Enrollment Form for Medical Insurance for Individuals and Families

AGENT/AGENCY INFORMATION

Agent Name: ______________________ Phone Number: ______________________

Agent Number: ______________________ E-mail Address: ______________________

Key Agency Contact: ______________________ Agency Name: ______________________

Fax Number: ______________________ Agency Number: ______________________

TYPE OF ACTIVITY *(Please check appropriate box.)*

☐ **NEW** *If not a new enrollee, check appropriate box and list affected policy number.*

☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** ______________

- ☐ Internal Replacement
- ☐ Adding Dependent
- ☐ Removal of Tobacco Rates
- ☐ Applying for Preferred Rates
- ☐ Removal of Condition Specific Deductible or Special Exception Rider
- ☐ Removal/Reduction of Special Class Premium
- ☐ Conversion (over age dependent/divorce)
- ☐ Policy/Benefit Change to an Existing Policy
  List Type Of Change Requested: __________
- ☐ Reinstatement of Coverage

PERSON(S) TO BE INSURED

	Name: *Last*	Name: *First*	Name: *M.I.*	Sex	Age	Birthdate *(MM/DD/YY)*	State of Birth	Height	Weight	Social Security Number
1. PRIMARY										
2. SPOUSE										
3. DEPENDENT(S)	Name: *Last*	Name: *First*	Name: *M.I.*	Sex	Age	Birthdate *(MM/DD/YY)*	Full-time Student?	Height	Weight	Social Security Number

4a. Resident Address: ____
(Street) *(City)* *(State)* *(ZIP)*

4b. E-mail Address: ____

5. Does any proposed insured live outside the above household? .... ☐ Yes ☐ No

If "Yes," explain. ____

6. Phone Number: (________) ______________________ Please list the phone number that would be the best to reach you during the day to inquire about medical history. (________)______________________

Insurance Specialties www.insspecial.com 800-789-0182

7a. **Primary Insured** Occupation: ______________________________

Company Name: ______________________ Work Number: (______) ______________

Duties: ______________________________

Is the Primary Insured self-employed? ☐ Yes ☐ No

Is the Primary Insured covered by Workers' Compensation? ☐ Yes ☐ No

7b. **Spouse** Occupation: ______________________________

Company Name: ______________________ Work Number: (______) ______________

Duties: ______________________________

Is the Spouse self-employed? ☐ Yes ☐ No

Is the Spouse covered by Workers' Compensation? ☐ Yes ☐ No

COMPLETE IF REQUESTING LIFE INSURANCE COVERAGE

8. Beneficiary for Primary Insured: ______________________________
(Full Name) *(Relationship)*

Contingent Beneficiary: ______________________________
(Full Name) *(Relationship)*

The Primary Insured is the beneficiary of any Spouse or Child(ren) Life Insurance.

OTHER COVERAGE IN FORCE OR APPLIED FOR

9. Are any of the proposed insureds covered by, or has application been made for any type of medical insurance? ☐ Yes ☐ No
If "Yes," complete the section below.

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date *(MM/DD/YY)*	Termination Date *(MM/DD/YY)*	Is this coverage being replaced by proposed coverage?

10. Were all proposed insureds covered under the prior plan listed above? ☐ Yes ☐ No
If "No," list those not covered. ______________________________

HAZARDOUS ACTIVITIES

11. Have any of the proposed insureds ever participated in organized racing including but not limited to, automobile, motorcycle or powerboat racing or any of the following activities: skydiving; ultralight flying; scuba diving; hang gliding; rock or mountain climbing? ☐ Yes ☐ No

If "Yes," indicate:

Who and Which Activity	When/How Often	Do you plan continued participation?
		☐ Yes ☐ No
		☐ Yes ☐ No

Insurance Specialties
7505 State Hwy 37 / PO Box 275
Purdy MO 65734
800-789-0182
www.insspecial.com

BILLING

☐ Monthly Check-O-Matic ☐ Quarterly ☐ Semi-Annual ☐ Annual ☐ List Bill *(monthly only)*

Credit Card: ☐ First Payment Only* ☐ Quarterly ☐ Semi-Annual ☐ Annual

**With this option, you must select a secondary billing mode for subsequent payments. Please make selection above and provide all necessary information.*

