



Missouri Health Access Plan A

No medical questions to qualify

Thank you for applying for health insurance through Assurant Health. Review the Assurant Affordable Health Access product brochure so you understand the benefits and limitations of Health Access Plan A. Talk to your agent to make sure the limited-benefit plan you're applying for is best suited to your needs.

Follow these steps to enroll now!

- 1. Decide who you want to cover** — just you, you and your spouse, just your children, or your entire family. If more than one adult person is applying, choose the youngest adult as the primary applicant.
- 2. Decide if you want additional options** — you'll find value in:
 - **SuiteSolutions™** — help pay out-of-pocket health related expenses by purchasing an upgraded membership to the basic Health Advocates Alliance membership.
 - **Dental-Vision Discount Plan** — this is a discount plan (not insurance) for your entire family.
- 3. Calculate your total premium** — transfer the monthly rate / fee from the prior selections to the calculation table to determine your total monthly premium.
- 4. Start the application process for Plan A.**
- 5. For quick approval, fully complete the enrollment form with your agent, including:**
 - All required questions
 - Requested effective date
 - Signatures — which are required for all applicants age 18 and older (child-only policies need a parent or guardian signature)

Agent: Leave this sheet with your client



Get quick pricing information on Assurant Affordable Health Access Plans by choosing from the options listed below. For the rates and optional coverage, circle the monthly rate and then copy the numbers into the CALCULATE YOUR TOTAL PREMIUM box on Page 2.

Be sure this name matches the primary applicant's name on the enrollment form, Line 1.

Complete the details below for the Primary applicant:

PLEASE PRINT

Last Name First Name MI Date of Birth State of Residence

Attention Agents: Be sure the Rate Sheet is complete and fax both pages, along with the enrollment form, to 414-299-6020. Provide your name and contact information to your client (you also can stamp the back of the brochure).

1. Choose who will be covered and the age of the primary applicant:

Circle the monthly rate of the coverage that applies.

If more than one adult person is applying, choose the youngest adult as the primary applicant. For child-only plans, the youngest is the primary applicant.

Table with 6 columns: AGE (0-17, 18-30, 31-40, 41-50, 51-63) and 6 rows of coverage options with corresponding monthly rates.

This membership is required; see footnote*.

Table with 2 columns: HEALTH ADVOCATES ALLIANCE (HAA) MEMBERSHIP* - REQUIRED and \$4.00 per month (circled).

See Page 2 for additional options and to calculate your premium

This Rate Sheet is for use with product brochures and state variations which contain details of Assurant Affordable Health Access Plans and the optional benefits. The rates for this limited-benefit plan are only valid for plans issued with effective dates from September 1, 2009, and later. Rates quoted more than 30 days in advance of the requested effective date are subject to change and are not guaranteed. Issuance of coverage is subject to approval. This proposal is not an insurance contract. Only the actual contract provisions apply. The effective date of the quote does not guarantee coverage and is subject to change. Rates are based on primary's age as of the effective date of the plan. Final rates may vary. All rates are subject to underwriting approval. *Membership in Health Advocates Alliance is required to obtain the opportunity to access this health insurance coverage. Fees paid for membership in Health Advocates Alliance are used for benefits, marketing, distribution and administrative expenses. Assurant Health may also realize some benefit from these fees. Assurant Health is the brand name for products underwritten and issued by Time Insurance Company. Form 29901 (Rev. 7/2009) © 2009 Assurant Inc. All rights reserved.

Last Name First Name MI Date of Birth State of Residence

2. Make your coverage even more valuable with these options:

To upgrade your Health Advocates Alliance membership, circle the rate that corresponds to the desired benefits level. Circle the "Family" column if your selected medical plan covers more than one person.

SuiteSolutions® - Enhance your coverage with this membership that can protect you financially from expenses due to accidents

SecureSolution Accident Medical Expense Benefit Level	Monthly Fee to Upgrade HAA Membership	
	Single	Family
\$2,500	\$29.95	\$39.95
\$5,000	\$33.95	\$43.95
\$10,000	\$38.95	\$53.95

NOTE: SuiteSolutions benefits are provided through membership in Health Advocates Alliance. Accident Medical Expense benefits are underwritten by National Union Fire Insurance Company of Pittsburgh, a member of American International Group, Inc. (AIG).

The primary applicant must sign and date here **only** if you have selected a SuiteSolutions upgraded membership level in HAA.

I have requested an upgraded membership level in Health Advocates Alliance. I understand that the Association membership fees that were included in my quote will be collected on behalf of the Association along with my insurance premium and are non-refundable.

Signature (required)

Date Signed

To add the Dental-Vision Discount Plan, circle the rate.

DENTAL-VISION DISCOUNT PLAN

The Dental-Vision Discount Plan covers everyone in your household. The Dental-Vision Discount Plan is a discount program and is not insurance. It is not available in AK, FL, MT, ND, NH, NV, SD, or WY.	\$9.95 per month
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3. Calculate your total premium

BENEFITS	MONTHLY RATE/FEE
Health Access Plan A Monthly Rate	
Health Advocates Alliance (HAA) Membership Fee	+ \$4.00
SuiteSolutions Upgraded HAA Membership Fee	+
Dental-Vision Discount Plan	+
TOTAL MONTHLY PREMIUM	=

Health Access Plan A

Enrollment form for limited benefit health insurance

PLEASE PRINT IN BLACK INK

PERSON(S) TO BE INSURED

Attach a separate sheet, signed and dated, if additional space is needed below.

