ASSURANT Health

Georgia Preferred Rating Questionnaire

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

______________________________________.
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:*

- **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 any citations for DUI or more than 1 moving violation including speeding ticket(s) within the past 2 years?	☐ Yes ☐ No	☐ Yes ☐ No
9. 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*

Assurant Health markets products underwritten by Time Insurance Company.
Form 29214 (Rev. 2/2006)

PDF processed with CutePDF evaluation edition www.CutePDF.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

Application Form for Medical Insurance for Individuals and Families

Time Insurance Company
501 West Michigan
Milwaukee, WI 53203
Fax: 414-299-6020

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 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 / First / 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 / First / 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. (________)______________________

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

OTHER COVERAGE IN FORCE OR APPLIED FOR

8. 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?

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

10. Have any of the proposed insureds ever been declined, postponed, charged an extra premium or had a portion of coverage excluded for life, disability, or medical insurance or had such coverage rescinded? ☐ Yes ☐ No
    If "Yes," give details. ______

HAZARDOUS ACTIVITIES AND DRIVING

11. Have any of the proposed insureds ever in the past 10 years 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

12. Have any of the proposed insureds been cited for driving while intoxicated in the past 5 years or had 2 or more moving violations in the past 2 years? ☐ Yes ☐ No
    If "Yes," indicate type of violation: ______ Date(s): ______

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: ___________

Jane Doe
1234 Any Street
Anytown, US 12345
1234
DATE
PAY TO THE ORDER OF $
EXAMPLE
DOLLARS
ANYTOWN BANK
MEMO
123456789 0987654321 1234
(ROUTING NUMBER - *9 DIGITS*) (ACCOUNT NUMBER) (CHECK 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 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:

13. 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

n-3) Is any person not named on this application form now pregnant by any person to be insured?...... ☐ Yes ☐ No

IF EITHER N-2 OR N-3 IS ANSWERED "YES," MEDICAL COVERAGE CANNOT BE ISSUED.

QUESTIONS N-4 – N-6 FOR FEMALE APPLICANTS:

n-4) Complications of pregnancy, including but not limited to caesarean section delivery or miscarriage? .... ☐ Yes ☐ No

n-5) Date of Last Pap Smear: ________________ Results: ________________________________

n-6) 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

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

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

16. 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

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

HEALTH STATEMENT *CONTINUED*

18. 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
19. 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.
20. 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
21. Used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs; or received treatment for drug abuse or chemical dependency? .... ☐ Yes ☐ No

ADDITIONAL QUESTIONS

22. 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

23a. 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

23b. 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.

24. Is any proposed insured currently taking, or taken within the past 12 months, any prescription medication, or receiving medical treatment of any kind or is currently taking, or taken, any non-prescription medication on a daily basis? .... ☐ 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 OR SPECIAL EXCEPTION RIDER

25. Has there been any medical treatment or medication use for, or have you consulted with a physician concerning the condition(s) which has 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

26. 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/Hospital and Complete Address and Phone Number
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
Person: **Condition:** **Question #:**		
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Person: **Condition:** **Question #:**		

AUTHORIZATION

I represent to the best of my knowledge and belief, that all statements and answers on this application form are complete and true. The application 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 application form; B) the requested Effective Date. A change in the health of the proposed insured(s) after the completion of the application 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 application form. We understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the application 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.

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 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: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Time Insurance Company.

____
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 application 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 application 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.

ADDITIONAL NOTICES

NOTIFICATION REGARDING 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 Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Time Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life, disability or medical insurance, or to whom a claim for benefits may be submitted.

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 application 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.

ASSURANT
Health

Underwriting Authorization

✻✻✻ IMPORTANT ✻✻✻

HIPAA Regulation: Please have your client sign this form along with the completed application/enrollment form. If we do not receive this signed form, the underwriting process could be delayed.

Name of Proposed Insured(s): ______________________________________

____

Address: ______________________________________

____

____

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 Assurant Health, its legal representative or any medical records retrieval service Assurant Health may engage, including, but not limited to, EMSI.

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, lab data and EKGs. This information may also be disclosed to any medical records company engaged by Assurant Health, 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 Assurant Health 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 Assurant Health to make eligibility or enrollment determinations relating to me and/or my minor children or for Assurant Health's underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, Assurant Health may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying Assurant Health in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Assurant Health, P.O. Box 3050, 501 West Michigan, Milwaukee, WI 53201-3050. Such revocation will not be valid if Assurant Health 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: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Assurant Health.

____
Signature of Primary Proposed Insured or representative*

____
Date

____
Signature of Spouse or Other Proposed 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

ASSURANT
Health

SuiteSolutions®

I hereby choose the following Health Advocates Alliance SuiteSolutions membership and benefit levels (please check the appropriate box):

SecureSolution	**Select**Solution
☐ $2,500 AME Benefit Level	☐ $2,500 AME and CIE Benefit Level
☐ $5,000 AME Benefit Level	☐ $5,000 AME and CIE Benefit Level
☐ $10,000 AME Benefit Level	☐ $10,000 AME and CIE Benefit Level

AME = Accident Medical Expense *CIE = Critical Illness Expense*

I understand that non-refundable dues are required for membership in the Health Advocates Alliance and authorize those dues to be billed and collected with my insurance premiums, if any.

I also understand that, if I fail to pay such dues, my membership will terminate and I will lose the right to participate in any of the association-sponsored programs or benefits.

Name (please print) Policy Number

Signature (required)

Date

SuiteSolutions benefits are provided through membership in Health Advocates Alliance. Accident and Critical Illness benefits are underwritten by National Union Fire Insurance Company of Pittsurgh, a member of American International Group, Inc. (AIG). National Union is rated A++ by A.M. Best Company.