If billing address is different than resident address, please complete:

____

Payor Name Address City State ZIP

AUTHORIZATION FOR CHECK-O-MATIC BILLING ONLY - *Choose the following option that applies:*

☐ **To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day (1-28): __________

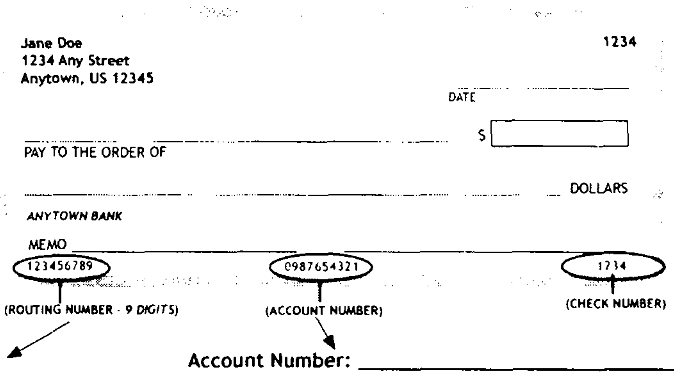
Bank Name: ______________________________

City: ____________________ State: __________

☐ **To add this policy to an existing Check-O-Matic:**

Existing COM Number: ____________________

Associated Policy Number: ____________________



Routing Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ **Account Number:** ____________________

Check-O-Matic *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

______________________________ ______________________________

Signature of Payor Date Signed

AUTHORIZATION FOR CREDIT CARD PAYMENTS

When selecting MasterCard/VISA Card: I authorize Assurant Health to charge my account for the Individual Medical policy listed above. I understand there will be no refund of premium after the 10-day free look period in the contract.

☐ VISA Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

☐ MasterCard Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Exp. Date: _____ / _____

Name as it appears on card: ______________________________

Signature of Payor: ____________________ Date: ____________________

HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the opportunity to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure (Form JI-1033).

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

____

Member Signature Date

Assurant Health 501 West Michigan Milwaukee, WI 53203 Fax 414-299-6020

Insurance Specialties
7505 State Hwy 37 / PO Box 275
Purdy MO 65734
800-789-0182
www.insspecial.com

HEALTH STATEMENT

IMPORTANT! PLEASE GIVE COMPLETE DETAILS OF EACH "YES" ANSWER ON THE "ADDITIONAL MEDICAL DETAILS" PAGE.

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

12. HAD ANY DIAGNOSIS OF, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYSICIAN CONCERNING:

a) The lungs or respiratory system including but not limited to: hayfever or other allergies; sinus infections; asthma; bronchitis; tuberculosis; pneumonia or emphysema? ☐ Yes ☐ No

b) The heart or circulatory system including but not limited to: high blood pressure; heart attack; heart murmur; chest pain; irregular heartbeat; varicose veins; phlebitis or elevated cholesterol? ☐ Yes ☐ No
If "Yes," please provide last known blood pressure and cholesterol reading on the "Additional Medical Details" page.

c) The digestive system including but not limited to: ulcer; gastritis; heartburn; intestinal disorder; colitis; gallbladder; hemorrhoids; hernia; disorder of the pancreas; spleen; or liver including but not limited to; hepatitis; jaundice or cirrhosis? ☐ Yes ☐ No

d) The nervous system including but not limited to: epilepsy; seizures; unconsciousness; convulsions; vertigo; headaches; paralysis; multiple sclerosis; cerebral palsy; Parkinson's disease; stroke or mini-stroke; TIA or brain attack? ☐ Yes ☐ No

e) Mental disease or nervous disorder including but not limited to: any emotional disorder; anxiety; depression; attention deficit disorder; eating disorder; or psychiatric treatment or counseling? ☐ Yes ☐ No

f) Congenital disorder, birth defects or developmental disorders including but not limited to Down Syndrome; mental retardation; autism; cleft palate; club foot; or congenital heart defects? ☐ Yes ☐ No

g) The genitourinary system including but not limited to: any kidney disorder; kidney stones; cystitis; prostatitis; bladder infections; or sexually transmitted disease? ☐ Yes ☐ No

h) Diabetes, high or low blood sugar or any disorder of the thyroid gland or other glandular disorder? ☐ Yes ☐ No

i) The muscular, skeletal or connective tissue disorder including but not limited to: arthritis; lupus (SLE); temporomandibular joint disease (TMJ); any back or spine disorder or treatment of any muscular or neuromuscular disorder or any manipulation therapy? ☐ Yes ☐ No

j) Blood or lymph disorders including but not limited to anemia or lymphadenopathy? ☐ Yes ☐ No

k) Cancer? ☐ Yes ☐ No
If "Yes," provide location, type of cancer and treatment received on the "Additional Medical Details" page.