Only complete the spouse and dependent information if it applies.

	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	
1. Primary						
2. Spouse						
3. Dependents (list relationship below)	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	Full-time student?

4. Resident Address: _____
(NO P.O. BOXES) (Street) (City) (State) (ZIP)

5. Phone Number: (_____) _____

6. E-mail Address: _____

7. Work Number: (_____) _____

REQUESTED EFFECTIVE DATE

8. Requested effective date _____

Your effective date is based on the date you sign your enrollment form. If you sign it on the 1st through the 15th of the month, your effective date will be the 1st of the following month. If you sign the enrollment form on the 16th through the 31st of the month, your effective date will be the 15th of the following month. Check with your agent for more details.

FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO 414-299-6020

BILLING

You have four choices for billing. It's important to note we'll request funds as soon as we issue your policy.

We recommend you pick an EFT draft date that is the same as your effective date.

The accountholder's signature is needed here if requesting EFT.

You have two options if choosing to pay by credit card – recurring or 1st payment only.

The cardholder's signature is needed here if requesting to pay by credit card.

Please complete this if your billing address is different than your home address.

You have four billing methods to choose from:

1. Monthly payroll deduction (list bill)

- Assigned list bill number, if known: _____
Note to agent: this option requires the employer have a List Bill agreement on file.

2. Monthly Electronic Funds Transfer (EFT)/Check-O-Matic

- To begin withdrawals:
Select a desired withdrawal date 1-28: _____
Bank name: _____
City: _____ State: _____
Routing number: _____
Account number: _____
- To add this policy to an existing EFT:
Existing EFT number: _____
Associated policy number: _____

Jane Doe
1234 Any Street
Anytown, US 12345 1234

DATE: _____

PAY TO THE ORDER OF: EXAMPLE \$ _____

ANYTOWN BANK

MEMO: _____

123456789 0987654321 1234

Routing Number Account Number
9 digits

Authorization for EFT – please sign 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.

Accountholder Signature: _____ Date: _____

- ### 3. Credit card
- Choose how often: Quarterly Semi-Annual Annual
or
→ Charge first payment only*

**You must also select a secondary billing method for subsequent payments.
Once you choose below, go to that section and complete.*

Choose method: Monthly EFT Bill me directly

Authorization for credit card payments – please sign below

I authorize Time Insurance Company to charge my account for the individual medical policy. I understand there will be no refund of premium after the 10-day free look in the contract.

Card number: _____ - _____ - _____ - _____

Card type: MasterCard VISA

Expiration date: ____/____

Name as it appears on card: _____

Address of cardholder, if different: _____

Cardholder signature: _____ Date: _____

- ### 4. Bill me directly:
- Choose how often: Quarterly Semi-Annual Annual

If your billing address is different than your home address, please enter it here:

Billing Address: _____
(Street) (City) (State) (ZIP)

Name of person paying, if different: _____

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HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION

Membership in Health Advocates Alliance (HAA) is required to apply for individual medical coverage. Enrollment starts at the low cost of \$4.00 per month. Your signature is needed here to complete HAA enrollment.

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

HIPAA ELIGIBILITY

Complete this section to help us determine if you're eligible for a HIPAA plan with no pre-existing condition limitation.

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 below statements are true at the time you or anyone to be insured applies 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 any of the above requirements.

Yes, I or anyone to be insured meet all of the above requirements.

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

By checking "yes" here, you agree that the insurance you're applying for will not be paid for by an employer.

You understand and agree that you are applying for individual limited benefit health insurance for you (and your family). You further understand that this application for health insurance is subject to eligibility requirements. You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? Yes No

Signatures are needed in this section. It's important to note you are applying for limited benefit health insurance. Coverage comes with a 10-day free look.

AUTHORIZATION

My enrollment form, recorded Authorizations and any amendments shall be the basis for the contract.

The insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The effective date is assigned by Time Insurance Company. The first full premium must be paid. A change in the eligibility 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. 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.

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

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

I acknowledge that I have read the completed enrollment form. I attest that all statements and answers on this enrollment form are complete, true and correct. I understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form, recorded Authorizations 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 understand that the coverage offered provides LIMITED BENEFITS and has specific benefit limitations.

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

Premium Amount Sent: \$ _____

Date and Time signed (including a.m./p.m.)

City and State signed in

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.

Licensed Resident Agent's Signature

Print Agent's Name

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

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ARE YOU AN EXISTING CUSTOMER?

Policy # _____

What do you want to do?

Internal Replacement

Conversion (over-age dependent/divorce)

AGENT/AGENCY INFORMATION

You don't need to do anything here. Your agent will complete this section.

Agent Name: _____

Agent Number: _____

Key Agency Contact: _____

Fax Number: _____

Phone Number: _____

E-mail Address: _____

Agency Name: _____

Agency Number: _____

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IMPORTANT NOTICES – LEAVE WITH CUSTOMER

These additional notices provide you with more information on your rights, fraud and privacy. Keep this sheet for your records.

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.

LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX