authorized persons.

The digital signature below indicates my understanding of this agreement and my promise to pay the rates advertised on the Companies’ Websites listed below, for the product(s) and product levels that I have chosen during this application process.

https://www.innovationsHR.com

https://ovation.health

https://www.patientphysiciancoop.com

https://www.kinetic-health.net

I, the named primary individual, agree to the above, am authorized to sign on behalf of any other persons on this policy, and agree that my Digital Signature suffices in place of a written signature.