l) Tumor, cyst or growth of any kind; any breast or skin disorders? ☐ Yes ☐ No
If "Yes," provide location, state if treated or removed and date on the "Additional Medical Details" page.

m) Any disorder of the eyes; ears (including ear infections or ear tubes); nose or throat. Tonsils or adenoids; any speech or hearing impairment? ☐ Yes ☐ No

n-1) Any disorder of the reproductive organs, including but not limited to: disorders of the penis; testes; vagina; ovaries and cervix; uterus; diagnosed or treated for infertility or irregular menstruation? ☐ Yes ☐ No

n-2) To the best of your knowledge, are you, your spouse or any dependent now pregnant? ☐ Yes ☐ No

IF N-2 IS ANSWERED "YES," MEDICAL COVERAGE CANNOT BE ISSUED.

QUESTIONS N-3 - N-5 FOR FEMALE APPLICANTS:

n-3) Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage? ☐ Yes ☐ No

n-4) Date of Last Pap Smear: ______________ Results: ______________________________

n-5) Have you been instructed to have a repeat Pap Smear or any follow-up treatment or tests as a result of your last Pap Smear? ☐ Yes ☐ No

13. Been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) by a member of the medical profession? ☐ Yes ☐ No

14. Been diagnosed as having or been treated for any immune deficiency disorder by a member of the medical profession? ☐ Yes ☐ No

15. Experienced any of the following: Signs and symptoms of an immune deficiency disorder may include lymphadenopathy (swollen lymph nodes); loss of appetite; weight loss; chronic fatigue; fever; oral thrush; skin rashes; unexplained infections; dementia; depression; or other psychoneurotic disorders with no known cause? ☐ Yes ☐ No

16. Had surgery or has diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed? ☐ Yes ☐ No

HEALTH STATEMENT *CONTINUED*

17. Does any person have any fixation/prosthetic devices present including but not limited to: plates; screws; pins; implants (including breast implants); shunts; pacemakers or valve replacements? .... ☐ Yes ☐ No
18. Had an electrocardiogram, chest x-ray, or blood test or any other diagnostic testing of any kind or been hospital confined in the past 10 years? .... ☐ Yes ☐ No

    If "Yes," give name of physician or hospital and results on the Additional Medical Details page.
19. Been a member of Alcoholics Anonymous or had any treatment, including but not limited to, counseling for alcoholism or alcohol abuse or been advised by a physician to discontinue or decrease alcohol consumption? .... ☐ Yes ☐ No
20. Used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs; or received treatment for drug abuse or chemical dependency? .... ☐ Yes ☐ No

ADDITIONAL QUESTIONS

21. To the best of your knowledge, does any person to be insured have any mental or physical impairment, disease or deformity not indicated above? .... ☐ Yes ☐ No

22a. Have you or your spouse (if to be insured) smoked cigarettes or used tobacco in any form or nicotine substitute within the past year? PRIMARY INSURED .... ☐ Yes ☐ No

SPOUSE (if to be insured) .... ☐ Yes ☐ No

22b. Have you or your spouse EVER smoked cigarettes or used tobacco products? .... ☐ Yes ☐ No

If "Yes," indicate who, amount per day and year quit on the Additional Medical Details page.

23. Is any proposed insured currently taking, or taken within the past 12 months, any prescription medication, or receiving medical treatment of any kind? .... ☐ Yes ☐ No

    If "Yes," provide details of treatment including name and dosage of all medications on the Additional Medical Details page.

