Requested Effective Date			Note	**Certificate/ Policy Number**
Month	Day	Year	**Note:** Effective date is assigned by Time Insurance Company. The effective date is the later of: 1. The day after: a) the date this form is signed; b) the date this form is postmarked for mailing to Time Insurance Company; or c) the date we receive your enrollment request by electronic transmission in our home office, OR 2. If dates cannot be determined, the day we receive this form by mail. **The agent cannot assign an effective date different than this.**	

Applicant's Name (print last, first, middle)	Gender	Birth Date	Social Security Number

Street Address	City, State, ZIP Code

Spouse's Name (if to be insured)	Gender	Birth Date	Social Security Number

Children (Name) (if to be insured)	Birth Date	Name	Birth Date	Name	Birth Date
1.		2.		3.	

Note: The plan cannot be issued if **YES** is answered to any questions. Under no circumstances can coverage become effective prior to the date this application is signed.

Answer the following questions completely and accurately. **YES** **NO**

1. Have/Are you, your spouse, or any person to be insured: .... ☐ ☐
   - ◆ over 300 pounds if male, or over 250 pounds if female?
   - ◆ now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?
2. For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for: .... ☐ ☐
   - ◆ heart disorder?
   - ◆ emphysema, Chronic Obstructive Pulmonary Disease (COPD)?
   - ◆ Crohn's disease, ulcerative colitis or hepatitis B or C?
   - ◆ AIDS or tested positive for HIV?
   - ◆ stroke?
   - ◆ diabetes, except Gestational Diabetes?
   - ◆ cancer or tumor except Basal Cell Skin Cancer which has been removed?
   - ◆ alcoholism, chemical dependency, drug or alcohol abuse?

Deductible Amount	Payment Option and Length of Coverage	Coinsurance	Total
☐ $ 1,000* ☐ $ 2,500 ☐ $ 3,500 * *Available only with 50% or 80% Coinsurance*	☐ Single Payment – Total number of days needed ______ ☐ Monthly Payment – Coverage is needed for: up to 6 months (30-180 days)	☐ 100%* ☐ 80% ☐ 50% * *Not available with the $1,000 deductible*	

OPTIONAL RIDERS ***(Additional premium required)*** I hereby select these optional benefits:
☐ Breast Cancer Treatment Benefits ☐ Child Health Supervision Services Benefits ☐ Speech and Hearing Benefits
☐ Diabetes Benefits ☐ Mental Illness Benefits ☐ Lead Poisoning Screening Benefits

Ins-Special, Inc
7585 State Hwy 37 / PO Box 218
Purdy, MO 65734
[illegible]
800-785-0182

The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. The undersigned also understands that this is not a continuation of any previous medical plan, including any prior Short Term Medical plan. If I am self employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (Internal Revenue Code sections 106,125,162 or 213).

Primary Physician's Name (if any)	Primary Physician's Telephone Number
Applicant's Signature	**Today's Date**

Day Telephone Number	Evening Telephone Number

Form 28786.MO (Rev. 1/2009)

Electronic Policy Option

I would like to receive my policy and the company's "Notice of Privacy Practice" via the Internet.................................... ☐ Yes ☐ No

To receive policy delivery via the Internet, you must provide your email address in the space to the right. ➡

Email Address

Payment Information

Step 1: Select a Method of Payment:

☐ MasterCard ☐ Visa ☐ Check Automatic charge: ☐ Checking ☐ Savings account

(Only available with the Monthly Payment Option)

When submitting via paper application, please submit first month premium via check along with a separate voided check

Bank Routing Number:________________ Account Number:________________

▼ Enter your Credit Card information here ▼

Card # ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐ Exp. Date: _____/_____

Authorized Amount $ __________ (Insert Initial Premium Payment Amount)

Important Reminders: The application fee is non-refundable. There will be no refund of premium after the 10-day free look period in the contract.

Step 2: Authorization

- **When selecting the single payment option with MasterCard/Visa:** I authorize Assurant Health to charge my account for the Short Term Medical policy listed above.
- **When selecting the monthly payment option with MasterCard/Visa or Automatic Charge to a checking or savings account:** I authorize Assurant Health to charge my account each month for the Short Term Medical policy listed above, until the end of the policy or until I request cancellation in writing. I understand I can request the charge be stopped if I notify Assurant Health seven days in advance of the charge occurring.

Account Holder's Signature	Date	App Source
Agent Name	Agent ID#	Confirmation Code (home office use only)

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company. (January 2010)

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy, MO 65734
service@insspecial.com
800-789-8182

Missouri

Chart 1 - Primary Insured/Spouse Daily Rate

AGE	Deductible $1,000	Deductible $2,500	Deductible $3,500
0-14	1.25	0.95	0.80
15-19	1.55	1.25	1.10
20-24	1.50	1.10	0.95
25-29	1.38	0.97	0.95
30-34	1.41	1.10	1.05
35-39	1.78	1.26	1.15
40-44	2.11	1.52	1.31
45-49	2.51	1.75	1.50
50-54	3.36	2.51	2.16
55-59	4.42	3.26	2.81
60-64	7.08	5.07	4.37

Chart 2 - Dependent Child Daily Rate

AGE	Deductible $1,000	Deductible $2,500	Deductible $3,500
Per Child	0.96	0.60	0.60

Chart 3 - Deductible and Coinsurance Factor Table

	Deductible $1,000	Deductible $2,500	Deductible $3,500
50%	.80	.80	.80
80%	1.00	1.00	1.00
100%	N/A	1.25	1.25

Premium Calculation Instructions

Refer to charts on the left when figuring the premium

Step 1. Choose a payment option single or monthly	Single Payment	Monthly Payment
Step 2. List each applicant's daily rate. Rate chart is set up by age and deductible*. **a) Primary insured rate** .... **b) Spouse rate** .... **(see Chart 1)** **SUBTOTAL =**	______ +______ ______	______ +______ ______
Step 3. List the per child rate (Chart 2). Enter the number of dependent Child(ren). Multiply the rate by the number of children. **SUBTOTAL =**	______ x______ ______	______ x______ ______
Step 4. Add the subtotal from Step 2 & 3. =	______	______
Step 5. Monthly factor. Multiply by the subtotal in Step 4. SUBTOTAL =	x 1.00 ______	x 1.28 ______
Step 6. Zip Code Factor. Multiply by subtotal in Step 5. SUBTOTAL =	x 2.08 ______	x 2.08 ______
Step 7. Enter the number of days of coverage. Multiply the number of days by the subtotal in Step 6. SUBTOTAL =	x______ Minimum 30 Maximum 180 ______	x 30 ______
Step 8. Coinsurance. Enter the Coinsurance Factor (Chart 3). Multiply by the subtotal in step 7. **SUBTOTAL =**	x______ ______	x______ ______
Step 9. Application Fee** *(Non refundable)* Add fee to subtotal in Step 8. TOTAL =	+ $25.00 ______	+ $25.00 ______
*Choose one deductible amount per policy ** Application fee is added to first month's premium only	**Enter this amount on the enrollment form in the box marked TOTAL**	

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