Form 28611 (Rev. 9/2005)

ASSURANT Health

UMB

HSA TOOLS ENROLLMENT FORM

for your Health Savings Account
with UMB Bank, n.a.

Instructions: Please complete this page and submit along with the insurance application to the Underwriting Department. If the Enrollment Form is mailed, be sure to make a copy for your records. Retain the HSA Documents, Pages 1-6, for your records. **If you have any questions, please contact Assurant Health HSA Service toll-free at 866-899-6200.**

A. Individual HSA Account Owner Information: Note: Participants in an HSA generally cannot be covered by another health plan [other than the High-Deductible Health Plan ("HDHP")], except with respect to certain types of "permitted" insurance. Additional information is available in the Q & A on Federal Tax Aspects of Health Savings Accounts (the "HSA Q&As").

TITLE ☐ MR. ☐ MRS. ☐ MS. ☐ DR.	NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER – –
STREET ADDRESS, CITY, STATE, ZIP CODE (STREET MAILING ADDRESS NEEDED TO SET UP ACCOUNT, P.O. BOXES WILL NOT BE ACCEPTED.)			
MAILING ADDRESS, (IF DIFFERENT FROM ABOVE)	TELEPHONE NUMBER (DAY) ( )	TELEPHONE NUMBER (EVENING) ( )	

We comply with Section 326 of the USA Patriot Act, which includes collecting and verifying certain information about you when processing your account application.

B. Beneficiary Designation: (See HSA General Information in the HSA Documents section). The Account Owner has the right to designate one or more persons who are entitled to receive funds in this HSA Account on the Owner's death. Unless the Owner signs a separate Beneficiary Designation form for UMB Bank, n.a. (UMB) available on UMB's Web site or by calling UMB at 866-735-8567 and files the form with UMB prior to his or her death, the sole beneficiary for this HSA Account shall be deemed to be the Account Owner's estate.

C. HSA Deposit Account and Investment Options: All contributions to your Health Savings Account are initially made into an interest-bearing HSA Deposit Account at UMB Bank, n.a. If collected funds in the HSA Deposit Account exceed an amount (a "Peg Balance") that UMB establishes from time to time, other investment options may be available. See HSA General Information in the HSA Documents section for details.

D. Debit Card: Account Owner will be sent a Visa® HSA Debit Card (the "Card") that will access the HSA after this application has been approved. The Card will be governed by the Cardholder Agreement that will be sent with the Card. If a spouse is indicated on the insurance application and coverage was issued, a second card will be provided in the spouse's name. For the spouse to have access to HSA account information and have check writing capabilities, the spouse's signature must be included below. The signatures of the Account Owner and spouse also allow UMB to obtain a personal credit report on each person. If the Account Owner does not want a spouse, who is indicated on the insurance application, to receive a Card, the Account Owner must notify Assurant Health HSA Service at 866-899-6200.

The Account Owner can authorize someone other than a spouse to have account privileges. To allow Additional Authorized Signers, call Assurant Health HSA Service at 866-899-6200 or visit www.assuranthealth.com. Instructions on the Web site are located under the "My HSA" tab.

E. Account Owner's Adoption and Enrollment Agreement: The Account Owner named above hereby certifies that the information set forth on this Enrollment Form is correct, and that the Account Owner is applying to open a health savings custodial account ("HSA") at UMB Bank, n.a. ("UMB"). UMB is the custodian of your HSA, which consists of all the funds in your HSA Deposit Account with UMB, as well as of any other investments you make through UMB with your HSA funds. The HSA is opened in the State of Missouri and will be governed by the laws of Missouri, except to the extent that Federal law supersedes Missouri law. Account Owner acknowledges receipt of UMB's HSA Custodial Agreement, the HSA General Information and the HSA Deposit Account Terms and Conditions (together, the "HSA Documents"). Account Owner and all other authorized users of the HSA agree to be bound by all of the terms and conditions contained in the HSA Documents, as they may be amended by UMB from time to time. Account Owner also acknowledges receipt of UMB's Privacy Statement for Individuals and the HSA Q&As, which provide information about qualifications for opening an HSA under Federal law. Account Owner acknowledges that he or she has not relied on UMB for personal tax or insurance advice related to the HSA, but will rely on the advice of his or her own tax and insurance advisors relative to those matters.

Account Owner directs that all funds remaining in the HSA at his or her death will be paid to the surviving Beneficiaries (if any) as designated in a beneficiary designation filed with UMB prior to Account Owner's death or to the Account Owner's estate if no beneficiary is designated. Account Owner agrees to pay all fees applicable to the HSA, as set forth in the HSA Documents, and authorizes UMB to deduct such fees from the HSA. Account Owner understands and agrees that UMB may provide information about your Visa HSA Debit Card and your HSA to the Insurance Provider or Broker that provides your High-Deductible Health Plan or to its third party service provider and to any company that provides or services investments within your HSA, in order to make such services available to you.

Account Owner's W-9 Certification: Under penalties of perjury, I certify (1) that the Social Security Number shown above is my correct Social Security Number (interest paid, if any, will be reported under this number) and (2) that I am exempt from backup withholding, or I am not subject to backup withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding, and (3) that I am a U.S. person (including a U.S. resident alien). Certification Instructions: Cross out item (2) above if you have been notified that you are subject to backup withholding because of under reporting interest or dividends on your tax return.

Note: The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

Signature of Account Owner (needed to establish an HSA Account) Date

Signature of Spouse (needed for access to HSA Account information and for check writing privileges) Date

Form 28747 (Rev. 12/2005)

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