REQUESTING THE REMOVAL OF A SPECIAL CLASS PREMIUM, SPECIAL EXCEPTION RIDER OR CONDITION SPECIFIC DEDUCTIBLE

24. Has there been any medical treatment or medication use for, or have you consulted with a physician concerning the condition(s) which has had a Condition Specific Deductible, been ridered or rated since the covered person's effective date? .... ☐ Yes ☐ No

    If "Yes," provide details on the Additional Medical Details page.

OTHER PHYSICIANS

25. Regular physician or medical practitioner for each proposed insured. If none, provide last physician seen, date, reason and results.

    Primary Proposed Insured's Physician ____________________

    Address ____________________

    Date Last Seen__________ Reason & Results ____________________

    Spouse's Physician ____________________

    Address ____________________

    Date Last Seen__________ Reason & Results ____________________

    Child's Name____________________ Physician ____________________

    Address ____________________

    Date Last Seen__________ Reason & Results ____________________

    Child's Name____________________ Physician ____________________

    Address ____________________

    Date Last Seen__________ Reason & Results ____________________

    Child's Name____________________ Physician ____________________

    Address ____________________

    Date Last Seen__________ Reason & Results

ADDITIONAL MEDICAL DETAILS

Attach a separate sheet if additional space is needed. Date and sign any additional sheets.

	Provide Dates, Type of Treatment and Results	Name of Doctor or Hospital, and Complete Address and Phone Number
Person: Condition: Question #:		
Person: Condition: Question #:		
Person: Condition: Question #:		
Person: Condition: Question #:		
Person: Condition: Question #:		
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HIPAA ELIGIBILITY

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the following statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

☐ **No, I or anyone to be insured do not meet one or more of the foregoing requirements.**

☐ **Yes, I or anyone to be insured meet all of the foregoing requirements.**

AUTHORIZATION

I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. The enrollment form and any amendments shall be the basis for the contract. I also agree that:

Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage will become effective on the later of: A) The date we receive the enrollment form; B) the requested Effective Date. A change in the health of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company. The contract may only be effective prior to the contract delivery subject to the terms of the Conditional Receipt.

I agree that a photographic copy of this authorization shall be valid for two years from the date signed.

I acknowledge receiving the notification regarding the Medical Information Bureau, the Abbreviated Notice of Insurance Information Practices and the Outline of Coverage for Health Insurance, if required.

We, the undersigned Proposed Insured(s) and agent, acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of enrollment, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.

____
Signature of Primary Proposed Insured

____
Signature of Spouse or Other *(if proposed to be insured)*

____
Signature(s) of Other Dependent(s) 18 or Over
(if proposed to be insured)

____
Guardian's Signature

Requested Effective Date: ______________

Premium Amount Sent: $ ______________

One-time Processing Fee Sent*: ______________
Not applicable in all states

Conditional Receipt Taken: ☐ Yes ☐ No

________ ________ A.M. / P.M. ________ ________
Date Signed | Time Signed | City | State

Attention: (Agent)

I have reviewed this enrollment form to ensure that all required items have been completed.

To the best of knowledge, there ☐ IS ☐ IS NOT a replacement of medical insurance involved in this transaction.

Are you aware of any mental or physical impairment, disease, or deformity of any proposed insured which is not disclosed on the enrollment form? ☐ Yes ☐ No

If "Yes," please explain. ______________

____

____
Licensed Resident Agent's Signature

____
Print Agent's Name

________ Initial here if you witnessed the signing of this form by the proposed insured.

Insurance Specialties www.insspecial.com 800-789-0182

ADDITIONAL NOTICES

NOTIFICATION REGARDING ("MIB") formerly known as the MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734.

Time Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

CONDITIONAL RECEIPT

This Conditional Receipt is received from ______________________________, this __________ day of

______________ *(month)* ____________ *(year)*.

If full premium is paid and Time Insurance Company accepts this application as applied for within (30) days of the date the application is signed, the effective date will be as specified above, but I agree that I have no insurance coverage under this application until Time Insurance Company notifies me in writing that my application is approved. No agent or broker of the Company is authorized to alter or waive the conditions of this conditional receipt.

For coverage to become effective, each individual to be covered must be a risk acceptable to Time Insurance Company as applied for and at a standard or preferred rate with no Special Exception Riders on the later of: the Requested Effective Date or the Date on which Time Insurance Company receives the application at its home office.

I understand that Time Insurance Company has the right to deny my application and if it does so I will be notified in writing and the premium I submitted will be returned.

