

AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY

39201 Seven Mile Road, Livonia, Michigan 48152-1094
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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT CERTIFICATION

This Certification is made a part of the application to which it is attached. It is subject to all provisions of the application not in conflict with the Certification.

The following statements must be true and correct to qualify for Health Insurance under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

1. I have 18 months of creditable coverage without a significant break in coverage. Creditable coverage includes health insurance coverage and other health coverage, such as coverage under group health plans, Medicare, Medicaid, and public health plans. A significant break in coverage is 63 days without any creditable coverage.
2. My most recent prior creditable coverage was under a group health plan, church plan, or governmental plan. A governmental plan is a plan for employees of government entities, not public welfare, Medicaid, Medicare or IHS.
3. I am not eligible for health insurance coverage under any of the following:
 - a. A group health plan
 - b. Part A or Part B of Title XVIII (Medicare) of the Social Security Act
 - c. A state plan under Title XIX (Medicaid) of the Social Security Act (or any successor program).
4. I do not have any other health insurance coverage.
5. I have not had my most recent coverage terminated because of nonpayment of premiums or fraud.
6. I have both elected and exhausted the COBRA continuation provision or any similar state program for which I am eligible.

ATTACH PROOF OF ELIGIBILITY FOR ALL APPLICANTS CURRENTLY APPLYING FOR COVERAGE

I certify that the above statements are true and correct.

Signature of Applicant	Date	Signature of Dependent (age 18 and over)	Date
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Signature of Spouse (if proposed for insurance)	Date	Signature of Dependent (age 18 and over)	Date
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AGENT CERTIFICATION

I certify that the above information is correct and true to the best of my knowledge and belief and that I witnessed the signatures above.

Agent Signature	Date
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Agent Name (Please Print)	Agent Number
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Any person, who with intent to defraud, or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.