Tele-App Part 1 Enrollment for Medical Insurance for Individuals and Families

Agent Information

Agency Name _____ **Agency Number** _____

Agent Name _____ **Agent Number** _____

Agent Fax Number _____ **Agent Phone Number** _____

Agent E-mail Address _____

Person(s) To Be Insured

Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number
(Primary) 1.						
(Spouse) 2.						

3. Dependent Children

Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number

4. Resident Address (Street, City, State and ZIP code. No P.O. Boxes)

Street _____ City _____ State _____ ZIP _____

5. Home Phone Number _____ 6. E-Mail Address: _____

7. Are any of the proposed insureds covered by any type of medical insurance? ❑ Yes (complete section below) ❑ No (go to Billing)

Proposed Insured's Name	Insurance Company Name	Insurance Company Phone Number	Group (G) or Individual (I)	Type of Coverage	Effective Date	Term Date	Is this coverage being replaced by proposed coverage?

Billing

❑ Check-O-Matic
(Complete form on next page and 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.

x _____
Signature of Payor

x _____
Date Signed

❑ Quarterly **❑ Semi-Annual** **❑ Annual**
(If billing address is different than above, complete section below)

Name _____

Address _____

City _____ State _____ ZIP _____

REMEMBER TO FAX PAGES 1 & 2, AND THE SOFTWARE PROPOSAL!

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): _____

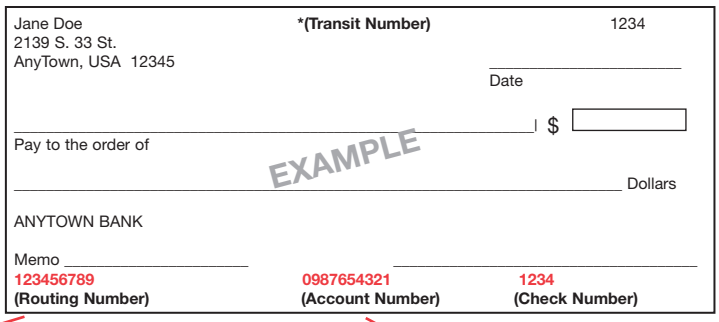
Bank Name _____

City _____ State _____

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

Existing COM Number _____

Associated Policy Number _____



Routing & Transit Numbers _____ Account Number _____

9 Digits

You must either submit a voided check, or complete the routing and account information. Do not send a deposit slip. Please print clearly.

Authorization To Obtain Medical Records and Attestation

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) I must call Time Insurance Company and complete the telephone portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto. (2) I understand that if at any time through the enrollment process any of the previous information provided becomes inaccurate or is updated, I have an obligation to contact Time Insurance Company and advise of such change. (3) 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. (4) 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. (5) 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. (6) 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.

_____ _____

Signature of Primary Proposed Insured

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

(Circle one)
A.M. / P.M.

_____ _____ _____ _____

Date Signed Time Signed City & State Requested Policy Effective Date

Conditional Receipt Given? ❑ Yes ❑ No

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

REMEMBER TO FAX PAGES 1 & 2, AND THE SOFTWARE PROPOSAL!

Conditional Receipt

This Conditional Receipt is received from _____, this _____ day of _____ month _____ year.

The proposed insured has authorized either an electronic transfer of funds or money in the sum of $_____ for the necessary amount of premium and/or any administrative processing fees, that will be paid in connection with completing a medical insurance enrollment form with Time Insurance Company.

No insurance will become effective prior to contract issue and acceptance by the proposed insured, except, insurance may become effective prior to the contract issue if and when each and every condition contained in this receipt is met. No agent or broker of the company is authorized to alter or waive any of the following conditions:

1. The proposed insured(s) must be, on the effective date, as hereinafter defined, a risk acceptable to the company under its rules, standards and practices for the exact contract and premium applied for, without any modification.
2. The amount of payment received with Part 1 or the actual withdrawal of funds by means of electronic transfer is an amount equal to the amount of the first full premium payment selected.
3. The proposed insured(s) must call Time Insurance Company and complete the telephone portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto.
4. The contract is issued exactly as applied for within 30 days from the date of commencement of the enrollment process. If the contract is not issued within 30 days from the date of commencement of the enrollment process, there will be no coverage provided under the terms of this onditional Receipt. Any coverage provided by the Conditional Receipt ends when the contract is delivered and accepted by you.
5. Proposed insured(s) completes all forms and provides all information required through the application and enrollment process.
6. Part 1 is submitted by an insurance agent or broker appropriately licensed to do business with the company and in the appropriate state jurisdiction.
7. Proposed insured(s) understands that if at any time through the enrollment process any of the previous information provided becomes inaccurate or is updated, he or she has an obligation to contact Time Insurance Company and advise of such change. Failure to do so may result in claim denial or rescission/revocation of coverage.
8. Within 30 days of policy issue, the proposed insured must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning the signed acceptance to Time Insurance Company.