If I do not select an effective date, Time Insurance Company will assign an effective date that is later than the date the application is approved.

I must advise Time Insurance Company of any change in information included in the application for me or any person to be insured that occurs after the date I sign the application until the later of the effective date of coverage or the date Time Insurance Company receives the application at its home office. Failure to update Time Insurance Company regarding these changes may result in coverage being voided.

Health Advocates Alliance Membership Application

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the right to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure, form JI-1033.

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored programs or benefits.

____

Member Name (please print)

____

Member Signature   Date

Form #26594

Insurance Specialties
7505 State Hwy 37 / PO Box 275
Purdy MO 65734
800-789-0182
www.insspecial.com

Authorized Representative Form

Complete and mail this form to:
Assurant Health, PO Box 354, Milwaukee, WI 53201-0354
or as otherwise directed

This form is used to confirm a Member's permission that Assurant Health* may discuss or disclose his/her protected health information to a particular person who acts as his/her Authorized Representative. Use of his/her information is strictly limited to that purpose described below.

Section A: Member Information

By signing this form in Section E below, I understand and agree that Assurant Health may release my personal health information as defined in Section B below to my Authorized Representative(s) named in Section C below.

Member Name:

Address:

Telephone Number: Member ID Number:

Last (4) Digits of Social Security Number:

Section B: Type of Information

- Personal Health Information, including, but not limited to, identification of treating providers of care, diagnoses, procedures, demographic information (but not including any psychotherapy notes).

Section C: Authorized Use and / or Disclosure

Intended Use or Disclosure:

I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination or payment of my health plan benefits. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my personal health information may no longer be protected by those privacy laws and my personal health representative may further disclose my personal health information without my authorization. I acknowledge that my authorization is voluntary.

Authorized Representative:

Name: **Phone Number:**

Address:

Relationship to You:

Section D: Expiration and Revocation

This authorization to release information to my Authorized Representative will automatically expire one year following the termination of my relationship with Assurant Health.

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain my Authorized Representative, I must revoke this authorization in writing by giving written notice of my decision to the Privacy Office, Assurant Health, P.O. Box 3050, Milwaukee, WI 53201-3050. I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Section E: Signature / Authorization

I have had full opportunity to read and consider the content of this Authorized Representative Form. I confirm that this authorization is consistent with my request. I understand that, by signing this form, I am confirming my authorization that Assurant Health may use and/or disclose my personal health information to the person(s) named in Section C for the purpose described above.

Signature: Date:

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION FORM AFTER YOU SIGN IT.

* Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, Union Security Insurance Company, and John Alden Life Insurance Company.
Form 28315 (Rev. 7/2008)

AUTHORIZED REPRESENTATIVE FORM

PLEASE RETURN THE SIGNED AUTHORIZATION FORM TO THE CONTACT PERSON LISTED BELOW.

Contact person:

Name: ______________________________

Address: ______________________________

Fax: ______________________________

Insurance Specialties
7505 State Hwy 37 / PO Box 275
Purdy MO 65734
800-789-0182
www.insspecial.com

ASSURANT Health

Missouri Preferred Rating Questionnaire

Complete this questionnaire to determine eligibility for the **Preferred** or **Preferred Smoker** rating classes. This questionnaire is part of the Enrollment Form for medical insurance made to Time Insurance Company for

__________________________________.
Primary Proposed Insured's Name

If a proposed insured meets any of the following conditions, that proposed insured is not eligible for a preferred rating:*

- **Condition Specific Deductible** (C-section, hazardous activities, hearing loss, inguinal and umbilical hernias, infertility and fractures may still qualify for preferred)
- **Special Exception Rider** (C-section, hazardous activities, hearing loss, inguinal and umbilical hernias, infertility and fractures may still qualify for preferred)
- **Special Class Premium**

*Note: A proposed insured *may* be eligible for a Preferred Smoker rating if he or she is able to truthfully answer questions 2, 3 and 4 "No." Underwriting reserves the right to apply tobacco ratings based upon lab results, phone verification or medical records.

Each proposed insured must complete and sign the appropriate sections. Spouses are considered separately for preferred rating eligibility and must also answer this questionnaire. This information is not required for dependents.

	PRIMARY	SPOUSE
1. Has the proposed insured used tobacco products at any time during the past 3 years? (If NO, go to question 5.)	☐ Yes ☐ No	☐ Yes ☐ No
2. Did the proposed insured previously smoke or do they currently smoke 10 or more cigarettes per day?	☐ Yes ☐ No	☐ Yes ☐ No
3. Did the proposed insured previously smoke or do they currently smoke more than 1 cigar or pipe per day?	☐ Yes ☐ No	☐ Yes ☐ No
4. Did the proposed insured previously use or do they currently use chewing tobacco?	☐ Yes ☐ No	☐ Yes ☐ No
5. Is the proposed insured currently outside the weight range listed in the build chart on the reverse side?	☐ Yes ☐ No	☐ Yes ☐ No
6. Has the proposed insured had blood pressure readings in excess of 140/90 or been treated for elevated blood pressure in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
7. Has the proposed insured had cholesterol readings above 220 or a cholesterol/HDL ratio above 3.5 or been treated for elevated cholesterol or triglycerides within the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
8. Has the proposed insured had a complete physical exam within the past 3 years?	☐ Yes ☐ No	☐ Yes ☐ No

Primary Proposed Insured Signature *Date* *Spouse or Other Insured Signature* *Date*

Driver's License Number *Driver's License Number*

Licensed Agent Signature *Date* *Agent Number*

Form 26660 (Rev. 6/2006)

Assurant Health 501 West Michigan Milwaukee, WI 53203 Fax 414-299-6020
Assurant Health markets products underwritten and issued by Time Insurance Company.

Insurance Specialties
7505 State Hwy 37 / PO Box 275
Purdy MO 65734
800-789-0182
www.insspecial.com

BUILD CHART

Male		Female	
Height (ft, in)	Weight (lbs)	Height (ft, in)	Weight (lbs)
5'0"	98 - 152	4'10"	90 - 138
5'1"	101 - 155	4'11"	92 - 140
5'2"	103 - 159	5'0"	94 - 143
5'3"	105 - 162	5'1"	96 - 146
5'4"	107 - 166	5'2"	98 - 150
5'5"	110 - 171	5'3"	101 - 153
5'6"	112 - 175	5'4"	104 - 158
5'7"	115 - 181	5'5"	107 - 163
5'8"	118 - 186	5'6"	109 - 168
5'9"	121 - 191	5'7"	112 - 173
5'10"	124 - 197	5'8"	115 - 178
5'11"	126 - 203	5'9"	117 - 185
6'0"	129 - 208	5'10"	119 - 192
6'1"	132 - 215	5'11"	122 - 197
6'2"	135 - 220	6'0"	123 - 202
6'3"	139 - 226	6'1"	126 - 207
6'4"	143 - 232	6'2"	130 - 213
6'5"	146 - 240	6'3"	134 - 219

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Underwriting Authorization

Application Number *(if known)* ______________________

Name of Proposed Insured(s): ______________________
(PLEASE PRINT)
____

Address: ______________________
____
____

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give Time Insurance Company (or any consumer-reporting agency authorized by Time Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded Personal Health History, Part 1 and any amendments shall be the basis for the contract. I also agree that: (1) Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to Time Insurance Company. (2) Except as otherwise provided in the Conditional Receipt, the insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company and accepted by me. (3) I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. (4) If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

I hereby authorize any health care provider or medically related facility, pharmacy or pharmacy related facility, the Medical Information Bureau, Inc., consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, EMSI and its agents.

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs. This information may also be disclosed to the Medical Information Bureau, Inc. and any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. A copy of this authorization will be valid as an original.

I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me and/or my minor children or for Time Insurance Company's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: 30 days after denial of my application, or declination of enrollment, or, if insured, 30 days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than 24 months from the date signed.

______________________ ______________
Signature of Primary Proposed Insured or representative* Date

______________________ ______________
Signature of Spouse or Other Insured (s) or representative* Date

______________________ ______________
Signature of Other Dependents 18 or over (if proposed to be insured) Date

*If you are the individual's representative and are not the parent or legal guardian of a minor, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

PLEASE RETAIN A COPY FOR YOUR RECORDS **PLEASE FAX TO: 414-299-6020**