If each of the above conditions is fulfilled, then the insurance as provided by the terms and conditions of the contract applied for will become effective on the effective date prior to the contract delivery. “Effective Date” as used herein means the later of a) the date of commencement of the enrollment process, or b) the requested effective date. If one or more of the conditions are not met, Time Insurance Company may rescind its offer of coverage and its liability shall be limited to the return of the sum received.

_____ _____

Proposed Insured Signature Agent Signature

Leave this Sheet with the Customer – Do Not Fax

Agent Name: _____
Last First

Agent Phone Number: _____

Personal Health History Interview
Applicant Instructions

Thank you for your interest in our individual medical insurance. In addition to Part 1 that you completed with your agent, this Personal Health History Interview will help us determine eligibility for health insurance. One of our representatives will conduct your interview.

Just follow these easy steps for a quick and accurate interview:

- ❑ **Choose one adult person who's applying for coverage to contact Assurant Health**.
- ❑ **Use this chart to provide information <u>on all applicants</u>**:

APPLICANT(S)	CURRENT HEIGHT & WEIGHT	BLOOD PRESSURE & CHOLESTEROL READINGS	LAST PHYSICIAN VISIT DATE (PAP RESULTS FOR FEMALES)	MEDICAL CONDITIONS IN PAST 10 YRS.	DATES WHEN SPECIFIC MEDICAL CONDITIONS OCCURRED	PHYSICIAN NAMES AND ADDRESSES	TYPES OF TREATMENT & NAMES AND DOSES OF MEDICATIONS

- ❑ **The caller will need to review the attached Medical Conditions list.** Please review all of the conditions and circle those that apply to each applicant. During your call, the representative will ask when the condition began, if it still exists and what type of treatment was provided.
- ❑ **Call within 10 days of completing the enrollment form with your agent.** This allows the terms of your Conditional Receipt to be honored.

- ❑ **Allow 20 minutes for the call**. Interview time may vary based on the number of proposed applicants and the extent of their medical conditions.
- ❑ **Dial 800-596-0049** to reach a representative for your interview.
- ❑ **Your agent will contact you** following the interview. Eligible applicants will be asked to attest to the interview information in writing.

Thank you again for choosing us for your health insurance.
Please keep this form for your records.

Assurant Health markets products underwritten by Time Insurance Company.

MEDICAL CONDITIONS LIST

Please review the following medical conditions and circle any that you or any person applying for coverage were diagnosed with, received treatment for, or consulted a physician for in the past 10 years. These conditions may be associated with the specific medical category under which they're listed. However, they are examples of the medical category and do not necessarily include all the conditions related to that category. Therefore, if you have a particular illness or condition which does not appear on the list or you are uncertain which category it's associated with, please tell your representative.

Lungs and Respiratory System

Hayfever/allergies	Tuberculosis	Emphysema
Sinus infections	Pneumonia	Sleep Apnea
Asthma	Pneumothorax	Chronic Obstructive Pulmonary Disease
Bronchitis	Other _____	

Ears/Eyes/Nose Disorders

Ear infections	Meniere's	Deviated Septum
Ear tubes	Tinnitus	Cataracts
Hearing loss	Labyrinthitis	Glaucoma
Speech/hearing impairment	Tonsils/adenoids	Other _____

Heart/Circulatory*

High blood pressure	Heart murmur	Elevated Cholesterol
Heart attack	Mitral valve prolapse	Peripheral vascular disease
Chest pain	Phlebitis	Irregular heart beat
Varicose veins	Other _____	

*Please provide the most current date and reading for blood pressure and cholesterol (including HDL, LDL and total cholesterol).

Blood pressure_____

Cholesterol_____

Diabetes/Thyroid

Diabetes	Hypothyroid	Goiter
High blood sugar	Low blood sugar	Hypoglycemia
Hyperglycemia	Hyperthyroid	Other _____

Blood/lymph/anemia

Anemia (type)	Swollen lymph nodes	Lymphadenaopathy
Other _____		

Cancer
Provide location, type of cancer and any treatment received. If you do not know the specific diagnosis, contact your physician for that information.

_____

_____

Tumor/Cyst/Growth

Tumor	Cyst	Polyp
Growth	Other _____	

Breast

Breast Implants	Fibrocystic breast disease	Other _____

Skin Disorders

Acne	Rosacea	Psoriasis
Skin cancer	Eczema	Other _____

Nervous System Disorders

Unconsciousness	Vertigo	Epilepsy/seizures/convulsions
Paralysis	Multiple Sclerosis	Headaches/Migraines
Cerebral palsy	Bell's palsy	TIA (transient ischemic attack)/brain attack
Stroke/mini-stroke	Parkinson's disease	Other _____

Mental/Nervous Disorders

Emotional disorder	Anxiety	Depression
Anorexia	Bulimia	Attention Deficit Disorder
Schizophrenia	Panic Attacks	Obsessive Compulsive Disorder
Dysthymia	Insomnia	Oppositional Deviant Behavior
Other _____		

Digestive Disorders

Ulcer	Gastritis	Heartburn
Intestinal disorder	Colitis	Gallbladder
Crohn's	Ulcerative colitis	Irritable Bowel Syndrome
Hemorrhoids	Hernia	Pancreas disorder
Spleen disorder	Liver disorder	Hepatitis
GERD	Jaundice	Cirrhosis
Other _____		

Bone/Muscle/Connective Tissue Disorders

Arthritis	Gout	Carpal tunnel syndrome
Low back pain	Fractures	Lupus/Systemic lupus erythematosus (SLE)
ACL tear	Spinal fusion	Joint replacement
Back/spine disorder	Manipulation therapy	Muscular/Neuromuscular disorder
Osteoarthritis	Herniated disc	Degenerative joint disease
Scoliosis	Sprain/Strain	Bunions
Bursitis/Tendonitis	Chronic Fatigue Syndrome	Other _____

Fixation /Prosthetic Device

Plates	Screws	Pins
Implants	Breast implants	Shunts
Pacemaker	Valve replacement	Joint replacement

Urinary System Disorders

Kidney stones	Cystitis	Bladder infections
Prostatitis	Glomerulonephritis	Nephritis
Kidney disorder	Other _____	

Reproductive System Disorders

Penis	Testes	Vagina
Ovaries	Cervix	Uterus
Infertility	Irregular Menses	Uterine fibroids
Endometriosis	Ovarian cyst	Sexually transmitted diseases (STDs)
Rectocele	Cystocele	Prolapsed uterus
PMS	Polycystic ovarian disease	Benign Prostatic Hypertrophy

Other _____

Complications of Pregnancy

Ectopic pregnancy	Miscarriage	Pre-eclampsia
Gestational diabetes	Pre-term labor	C-section

Other _____

Pap Smear (date of exam and results)

Cervical dysplasia	Cervicitis	Atypical squamous cells (ASCUS)
Inflammation	Cervical cancer	Other _____

Immune Deficiency

Swollen lymph nodes	Loss of appetite	Weight loss
Chronic fatigue	Fever	Oral thrush
Skin rashes	Unexplained infections	Dementia
Depression	Pneumonia	Psychoneurotic disorders

Congenital Disorders/Birth Defects/Developmental Disorders

Down syndrome	Mental retardation	Autism
Cleft lip/palate	Club foot	Congenital heart defects
Speech therapy	Occupational therapy	Physical therapy

Other _____

Diagnostic Testing

EKG (electrocardiogram)	Chest x-ray	Echocardiogram
Stress test	Angiogram	MRI
CT scan	Ultrasound	Mammogram
Colonoscopy	EGD (endoscopy)	Holter monitor
EEG	Bone density	Urinalysis
Blood test	Other _____	

Hazardous activity

Participation in any hazardous activity:

Automobile racing	Motorcycle racing	Powerboat racing
Skydiving	Ultralight flying	Scuba diving
Hang gliding	Rodeo participation	

Driving record

Any adverse driving history:

DUI (past 5 years)	Moving violations (past 2 years)	Speeding
Reckless driving		

Dates _____

Types of Violations _____